COUNTY OF LOS ANGELES-DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE MEDICAL DIRECTOR

4.18 PARAMETERS FOR ASSESSMENT AND TREATMENT OF INDIVIDUALS WITH CO-OCCURRING INTELLECTUAL DISABILITIES (CID)

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I. INTRODUCTION

According to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, the prevalence of mental disorders in people with intellectual disabilities is three to four times higher than in the general population. For example, individuals with CID have unique needs with regard to mental health assessment and treatment, education, employment and, at home, in residential and other community settings.

CID is a risk factor for developing a variety of mental disorders and can affect clinical presentation. CID is often associated with additional medical problems and/or substance abuse. Additionally, individuals with CID are at greater risk for abuse and exploitation than the general population.

Mental health services for individuals with CID can effectively treat their mental health problems and also help to develop and sustain healthy meaningful relationships and achieve personal goals. In order to achieve this goal, mental health systems should have the resources necessary to appropriately assess and treat individuals with CID.
Reference 1

The Diagnostic Manual - Intellectual Disability (DM-ID), which provides a more detailed examination of the subject and includes clinical guidelines and adaptations of mental health disorder diagnostic criteria for persons with Intellectual Disability, can serve as a resource for providers. ICD-10 may further inform descriptive and diagnostic practices in this area.
Reference 2, 3

II. GENERAL DESCRIPTION OF INTELLECTUAL DISABILITY

A. Intellectual disability (formerly referred to as Mental Retardation) is defined as impairments of general mental abilities that impact adaptive functioning in three domains. These domains determine how well an individual copes with everyday tasks.

1. The conceptual domain includes skills in language, reading, writing, math, reasoning, knowledge, and memory.

2. The social domain refers to empathy, social judgment, interpersonal communication skills, the ability to make and retain friendships, and similar capacities.

3. The practical domain centers on self-management in areas such as personal care, job responsibilities, money management, recreation, and organizing school and work tasks.

B. While intellectual disability does not have a specific age requirement, an individual's symptoms originate during the developmental period, which is between the ages of 0 to 18. The diagnosis is based on the severity of deficits in both intellectual and adaptive functioning.

C. Intellectual disability is usually life-long, and often co-occurs with mental disorders such as depression, attention-deficit/hyperactivity disorder and autism spectrum disorder.

III. GENERAL PARAMETERS

A. The presence of an intellectual disability should never be the sole exclusionary criterion for treatment of a co-occurring mental disorder that meets medical necessity criteria for treatment in specialty mental health systems.

B. The presence of mental health signs and symptoms should be attributed solely to the presence of an intellectual disability only after thorough assessment has ruled out the presence of other mental disorders as contributory.

IV. ASSESSMENT

A. DMH clinical staff should request and review available records from Regional Centers and other health, mental health and systems that provide services to individuals with CID. Any relevant issues they contain should be addressed. Special attention should be given to records of standardized tests of intelligence and adaptive function.

B. DMH clinical staff should assess for the presence of repetitive, stereotypic and/or self-injurious behaviors associated with CID and document these when present, as separate diagnoses.

C. DMH clinical staff should assess for the presence of abuse, trauma and exploitation associated CID, and provide ongoing risk and safety assessments.

D. DMH clinical staff should assess the strengths of clients with CID, and also identify challenges, barriers, and needs associated with achieving identified clinical goals.

E. DMH clinical staff should assess the abilities of family members and caregivers to meet the needs of clients with CID, and also assess for the presence of stressors related to caring for people with CID.

V. TREATMENT PLANNING AND DELIVERY

A. Treatment plans should include those mental health resources and treatments that can address and improve functioning in individuals with CID.

B. Treatment planning should address access challenges to mental health services related to CID and include strategies to overcome those challenges.

C. Treatment planning should address access to the full array of community services and resources that promote optimal function of individuals with CID. Clinical staff

should know how to effectively access Regional Center Services, as well as services from health and educational agencies.

D. Mental health treatment delivery should promote effective collaboration and coordination with such systems providing services to individuals with CID.

E. Treatment planning should address any self-injurious, destructive, aggressive, and disruptive behaviors.

F. Psychotropic medication should be prescribed judiciously, and not be used solely for long term behavioral control. Close monitoring for potential adverse effects should be carefully documented, and polypharmacy should be avoided when possible.

G. If the CID is secondary to an underlying medical condition requiring medication, psychotropic medications should only be prescribed after assessing and addressing underlying physiological conditions to determine potential drug interactions or adverse effects related to those conditions.

H. Family members, caregivers and significant others should be included in the individual's treatment whenever consistent with the desire of the client and with consideration of their ability to support and participate in implementing the plan.

I. General health issues associated with CID should be addressed. These include: smoking, diet and exercise and sexually transmitted diseases in collaboration with health care providers and caregivers if indicated.

J. Treatment planning and delivery should address and monitor for the presence of the forms of exploitation to which individuals with CID are especially vulnerable, and should include direct discussion with both the client and caregivers.

VI. TRAINING

A. All DMH clinical staff should be familiar with diagnoses associated with intellectual disability and be able to use the appropriate diagnostic terminology associated with intellectual disabilities across age categories.

B. All DMH clinical staff should know the mental disorders commonly associated with CID, be able to identify and understand the ways mental disorders can present in persons with CID, and seek consultation in order to adapt assessment methods and treatment interventions, such as evidence based practices, in accordance with the individual's cognitive skills and adaptive functioning.

C. All DMH prescribing staff should have comprehensive knowledge regarding the manner in which CID and associated underlying conditions affect the response of individuals to psychotropic medications, and to understand the risk and the benefits for use of psychotropic medication in individuals with CID.

D. DMH staff working with people with CID should be aware of community resources to address CID and know how to effectively access these resources.

VII References

1. Diagnostic and Statistical Manual of Mental Disorders: American Psychiatric Publishing; 5th edition.
2. Diagnostic Manual -- Intellectual Disability (DM-ID): A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability. NADD Press (in revision)
3. ICD10.