I/DD and Mental Health

Intersections and clinical considerations

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Disclosures

Today's speaker has no financial relationships with an ineligible company relevant to this presentation to disclose.

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All relevant financial relationships have been mitigated

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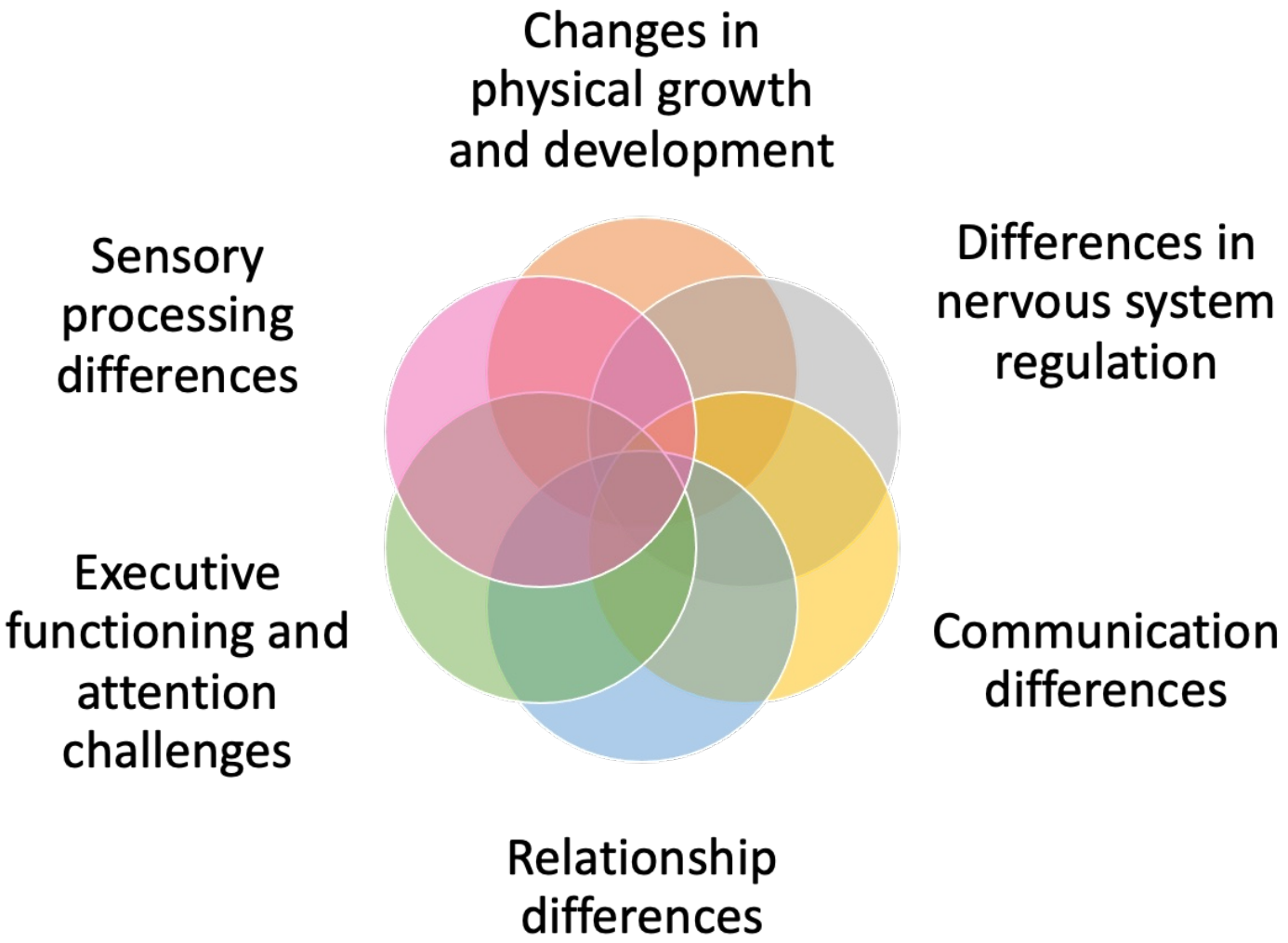
Objectives

- To bring awareness to co-occurring mental health conditions in I/DD and barriers to care
- To discuss modes of treatment and adaptations to evidence-based practices
- To introduce an upcoming training series on this topic

Features (often) observed in I/DD



Increased rates of mental health conditions in I/DD

Anxiety (~7%)

- ADHD: ~30-40%
- ASD: ~20-50%
- ID: ~3-20%

OCD (~1%)

- ADHD: ~8%
- ASD: ~5%
- ID: ~1%

Depression (~7%)

- ADHD: ~30-50%
- ASD: ~20-70%
- ID: ~1-5%

Suicidality (SI: 0-25%; SB: 4-8%)

- ADHD: SI 68%; SB18%
- ASD: SI 60-70%, SB 7-47%
- IDD: SI 20-60%; SB 17-48%

Slide credit to Karis Casagrande

Diagnostic Overshadowing

The *Encyclopedia of Autism Spectrum Disorders* defines the term 'diagnostic overshadowing' as a 'negative bias impacting a clinician's judgment regarding co-occurring disorders in individuals who have intellectual disabilities or other mental illness'

- *This patient can't be depressed because they have intellectual disability*
- *This isn't anxiety because the child has autism*
- *We are prescribing medication and ABA therapy for a child who is head-banging (further investigation reveals the child has tooth decay)*

Slide credit to Karis Casagrande)

Missed Diagnosis and Misdiagnosis

1) Missing I/DD in the presence of *externalizing* behaviors
   - BIPOC individuals more likely to be misdiagnosed with a disruptive behavior disorder (e.g., ODD/CD) or adjustment disorder than a developmental disability
   - BIPOC individuals are often diagnosed with I/DD later than white peers

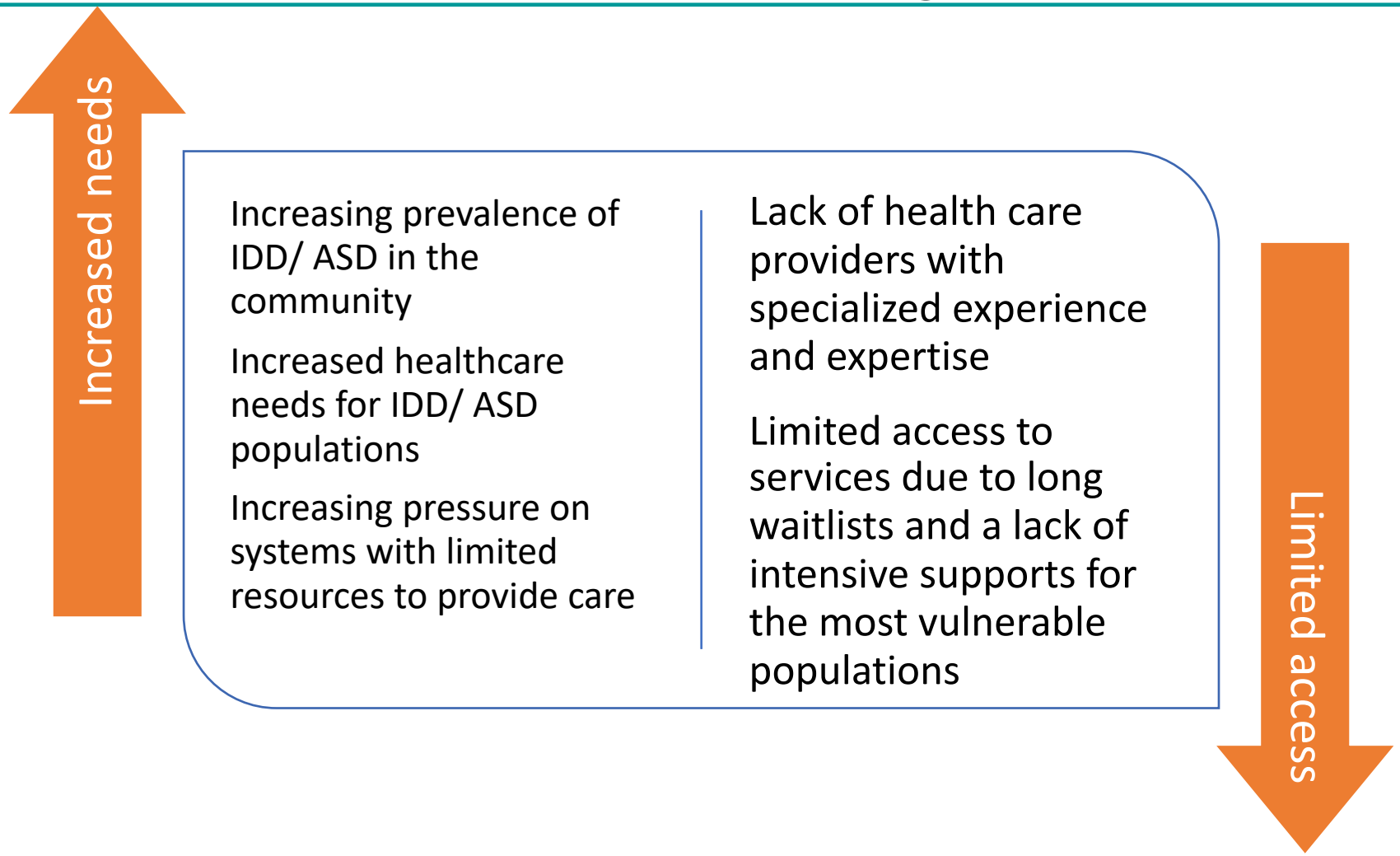
2) Missing I/DD in the presence of *internalizing* behaviors
   - Those assigned female at birth (AFAB) are more likely to be misdiagnosed with internalizing mental health diagnosis (e.g., anxiety, bipolar) or personality disorder (e.g., borderline) than developmental disabilities
   - AFAB individuals are often diagnosed later than AMAB peers

Content credit to Karis Casagrande; *Kanne (2013)*

System barriers to appropriate care

- High rates of co-occurring mental health challenges
- Siloed service and state support systems
- Long waitlists for preventative and routine care
- Shortage of providers trained in mental health AND development
- High costs for families and low reimbursement rates for providers

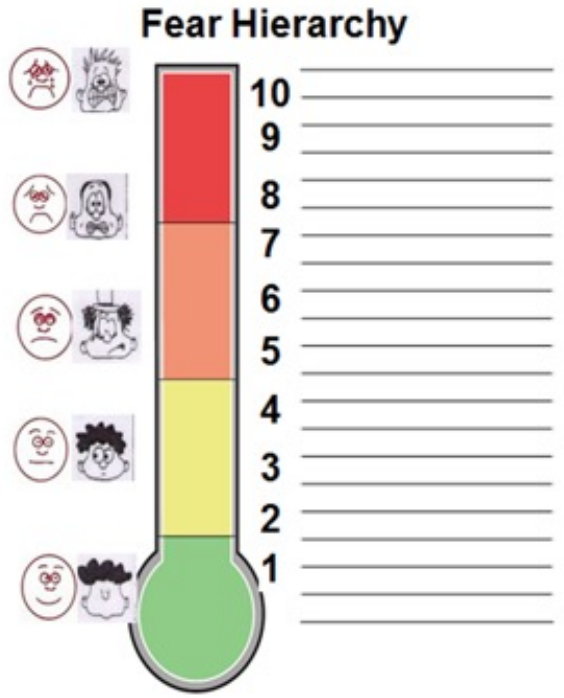
In summary

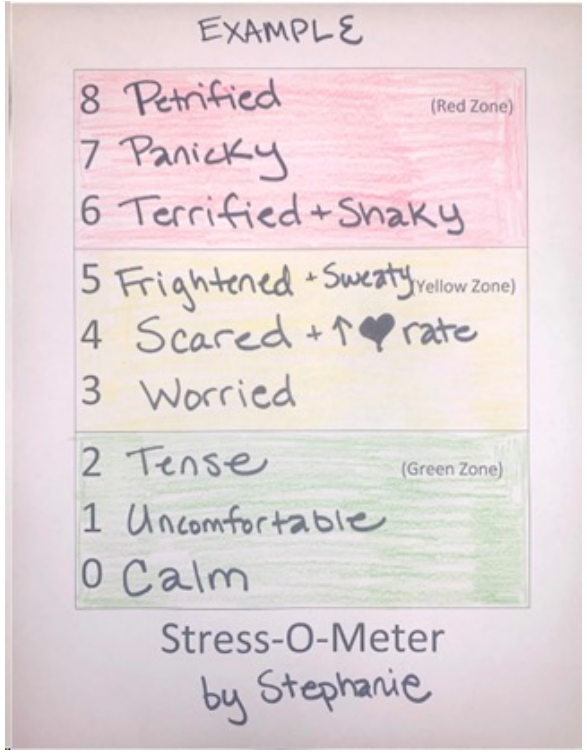


Slide credit to Karis Casagrande

Anxiety

- Rapport and treatment motivation may take more time
- Cognitive skills may require adaptation
  - Frame anxiety/OCD as something "trying to take control"/an external force
  - Client can "talk back" to anxiety/OCD
  - Get concrete: use a name, image/drawing
- Exposure WORKS, needs to be gradual and pre-planned
- Coach pitfalls of reassurance seeking for caregivers
- Determine a reward for completing exposure





Depression

- Behavioral activation is a promising treatment for depression among those with intellectual and developmental disabilities
  - Enhancing enjoyable experiences to improve mood
- Mindfulness-based therapies show benefits (e.g., Menezes et al., 2020)
- Incorporating values and mindful awareness into behavioral activation is recommended

Content credit to Alana McVey

BEHAVIORAL ACTIVATION TIPS

- Find out what your client enjoys or used to enjoy doing
- Spend time during each session offering to talk about their interests
- Discuss values or complete a values activity to identify how the client might enjoy spending their time
- Offer lists of enjoyable activities and solicit their feedback
- Have your client schedule enjoyable activities and plan for how they will engage in them, including any support needed
- Troubleshoot any challenges
- Consider hierarchy of ease of activity, shaping, support from others

Suicidality

Triggers, warning signs, and supports are unique to each person. A helpful escalation cycle chart will be tailored uniquely to that client, giving insight to both the client and the client's supports.

Triggers:

- Sensory (internal & external)
- Social
- Trauma
- Negative self-talk
- Incongruence

Warning Signs:

- Changes in behavior, physiology, sensory sensitivities, thought process

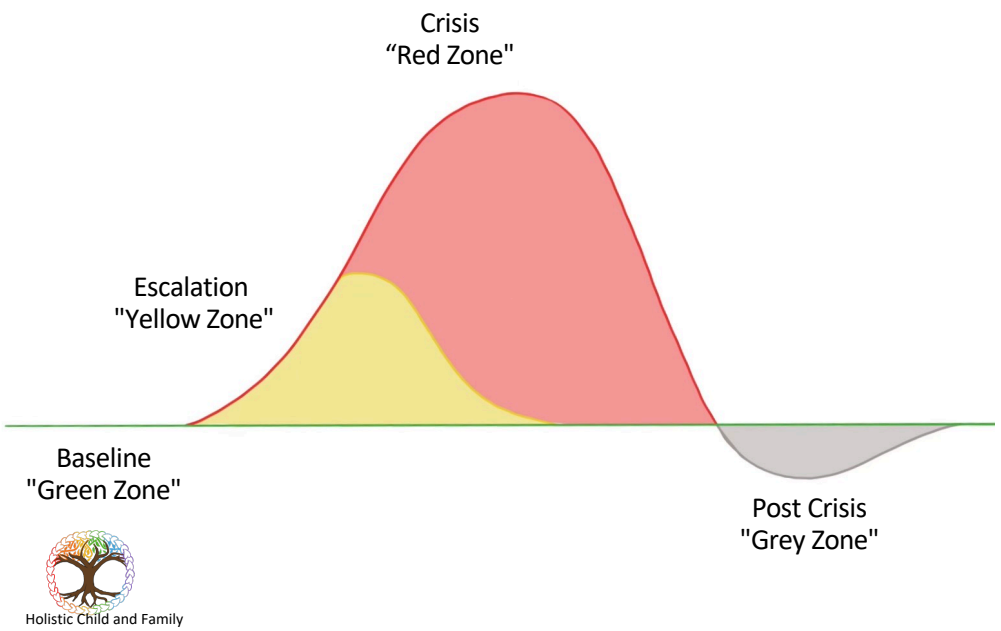
Identify those the client and others can notice

Interventions & Supports:

- Coping and calming skills for lower levels of escalation.
- Distraction and safety precautions for high levels of escalation.
- Supports to text or call

Content credit to Alana McVey

Safety Planning



Triggers

- Being excluded, receiving critical feedback publicly

Early Warning Signs

- Stop breathing, feel hot, clenched fists, urge to lash out, become quiet

Things I Can Do

- Take slow and deep breaths, walk away for a moment, validate my experience, release tension by stretching

Things Others Can Do

- Listen to and validate my experience, offer caring and encouragement

Content credit to Alana McVey and Marie Loeb

Safety Planning

- **Means** restriction is an evidence-based suicide prevention strategy
- Decreases incidents of impulsive self-harm behaviors
- Increases time for de-escalation
- Effective even if client is locking items up for themselves!
- Provides safety measures and support outside of 24/7 supervision
- Decreases fatality rate of suicide attempts

- What to restrict:
  - Most lethal methods
  - Most easily accessible methods
  - The preferred/planned method

Yip et al., (2012)

Content credit to Alana McVey and LE Jibol

There's so much more!

- If you're interested in learning more about the intersection of I/DD and mental health, join us for the Mental Health Institute this spring!
- One-day introductory workshop, Friday March 22, 9-4:30
- Weekly clinical skill-building series, Fridays 11:00-1:00 April 5- May 24
- CEUs available for therapy providers
- Registration details coming soon!

Questions

THANK YOU!

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