MENTAL HEALTH & INTELLECTUAL DISABILITIES

KRISTINA RANDALL, M.ED.
NICOLE BENVENUTO, B.S.
ERICA WALTERS, ED.S.
JOSEPH RYAN, PH.D.

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College of Education

WELCOME & INTRODUCTION
AGENDA

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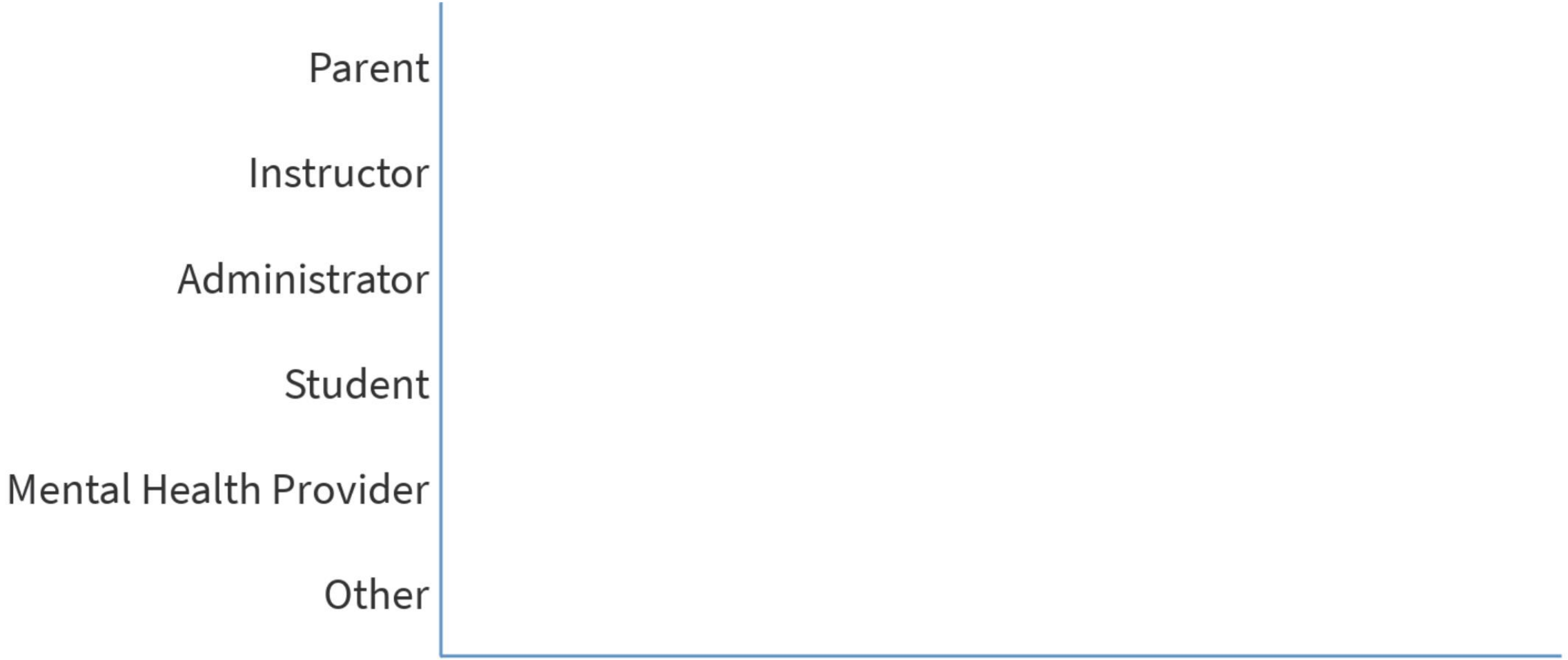
- Overview
- Mental Health & ID
- Screening
- Therapy Recommendations
- Resources
- Questions

I am a....

When poll is active, respond at **PollEv.com/tinarandall674** Text **TINARANDALL674** to **37607** once to join



WHAT IS CLEMSONLIFE?

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Serve:

- Students ages 18-26
- Intellectual disability

Teach:

- Employment skills
- Independent living skills
- Social skills
- Self-advocacy
- Functional academics

Goal:

- Competitive employment
- Independent living to the greatest extent possible.

	ClemsonLIFE	National Average (NLTS2)
Employment Rate	96% have been employed 84% currently employed	14-34%
Average Wage	$8.93	$7.82
Independent Living Rate	44%	21%

Program Overview

Currently 40 students in LIFE Program

- 13 Freshman
- 11 Sophomores
- 9 Juniors
- 7 Seniors

Two-year basic certificate program with optional invite-only two year advanced certificate program

BASIC PROGRAM

Freshman and Sophomores:

- Attend ClemsonLIFE classes
- Take 1 University leisure skills course
- Live on campus with an ILA (Independent Living Asst.)
- Participate in employment internship experiences
- Participate in cooking classes in their apartment
- Participate in various other service, volunteer, and social activities around campus

ADVANCED PROGRAM/TRANSITION

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- Students live off campus with no ILA
- Work 20+ hours a week
- Attend 1 University leisure skills course and/or traditional academic course
- Attend classes to refresh LIFE skills
  *Transition *Employment *Health/Wellness *Building Relationships
- Participate in cooking class in the apartments with food/science and nutrition students
- Participate in workouts, social activities/events, sporting events, etc.
- Receive (limited) supports in the apartment and employment settings

MENTAL HEALTH & ID

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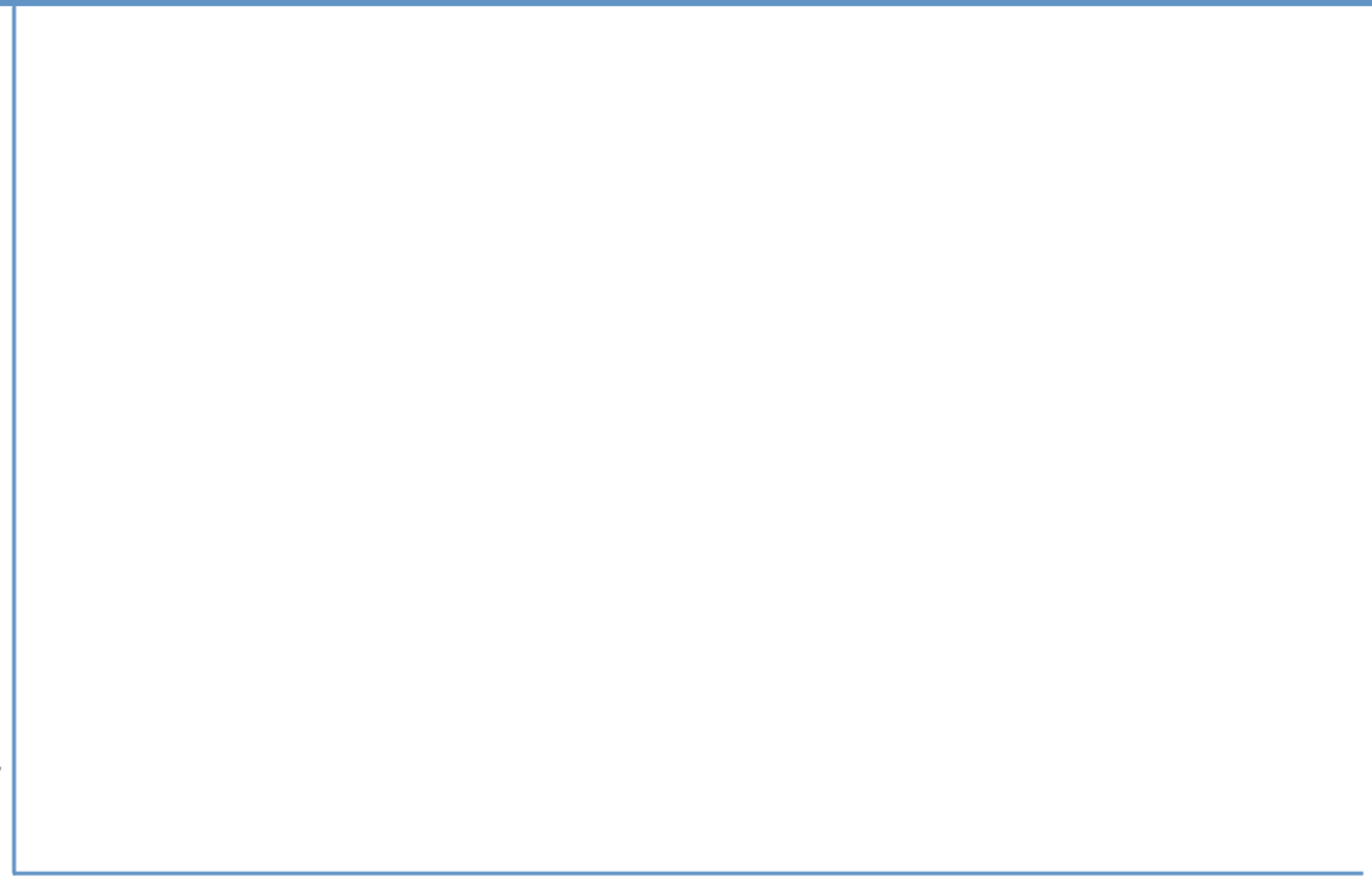
- Individuals with intellectual disabilities (ID) are classified typically by IQ, and often by a medical diagnosis (e.g., Downs Syndrome, Fragile X)
  - Mild ID - IQs range from 50-69
  - Moderate ID – IQs range from (36-49)
  - Severe ID – IQs range from (20-35)
  - Profound ID – IQs < 20
- Individuals with ID are at increased risk of mental health disorders

What IQ range do you primarily work with?



PREVALENCE

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- Nearly half (46%) of young adults with disabilities experienced a mental health concern (Poppen et al., 2016)
- Greater with individuals with ID – 55% experience a mental health condition (National Core Indicators, 2016)
- Additionally, individuals with ID experience depression and anxiety at a significantly higher rate than the general population (Davis, Saeed, & Antonaccci, 2008).
    - Also – mental health disorders in individuals with ID are more prevalent across ALL age ranges

What mental health concerns do you see?

DEPRESSION & ANXIETY

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- Rates of depression decrease with more severe ID – highest prevalence rates are with individuals with mild ID (Scott & Havercamp, 2015)
    - Much higher levels of depression across all levels of ID when compared to nondisabled individuals
- Individuals with ID experience comorbid anxiety disorders at a much higher rate than individuals in the general population (Davis et al., 2008)
    - Generalized anxiety disorder, obsessive-compulsive disorder, phobias

NONTYPICAL BEHAVIORS

- Presentation of symptoms is different (abnormal clinical presentation and challenging behavior)
  - Non-typical behaviors, or behaviors that are not normal for the individual
    - Stealing
    - Preoccupation with TV shows that include suicide
    - Start dressing differently

What types of behaviors are you seeing?

When poll is active, respond at **PollEv.com/tinarandall674**

Top

DIFFICULTY IN SCREENING

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- Screening for mental health disorders in individuals with ID is difficult for many reasons:
  - Lack of receptive and expressive language skills
  - Lack ability to self-reflect
  - Presentation of symptoms is different (abnormal clinical presentation and challenging behavior)

SCREENING TOOLS

- Due to the differing symptomology and presentation of mental health disorders in individuals with ID – modified screening measures have been developed (Davis et al., 2008)
  - **Mental Measurement Yearbook:**
    - Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996)
    - Reynolds Adolescent Depression scale (RADS-2; Reynolds, 1987, 1988)

SCREENING TOOLS

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- **Online availability:**
  - The Aberrant Behavior Checklist (ABC; Aman & Singh, 1985, 2017)
    http://www.slossonnews.com/ABC.html
  - Mood, Interest and Pleasure Questionnaire (MIPQ; Ross & Oliver, 2002, 2003)
    http://www.findresources.co.uk/professionals/login
  - Glasgow Anxiety Scale for people with ID (GDS; Cuthill, Espie, & Cooper, 2003)
    www.derbyshirehealthcareft.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=7840

GLASGOW DEPRESSION & ANXIETY SCALE

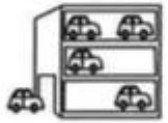
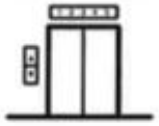
CUTHILL, ESPIE, & COOPER, (2003)

Glasgow Depression Scale

(score of 13 or over indicates depression).

In the last week...		Prompts	no	some times	a lot
1.	 Have you felt sad?	Have you felt upset, depressed, miserable, fed up, low?	0	1	2
2.	 Have you been in a bad mood?	Have you felt bad tempered, wanted to shout at people?	0	1	2
3.	 Have you enjoyed doing things?	Have you had fun?	2	1	0
4.	 Have you enjoyed talking and being with people?	Have you liked having people around?	2	1	0

GLASGOW ANXIETY SCALE

		Prompts.	no	some times	a lot
11.	 Are you scared of the dark?	Do you turn the lights off at night.	0	1	2
12.	 Do you feel scared when you are high up?	Do you like multi storey car parks.	0	1	2
13.	 Do you feel scared in lifts?	Would you get in one.	0	1	2
14.	 Are you scared of dogs?	Would you stroke one.	0	1	2
15.	 Are you scared of spiders?	Would you touch one.	0	1	2

CHALLENGES WITH DIAGNOSIS

- Diagnostic Overshadowing
  - Symptoms of a mental health disorder are attributed to the individuals disability
  - i.e., a mental health practitioner meets with an individual with Down's Syndrome who is displaying increased disruptive behavior, and accredits this behavior to the individual's disability.
    - Results in effectively covering up any co-morbid mental health diagnoses (Fletcher et al., 2009; Reiss et al., 1982)
  - Hurley & colleagues (2008) found that many patients in a study did not meet the diagnostic criteria for major-depressive disorder due to deficits in self-reporting or observational skills of caregivers.

Table 1.

Symptomatic Presentation of Depression in an Individual with ID

DSM Symptom for Depression	Presentation in Someone with ID	Presentation in Average Population
Psychomotor Agitation	• Restlessness, fidgety, pacing • Increased disruptive behavior	• Must be observable by others • Inability to sit still, pacing, hand-wringing, pulling or rubbing of clothing, skin or other objects
Psychomotor Retardation	• Sits for extended periods • Moves slowly • Takes longer than usual to complete activities	• Must be observable by others • Slowed speech, thinking, and body movements
Fatigue/Loss of Energy	• Needs frequent breaks to complete simple activity • Slumped/tired body posture • Does not complete tasks with multiple steps	• Person may report decreased energy, tiredness and fatigue. • Individuals may report that even the smallest tasks seem to take substantial effort. • The efficiency with which tasks are accomplished may be reduced.
Feelings of Worthlessness	• Statements like "I'm dumb", "I'm retarded", etc. • Seeming to seek punishment • Social isolation	• May include unrealistic negative evaluations of one's worth, guilty preoccupations or ruminations over minor past failings. • May have an exaggerated sense of responsibility for unfortunate events

Symptomatic Presentation of Depression in an Individual with ID

DSM Symptom for Depression	Presentation in Someone with ID	Presentation in Average Population
Lack of Concentration/ Diminished Ability to Think	• Decreased work output • Does not stay with tasks • Decrease in IQ upon retesting	• Easily distractible, impaired ability to think, concentrate or make even minor decisions • May complain of memory difficulties
Thoughts of Death	• Preoccupation with family member's death • Talking about committing or attempting suicide • Fascination with violent movies/television shows	• Thoughts of death, suicidal ideation or suicide attempts • Preoccupation with getting one's things in order (updated will, unsettled debts) • Belief that others would be better off if they were dead
Depressed Mood	• Frequent unexplained crying • Decrease in laughter and smiling • General irritability and subsequent aggression or self-injury • Sad facial expression	• Individuals may describe their mood as sad, discouraged, hopeless, "down in the dumps" • Individuals may report somatic symptoms (body aches and pains) • Some may report or exhibit increased anger and irritability
Loss of Interest in Pleasure	• No longer participates in favorite activities • Reinforcers no longer valued • Increased time spent along • Refusals of most work/social activities	• Feeling less interested in hobbies • "Not caring anymore" • Not feeling enjoyment in activities that were previously considered pleasurable.

Symptomatic Presentation of Depression in an Individual with ID

DSM Symptom for Depression	Presentation in Someone with ID	Presentation in Average Population
Weight Change/Appetite Change	• Measured weight changes • Increased Refusals to come to table to eat • Unusually disruptive at meal times • Constant food seeking behaviors	• Appetite changes may involve either a reduction or increase. • Individuals may report they have to force themselves to eat. • Others may crave specific foods or eat more (e.g., sweets)
Insomnia	• Disruptive at bed time • Repeatedly gets up at night • Difficulty falling asleep • No longer gets up for work/activities • Early morning awakening	• Typically takes the form of middle interminal insomnia (waking too early and being unable to return to sleep) • Initial insomnia (difficulty fall asleep may also occur
Hypersomnia	• Over 12 hours of sleep per day • Naps frequently	• Oversleeping may cause prolonged sleep episodes at night or increased daytime sleep

DIAGNOSTIC COMPANION TEXTS

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- The Diagnostic Manual – Intellectual Disability (DM-ID) corresponds directly with the DSMV

- The Diagnostic Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities (DC-LD) works in tandem with the International Statistical Classification of Diseases and Related Health Problems (ICD)

PROVIDING MENTAL HEALTH COUNSELING TO THE ID POPULATION

- ClemsonLIFE Counselor, Graduate Assistant
  - Individual sessions
  - Group class- social skills, relationships, emotions, etc.
  - Small groups- art therapy & guys group
  - CAPS

TRAINING

- Within the residency programs in the US, psychiatry of ID is much less represented (Ruedrich et al., 2007), than in other countries such as the U.K..
- More training days, the more confident professionals were in their skill and knowledge of treating individuals with ID who had mental health disorders (Werner, 2012).
- Attitudes toward working with individuals with ID need to be changed – Ruedrich et al., 2007 found that even with training many psychiatrists chose to not work with patients who had ID.
  - Training and programming in reducing negative attitudes should be included
- Direct contact and supervision with treatment of patients with ID

PROVIDING MENTAL HEALTH COUNSELING TO THE ID POPULATION

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- 46% of young adults with disabilities experience a mental health concern (Poppen et al., 2016)
- Is easily overlooked and underserved
- Same needs as the rest of us, if not more
- Need to become familiar with each individual to work effectively with them (strengths, weaknesses, etc.)

ASSESSING A POTENTIAL CLIENT

- Important to assess potential clients before determining if counseling is appropriate (Sturmey, 2004)
  - Ability to give informed consent (Hatton, 2002)
    - In a study of 40 individuals, Arscott et al. (1998) found that most participants were able to understand nature of study, but had limited understanding of risks, benefits, and their right to refuse or drop out of the study
    - Most difficult questions to answer were the ones concerning abstract thinking
- Also want to assess extent of communication skills and cognitive aptitude
  - Ability to recognize, learn, and apply different things addressed in counseling (Hatton, 2002)

MEDICATIONS & ID

Often jump to medicating without considering addressing the root of the problem

Combination of approaches, including use of pharmacological and psychosocial approaches have been used in the treatment of anxiety in individuals with ID

- Little or no research to support using antipsychotics in children (Findling et. al., 2005)
- Benzodiazepines used for a maximum of 3 weeks, and side effects are often under recognized (Antochi, Stavrakaki, Emery, 2003)
- Treatments that include multiple components (e.g., behavioral, psychosocial, pharmacological) are more effective in adults (Bogacki, Newmark, & Gogieneni, 2006)

EFFECTIVE THERAPY WITH ID POPULATION

1. Cognitive Therapy: used to treat **depression** (Sturmey, 2004)
2. Behavioral Therapy: effective with **phobias** (Rosen, Connell, & Kerns, 2016)
3. Cognitive Behavioral Therapy (CBT): used to treat **anger, depression**, **anxiety,** or **mood disorders** (Cooney, Tunney, & O'Reilly, 2017)
4. Applied Behavior Analysis (ABA):
   - **Goal-oriented** while breaking down into small tasks
   - **Positive reinforcement** used to teach and help reach goals

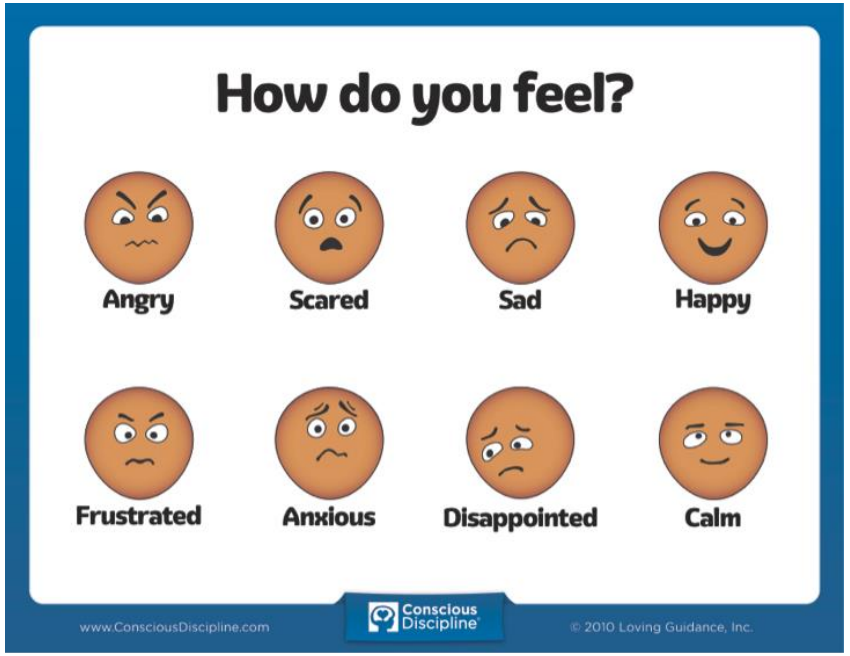
MODIFICATIONS TO THERAPY

1. Prime client
   - Properly prepare and explain procedures
2. Consistent routine
3. Provide calm environment
4. Parental involvement
   - Reinforce outside of counseling
   - Supported decision-making model

(Werner, Yalon-Chamovitz, Tenne Rinde, & Heymann, 2017)

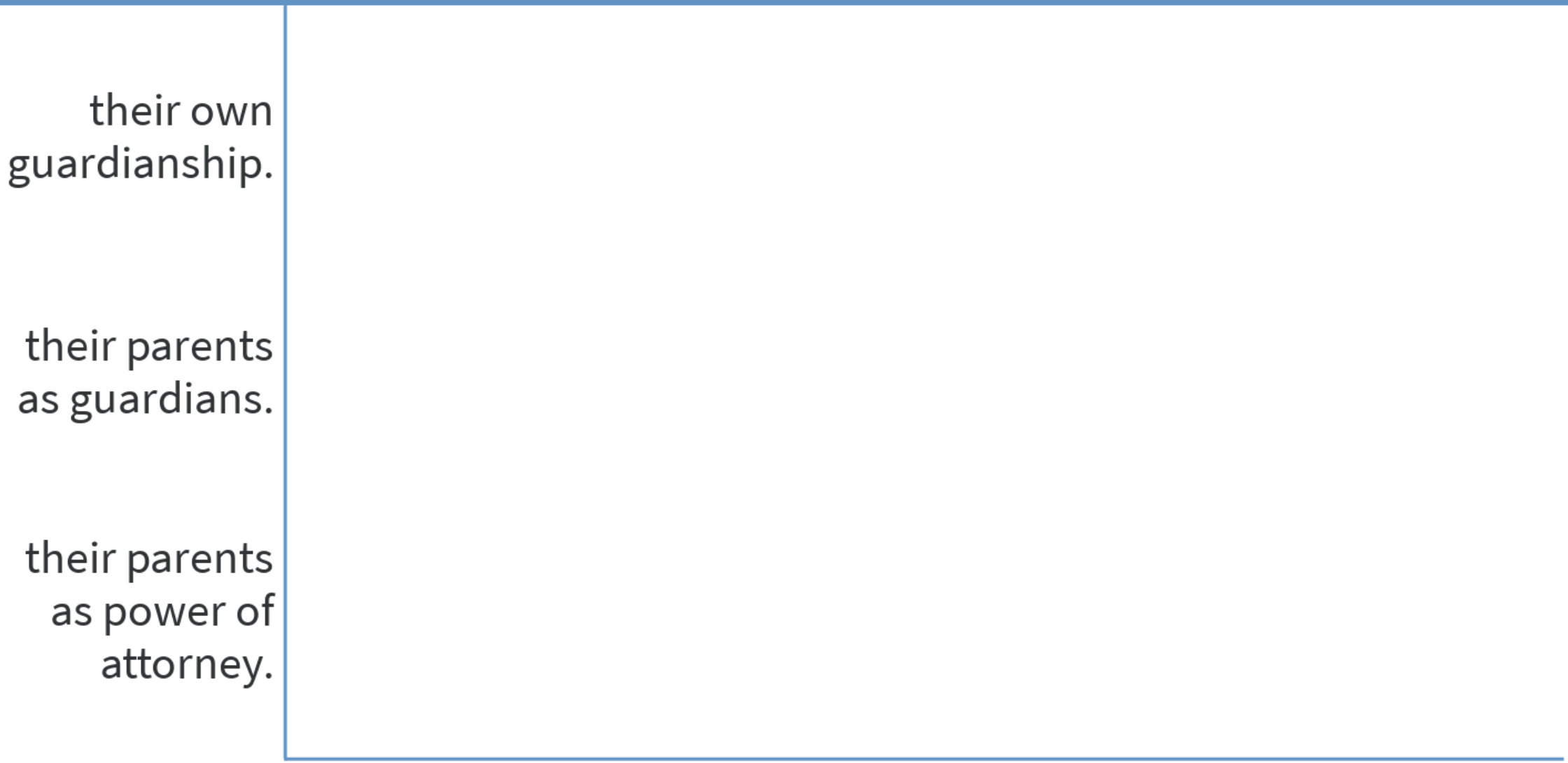
MODIFICATIONS TO THERAPY

1. Effective Communication Principles
   - Simplify language and adapt speech
   - Includes body language and gestures
2. Concrete examples
   - Pictures, role play
3. Shorter, more frequent sessions
   - Repetition is key



(Werner, Yalon-Chamovitz, Tenne Rinde, & Heymann, 2017)

My students mostly have...



THE PROBLEM WITH GUARDIANSHIP

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- Individuals with ID who are their own guardians, are able to consent for treatment as well as request others partake in their therapy sessions

- Individuals with ID who do not have legal guardianship, require their guardians to provide consent for treatments.
  - How does this work with asking others involved in the student's mental health program to be included in the therapy?

WHAT DOES THIS MEAN FOR MENTAL HEALTH?

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- Supported-Decision Making (SDM) states that the individual is the sole decision-maker (Dinerstein, 2012)
  - Point is to assist and support individuals with disabilities to make life decisions – for others to speak with the individual with ID, rather than speak for them
  - Helping to overcome communication barriers (interpreter assistance, assistive technologies, plain language)
  - Preventing and solving conflicts between supporter and supported person.
  - Implementing precautions

WHY IS SDM ALSO IMPORTANT??

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- Individuals who are their own guardian have higher self-determination.
- People with greater self-determination are:
  - Healthier
  - More independent
  - More well-adjusted
  - Better able to recognize and resist abuse

CASE LAW AND SUPPORTED DECISION-MAKING

- **<u>Terminology has been included in cases in:</u>**
  - Washington, D.C.
  - Tennessee
  - Kentucky
- **<u>Legal Cases currently pending in:</u>**
  - Pennsylvania
  - New York
  - Virginia
  - Vermont
  - Texas
  - Delaware

RESOURCES

Therapy

- https://beckinstitute.org/get-informed/tools-and-resources/ - CBT

Diagnostic

- The Diagnostic Manual-Intellectual Disability (DM-ID) corresponds directly with the DSMV
- The Diagnositc Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities (DC-LD) works in tandem with the ICD-10

Training

- http://thenadd.org/resources/consultation-and-training-services/
- http://www.iddhealthtraining.org/module-2/scenario-1/resources/online-training/
- http://aaidd.academy.reliaslearning.com

QUESTIONS


IF THERE ARE NO QUESTIONS, WE'LL MOVE ON TO THE NEXT CHAPTER.
I HAVE A QUESTION.
CERTAINLY, CALVIN. WHAT IS IT?
WHAT'S THE POINT OF HUMAN EXISTENCE?
I MEANT ANY QUESTIONS ABOUT THE SUBJECT AT HAND.
OH.
FRANKLY, I'D LIKE TO HAVE THE ISSUE RESOLVED BEFORE I EXPEND ANY MORE ENERGY ON THIS.
3-6

CONTACT INFORMATION

CLEMSON LIFE College of Education

- Kristina Randall
  - knranda@clemson.edu
- Nicole Benvenuto
  - nlbenve@g.clemson.edu
- Erica Walters
  - escheff@g.clemson.edu
- Joe Ryan
  - jbryan@clemon.edu

REFERENCES

CLEMSON LIFE College of Education

- Arscott, K., Dagnan, D. & Kroese, B.S. (1998). Consent to psychological research by people with an intellectual disability. Journal of Applied Research in Intellectual Disabilities, 11, 77–83.
- Arscott, K., Dagnan, D. & Kroese, B.S. (1999). Assessing the ability of people with a learning disability to give informed consent to treatment. Psychological Medicine, 29, 1367–1375.
- Davis, E., Saeed, S.A., & Antonacci, D.J. (2008). Anxiety disorders in persons with developmental disabilities: Empirically informed diagnosis and treatment. *Psychiatry Quarterly, 79,* 249-263.
- Dinerstein, R. D. (2012). Implementing legal capacity under Article 12 of the UN Convention on the Rights of Persons with Disabilities: the difficult road from guardianship to supported decision-making. *Human Rights Brief, 19*(2), 7-12.
- Cooney, P., Tunney, C., & O'Reilly, G. (2017). A systematic review of the evidence regarding cognitive therapy skills that assist cognitive behavioural therapy in adults who have an intellectual disability. *Journal of APplied Research in Intellectual Disabilities, 31*(1), 23-42.
- Fletcher, R. J., Havercamp, S. M., Ruedrich, S. L., Benson, B. A., Barnhill, L. J., Cooper, S. A., & Stavrakaki, C. (2009). Clinical usefulness of the diagnostic manual-intellectual disability for mental disorders in persons with intellectual disability: results from a brief field survey. *The Journal of clinical psychiatry*, *70*(7), 967-974.
- Hatton, C. (2002). Psychosocial interventions for adults with intellectual disabilities and mental health problems: A review. Journal of Mental Health, 11(4), 357-374.
- Poppen, M., Sinclair, J., Hirano, K., Lindstrom, & Unruh, D. (2016). Perceptions of mental health concerns for secondary students with disabilities during transition to adulthood. *Education and Treatment of Children, 39*(2), 221-246.
- Reiss, S., Levitan, G.W., & Szyszko, J. (1982). Emotional disturbance and mental retardation: Diagnostic overshadowing. *American Journal of Mental Deficiency, 86*(6), 567-574.
- Rosen, T.E., Connell, J.E., & Kerns, C.M. (2016). A review of behavioral interventions for anxiety-related behaviors in lower-functioning individuals with autism. *Behavioral Interventions, 31*(2), 120-143.
- Sturmey, P. (2004). Cognitive therapy with people with intellectual disabilities: A selective review and critique. *Clinical Psychology & Psychotherapy, 11*(4), 222-232.