



# Transitional Aged Youth

## Developmental Disabilities and Psychiatric Disorder

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### Outline

- Overview of the literature regarding transitional aged youth with dual diagnosis
- Introduction to the prevalent issues for assessment and treatment for this population
- Case examples

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### Prevalence

- High rates of mental problems in Canadian children; approx 14% have identified mental illness (Waddell et al, 2002)
- For children with ID, rates of psychopathology have been found 3-4 times higher, in the range of 30-50% (Dekker, 2002; Einfield, 1996, 2006; Wallender, 2003)
- Biological susceptibility and poor psycho-social resilience due to sheltered experiences and limited coping skills

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## Prevalence



- Major emotional and behavioural disturbances affect 40% of children with ID and their families (Einfeld, 2006)
- ADHD and Autism Spectrum Disorders were found the most prevalent diagnoses (Stromme & Diseth, 2000).
- Aggression and behaviour problems are the most prevalent referral problems for services

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## Definitional Difficulties



- Heterogeneity of Intellectual Disability
  - no one child is alike therefore generalisation of specific profile is difficult
- 'Moving Targets'
  - Developmental period of 'normal' milestones: developing self-identity, own sexuality and differentiation from others
  - Delayed intellectual development and emotional maturity

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## Definitional Difficulties



- Critical diagnostic period
  - Susceptibility to first episode psychosis/schizophrenia
  - Vulnerable to anxiety due to adolescent instability
  - Vulnerable to depression due to comparisons
- Scattered/uneven cognitive profile
  - Myth of 'flat profile'
  - More usual to have varied verbal/non-verbal profile – risk of under/over estimation

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## TAY clinic (YITC)



- Interprofessional clinical consultation service for adolescents with intellectual disabilities who present with emotional/behavioural difficulties. Query emerging mental health problems?
- Interdisciplinary assessment and treatment by Psychiatry, Psychology, Social Work, Occupational Therapy and Speech and Language Pathology
- Based on 2+1 consultation model (Heywood et al., 2003<sup>1</sup>; Street & Downey, 1996<sup>2</sup>)

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## TAY clinic (YITC)



- Initial two sessions focus on client/parental views of the problem, developmental history, etiology, working diagnosis and treatment needs/expectations
- Final consultation stresses an alliance with parents, facilitation of change and treatment recommendations
- Assessment and consultation model focuses on
  - an interactive referral process
  - understanding the family's perception of the problem
  - collaboration with parents in case conceptualization
  - developing a client-centered plan that meets parental expectations

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## TAY Clinical Issues



- Who is the client? Child or Parent or Family?
  - Can fluctuate between all
- Reliance on caregivers/third party informants
  - Biased information
  - influenced by perceived attributions of problem
- Consent issues: child to adult services
  - Capacity issues (personal, financial)
  - Consent to treatment

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## TAY Clinical Issues



- System navigation: health, social & education
  - Family physician, pediatrician, psychiatrist
  - Lead DS agency: SSAH, ASCD, Respite
  - Special education: IPRC, IEP
- Loss of education ministry for services
  - Transition into adulthood (day programming)
  - Educational buffer up to age 21

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## Who? 2010 TAY



- Children and Adolescents between 10-25
- All have confirmed ID and/or ASD
- Majority (52%) live with both parents
- Quarter (26%) live with single parent, grandparents, extended family or foster family
- Approx (17%) live in a group home eg CAS
- Others i.e transitional, hospital, spouse

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## Referral reasons



- Referrals from physicians: FP, pediatricians or C&A psychiatrists
- Aggression, behavioural problems, autistic behaviours, school difficulties, mood swings, sexual behaviours and legal conflict
- Query anxiety, depression, psychosis
- Existing diagnoses ADHD, ODD, behs
- Multiple medication trials: stimulants, anti-psychotics, anti-depressants, anti-convulsants

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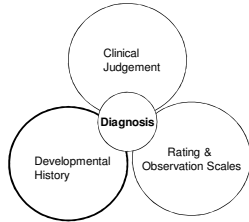
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## Assessment and Diagnosis



- Clinical Interview & Developmental History
- Informant Rating Scales
- Observation Scales
- Diagnostic Assessment



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## Assessment & Diagnosis



- Clinical interview and Developmental History
  - Caregiver: presenting problem, previous similar symptoms, successful strategies, predictability, 'subjective' examples
  - Client: insight, personal language, stress levels/situations, real life examples
  - Together initially and then seen individually
- Assessment scales/measures:
  - Mood questionnaires, symptom scales
  - behavioural assessment/ functional analysis (eg baseline data - ABC: profile, scatterplot: freq/sev)

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## Clinical Interview (BPS)



### PHYSIOLOGICAL:

- Mood, energy, motivation
  - e.g. non-compliant, oppositional to regain control, acquiescent
- Physical state
  - e.g. restless, agitation, 'eggshells', calm, disengaged
- Somatic states
  - e.g. stomachaches, breathing difficulties, panic attacks
  - Re/ship feelings/body

### BEHAVIOUR:

- Intolerance to unpredictability
  - e.g. seeks familiarity in routines, habits
- Difficult or disruptive behaviours
  - e.g. repetitive questions to seek reassurance of same response
- Loss of enjoyment in regular activities
  - e.g. time spent 'worrying' about 'what ifs'

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## Clinical Assessment: Red Flags



- Origin of referral: who is the client?
- Cloak of competence:
  - tendency to overestimate ability level due to perceived adequate social skills, discrepancy between verbal and performance ability
- Acquiescence/Suggestibility
  - tendency to give an affirmative response/tendency to be swayed and open to suggestion
- Communication difficulties:
  - limited verbal expression of subjective states, emphasis on concrete concepts, personalised vocabulary

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## Clinical Assessment: Red Flags



- Diagnostic overshadowing
  - tendency to attribute symptoms to MR/DD
- Unclear social/sexual boundaries:
  - lack of insight into social understanding & social roles due to sheltered experiences
  - increased prevalence of abuse history
- Behavioural Masking:
  - diagnostic difficulty with increased disability severity
  - emphasis on behavioural cues and subjective reports

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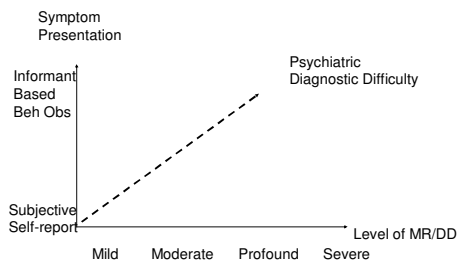
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## Assessment in Dual Diagnosis...



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## Assessment & Diagnosis



As a team develop:

- Clinical Formulation (Bio-psycho-social perspective & developmental framework)
- Working Hypothesis about treatment plan with combined behaviour program, medication protocol and rehabilitation program
- Evaluate implementation with data collection and regular clinical meetings

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## Treatment Planning



Treatment should be multi-dimensional and individually tailored rather than 'blanket' approach

- Diagnostic assessment and client/parental psycho-education
  - Explaining diagnoses in context to prognosis
  - Differentiating labels eg ID vs MID
- Psychotropic medication; addition/change plus supplemental medical investigations
  - Psychopharmacology (SSRI's, anti-psychotics, anti-convulsants, anti-anxiety)

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## Treatment Planning



- Behavioral intervention strategies and/or referral to local team
  - Psychotherapy (CBT, DBT and systemic)
  - Social stories, picture books and cartoons
  - Behavioral intervention: rehearsal, role-play and skill acquisition
- OT program: sensory assessment, ADL skill training, vocational/interests
  - Sensory assessments: under/over sensoryseeker, sensory diets
  - ADL's (cooking, budgeting, transportation, hobbies)

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## Treatment Planning



- SLP program: speech assessment, communication skills training eg ACS
  - Speech/articulation vs language impairments
  - augmentative communication: visual choice boards, PECS, sign
- Interprofessional systemic advocacy with schools
  - Liaison between health system and educational goals
  - Differentiating between treatment and support plans

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## Facilitating Management



- Ensure Treatment Cross-fertilization
  - monitoring of impact of behaviour program, rehab program, psychotherapy and/or medication protocol on symptoms/behaviours
- Environmental change sustainability
  - Realistic changes that can continue
  - Beyond assessment resources included
  - Build in 'road bumps' for resilience

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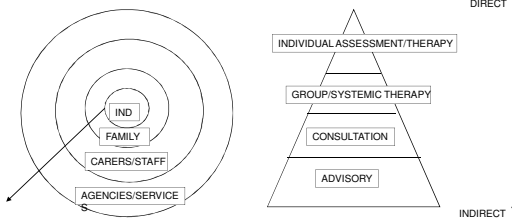
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## Treatment/ Management



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## Sustainability



- Individual: problem focused
  - Anger management, social skills
  - CBT, DBT
  - Behavioural strategies, positive behavioural support
- Families and care providers: solution focused
  - developmental & life-cycle issues (transitions)
  - inter-relationship/systemic (caregivers/family stress)
- Consultation and program evaluation
  - staff education/ training, service consultation

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## Case examples..



### Intellectual Disability & Challenging Behaviour

- 14 year old boy, Mod ID referred by CAS for severe aggression and SIB following hospitalization
  - Developmental history and behavioural/biomedical profile
  - Geddes seizure checklist and functional analysis of 'outbursts'
- 15 year old boy, Mod ID referred for aggression in group home
  - Medication review and sensory assessment
  - crisis protocol for 'addiction to restraints' and sensory diet
- 13 year old girl, Mild ID, Down, for absconding hypersexuality
  - Psychological assessment to identify 'cloak of competence'
  - Sensory assessment to address clothing sensitivity

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## Cases examples..



### Autism Spectrum Disorders

- 16 year old Aspergers boy referred by school following suspension for aggression and behavioural outbursts
  - Psychological assessment (NVLD), school conference
  - school reintegration with social stories scripts for EA
- 18 year old boy referred for speech diffs & social anxiety
  - Assessment and psychoeducation confirming ASD and OCD
  - Anxiety medication, anger management, ADL skill building
- 9 year old PDD boy referred for differential diagnosis of anxiety and behavioural problems
  - parental education about PDD and sensory issues
  - medication trial and individual counselling for client

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### Cases examples..

#### ID & Sexuality..

- 13 year old boy referred following threats and assault of a female student
  - School conference on diagnosis and emotional dysregulation
  - individual therapy on social-sexual issues
  - Parenting strategies for sexual education
- 16 year old girl referred for promiscuity & aggression
  - Confirmation of ID and low self esteem
  - Individual sexuality therapy, interest development, anger mgmt
  - Psycho-education for caregiver about over-expectations
- 18 year old male with sexual behaviours referred by CAS for offending risk
  - History review and normalization of 'normal' sexual behaviour
  - Differentiation of paraphilia and sexually inappropriate behaviour
  - Facilitation of risk assessment and management plan



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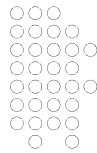
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***Thank you!***

Email: [jonesj@queensu.ca](mailto:jonesj@queensu.ca)



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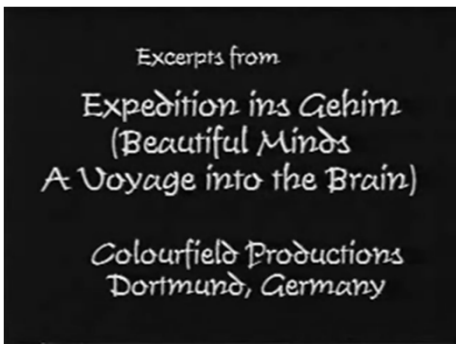
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### Eccentricity or Genius?



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