Forming Interagency Partnerships for clients who have Co-occurring Intellectual/Developmental Disabilities and Mental Health Disorders

Teresa Celada-Dalton, PhD; Lorraine Viade, PsyD;
Amanda Seon-Walker, PsyD; & Karin Woo, LMFT

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LEARNING OBJECTIVES

- Identify at least 3 benefits of Interagency Collaboration
- Identify Strategies to overcome challenges when coordinating treatment
- Identify Cultural considerations related to clients with Co-occurring ID/DD and MH
- Identify Best Practices when working with clients with Co-occurring ID/DD and MH

RELEVANT TERMINOLOGY

- Intellectual Disability (ID) – characterized by significant limitations both in intellectual functioning (reasoning, learning, & problem solving) and in adaptive behavior (conceptual, social, & practical skills).
- Developmental Disability (DD) – umbrella term that includes ID but also includes other sever chronic lifelong disabilities that can be cognitive or physical or both. For example, Cerebral Palsy & Epilepsy are largely physical, while Down Syndrome & Fetal Alcohol Syndrome include a physical & intellectual disability.

DUAL DIAGNOSIS

- For the purposes of this presentation the term **Dual Diagnosis** includes individuals who are challenged with both:
  - Mental Health Disorder
  - Developmental Disorder
- **CDD/ASD** = co-occurring developmental disability/autism spectrum disorder
- **CID** = co-occurring intellectual disability

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

- Traditionally, Department of Mental Health (not just LA) and Regional Center were seen as two distinct entities.
- Assessment and treatment of individuals with "co-occurring developmental disabilities" (CDD) identified as important.
- On-going collaboration to promote coordination of care

COLLABORATION BETWEEN DMH AND REGIONAL CENTERS

- Collaborative meetings started as a result of the 1st MOU between DMH and Regional Centers in 1998/1999.
- In LA County, the MOU with SA7 and SA3 together states that there should be case collaboration and training at the local level.
- Through the years has expanded to include SCLARC, FDLRC, and HRC. Latest update now includes Probation and DCFS.

WHY DOES IT MATTER?

- A Statewide Needs Assessment funded by the California Department of Developmental Disabilities as a wellness project was completed in 2005-2006.
- The assessment identified how many Regional Center consumers had documented co-occurring mental health diagnoses.
- * Likely underestimated – MH concerns are not always documented once a developmental disability is diagnosed.

CALIFORNIA – DUAL DIAGNOSIS

Of the total number of people served by the Regional Center System:

- 16.1% (1 in 6 people) are listed as having a co-occurring psychiatric condition
- 24% of these individuals are children

PREVALENCE

In the US:

- Approximately 33% of people with I/DD have a co-occurring MI
- Approximately 1.6% of the general population have an ID
- 2010 census = over 300 million people = 5 million w/CDD

In Canada:

- Number of people in total population w/I/DD = 1.67%
- Number of people with I/DD who have MI = 33%

REGIONAL CENTER ELIGIBILITY
(for ages 3 years and above)

RC Assessment & Diagnosis of eligible condition:

- Cerebral Palsy
- Epilepsy
- Autism
- Intellectual Disability (ID)
- Other conditions closely related to ID or that require similar treatment

  (referred to as "The 5th Category)

AND

REGIONAL CENTER ELIGIBILITY

(ages 3 and above cont.)

Disability originated prior to age 18 years

AND

Is likely to continue indefinitely

AND

Constitutes a substantial disability in 3 or more of the following areas:
Communication (receptive & expressive language); Learning; Self-Direction; Capacity for Independent Living; Economic Self-Sufficiency; Self Care; Mobility

RC EARLY START SERVICES

(ages 0-36 months old)

Developmental delay in one or more of the following five areas: *Cognitive; Communication; Social/Emotional; Physical; Adaptive* (33% delay in at least one developmental area)

OR

Established Risk for developmental disability:

- Conditions known to cause delays in development (e.g. Down syndrome, Prader-Willi, Spina Bifida)
- Need not be demonstrating delays at time of referral.

OR

RC EARLY START SERVICES
(ages 0-36 months old cont.)

- AT RISK for developmental disability (two or more factors):
- Less than 32 wks gestation and/or birth weight less than 3.5 lbs
- Assisted ventilation for 48 hours or longer during first 28 days of life
- Small for Gestational Age
- Asphyxia neonatorum (lack of adequate oxygen during birth process)
- Severe and persistent metabolic seizures during the first 3 years of life
- Neonatal or nonfebrile seizures during the first 3 years of life
- CNS lesion, abnormality, or infection

RC EARLY START SERVICES
(ages 0-36 months cont.)

- Biomedical insult (injury, accident or illness) which may affect developmental outcome
- Multiple congenital anomalies
- Prenatal exposure to teratogens; prenatal substance exposure (agent which causes malformation of embryo)
- Clinically significant failure to thrive
- Persistent hypertonia or hypotonia (muscle over/under activity)

OR

- The parent of the infant/toddler is a person with a developmental disability

MENTAL HEALTH NEEDS

- The full range of psychopathology that exists in the general population also can co-exist in persons who have intellectual or developmental disabilities.
- Can have serious effects on the person's daily functioning by interfering with educational and vocational activities, by jeopardizing residential placements, and by disrupting family and peer relationships.
- Can greatly reduce the quality of life of persons with intellectual or developmental disabilities. It is imperative that accurate diagnosis and appropriate treatment be obtained in a timely manner.

When determining the needs, diagnoses and interventions, there are several things you must consider.

WHY DO WE COLLABORATE?

- Consistency
- Accuracy
- Sharing (Information, ideas, solutions)
- Effectiveness (Better care plans, Better outcomes)

SYSTEMS OF CARE

Medical

Dental

Educational

Rehabilitation

Law Enforcement

Family

Faith Community

Recreational

Mental Health

Regional Center

DCFS

College / University

Workplace

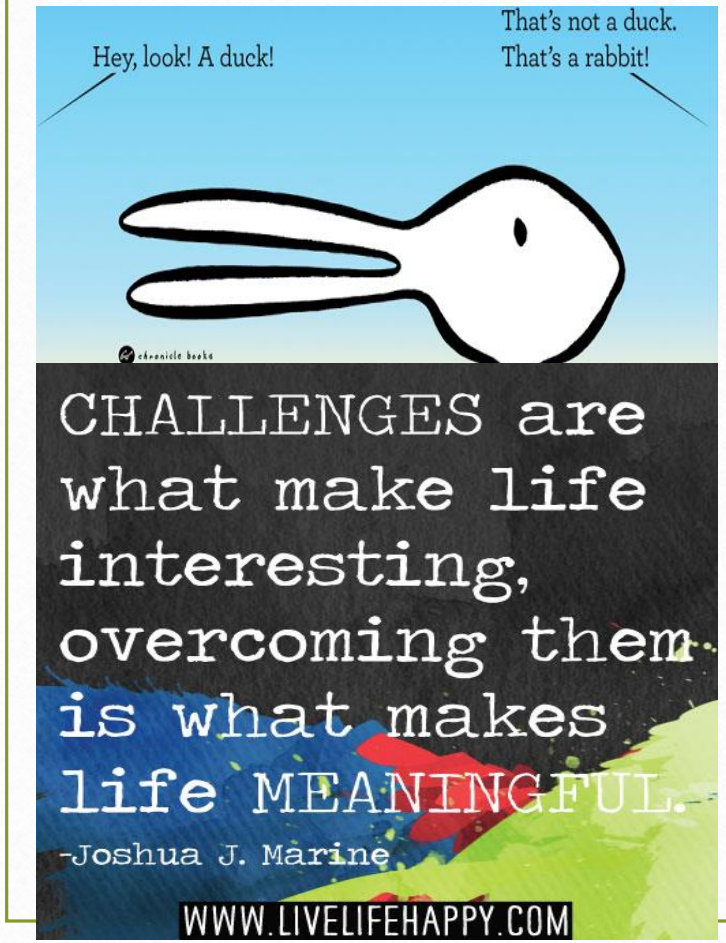
SYSTEM PARTNERS

- The Person
- Physicians
- Parent Partners
- ABA Workers
- Case Managers
- Therapists / Counselors
- School Nurses
- Afterschool Program Staff
- Extended Family Members
- First Responders
- Neighbors / Friends
- Coaches
- Clergy
- Probation Officers
- Nursing home staff
- Court Appointed
- Case Workers
- Supervisors
- Tutors
- Educational Liaison
- Speech Therapist
- Group Home Staff
- Siblings
- Bosses
- Co-workers
- Foster Parents
- Caregivers

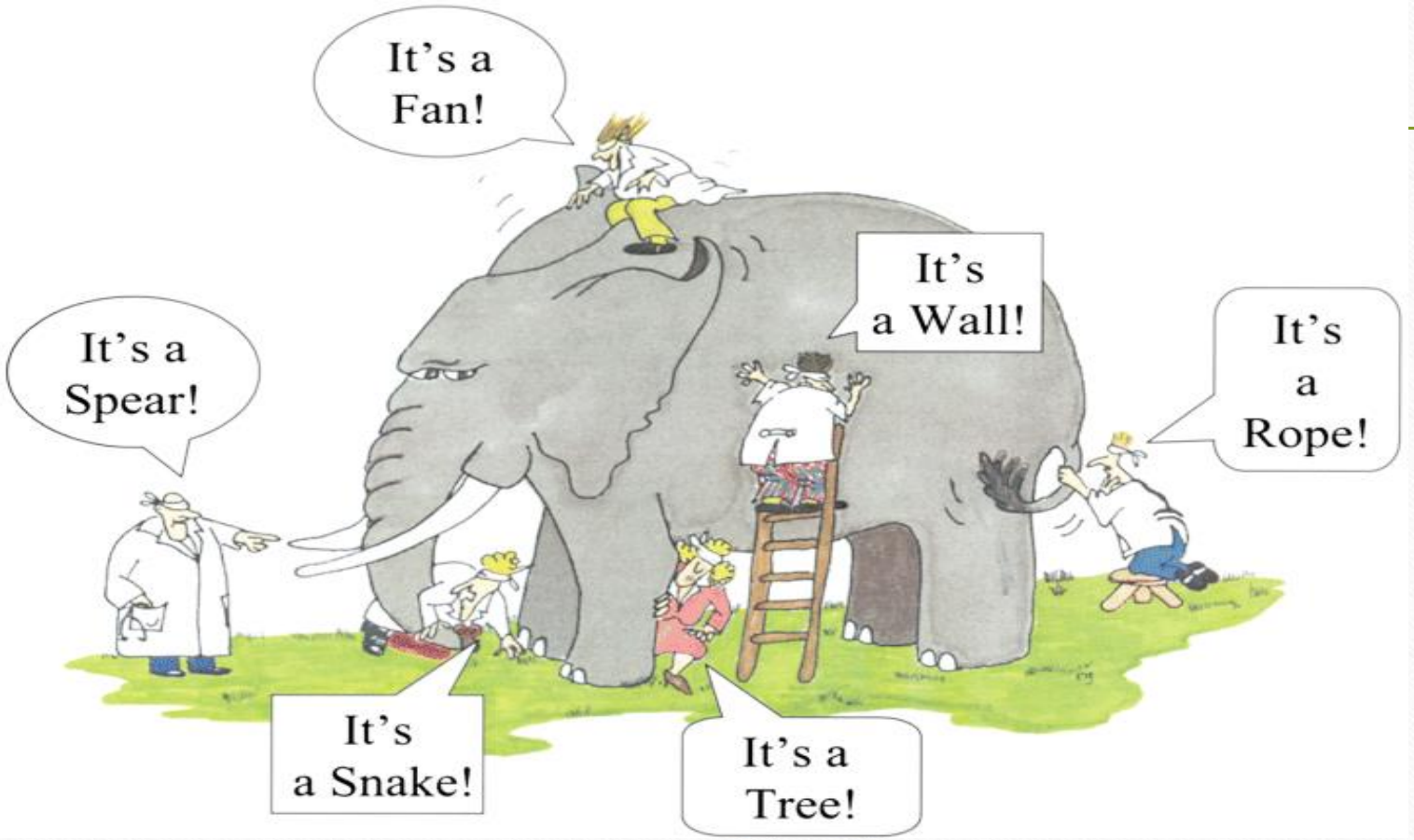
COLLABORATE

Consistency Optimism Listen Learn Assess Behavioral Observations Research Assist Teach Emotions

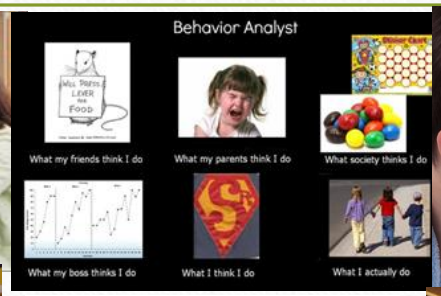
Collaboration: Benefits & Challenges



CHALLENGES







Behavior Analyst
What my friends think I do
What my parents think I do
What society thinks I do
What my boss thinks I do
What I think I do
What I actually do


Safety








Community Helpers
Teacher
Police Man
Mail Man
Fire Fighter
Doctor
Nurse
Farmer
Dentist
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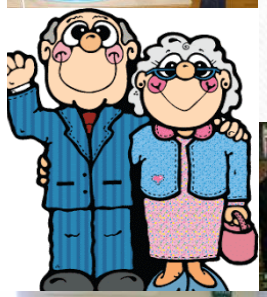
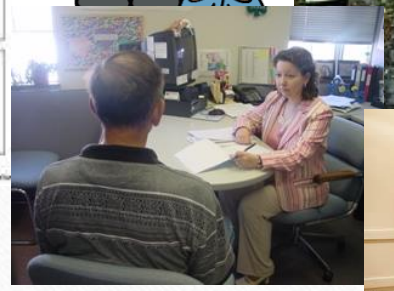








Client-Centered Approach

CASE STUDY: JOHN

- Relevant background information:
- 10-Year-old African American male Living in South Los Angeles in a public housing development
- Youngest of 7. Only boy. There were complications at birth and client almost died
- Enrolled in an Elementary School in a Special Education classroom. Mother kept him out of school until age 7

CASE STUDY: JOHN (Con't)

- School was concerned that client would not stay in class; would run out of the doors into the street and in between the cars to try and go home
- Poor memory/concentration, poor regulation, restless, irritability, anxious about his mother's well-being (Mother was out 'partying' while he was in school)
- John's strengths: caring; funny; desire to be liked by his peers and to take care of his mother; sharp dresser/good hygiene to figure out how to play a video game without understanding of the education concepts driving it.

Previously Tried Interventions:

- telling mother to keep client home from school for several days;
- video game time as a reward;
- repetition; and
- being arrested by the police (Handcuffs) .

COLLABORATIVE PARTNERS

- DCFS Children's Service Worker (CSW)
- DMH Specialized Foster Care Psychologist/Psychiatrist
- Educational Liaison
- Special Education Teacher
- Principal/Vice Principal
- Recreation Center Director
- School Psychologist
- Mother

SYSTEMS CONSIDERATIONS FOR THE PLAN

- Education about Dual Diagnosis
- Program Adaptations
- Cross Systems Collaboration
  - Plan consistency
  - Help identify gaps
  - Explore additional supports
  - Prevent Overlap

PROTECTIVE & RISK FACTORS

- Family and social support
- Language
- Household rules and child monitoring
- Nurturing parenting skills
- Stable family relationships
- Parental employment
- Adequate housing

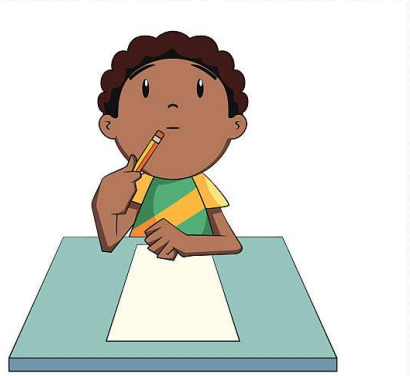
- Social isolation
- Impaired communication
- Lack of body knowledge
- Reinforced to be compliant
- Large number of caregivers
- Scarce training
- Increased caregiver stress
- Myths
  - "No one would abuse a person with a disability"
  - "People with a disability don't understand what is happening so they don't suffer like other youth do"
  - "Keeping child at home will lessen the risk of abuse"

CULTURAL CONSIDERATIONS

- Family's perception of disability
- Interventions attempted
- Understanding of professional's role
- Trust in the systems
- Stigma
- Value of sexual education

INDIVIDUAL CONSIDERATIONS FOR THE PLAN

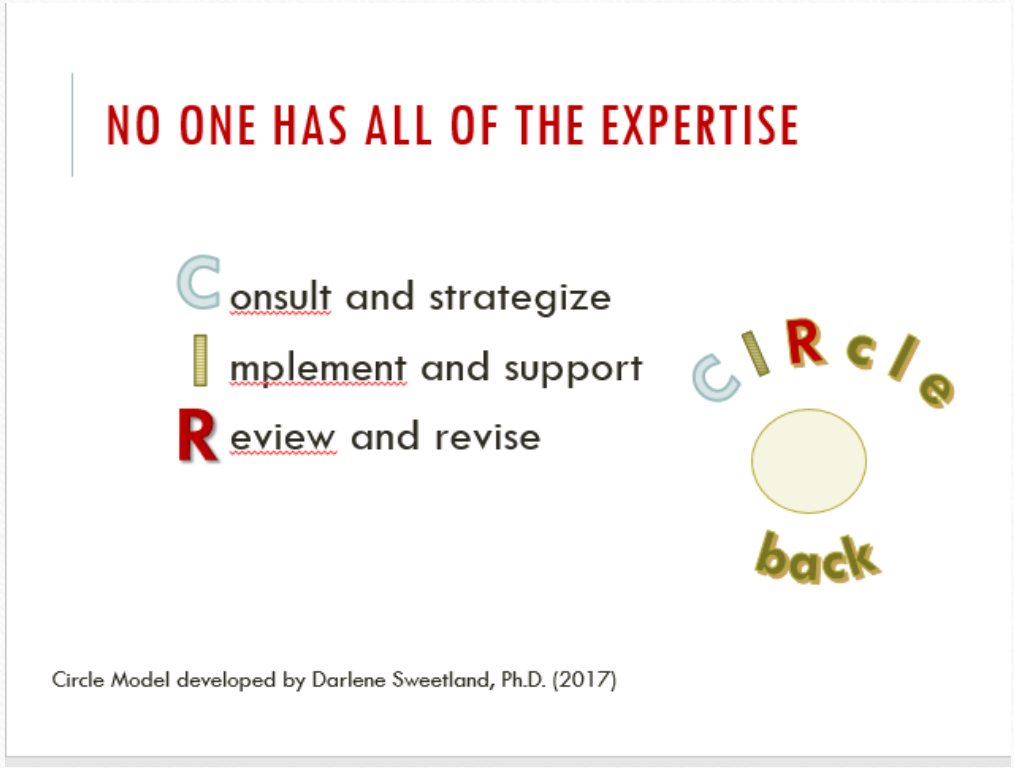
- Atypical family involvement (mother typically unavailable, father absent);
- Multiple support people from different disciplines;
- Client recently switched classrooms/Teachers
- Client had not yet been evaluated by the Regional center;
- Concerns regarding FAS which mother denied;
- Client was displaying difficulty retaining ABCs, Numbers, people, etc.



CREATING THE PLAN

Therapeutic Goals:

- The School agreed to call therapist when client was irritable instead of calling the police.
- Psychologist would go to the school and engage client in self-regulation techniques to assist with his anxiety.



BEST PRACTICES: ASSESSMENT

1. The behavior occurs in all environments; it is not just exhibited in specific settings.

2. Behavioral strategies have been largely ineffective.

3. The individual doesn't appear to have control over their behavior. They don't appear to be able to start or stop the behavior at will.

4. There are changes in sleep patterns; increased, decreased or disturbed sleep.

Source: Behavioral Practices in Regional Centers (Draft 2, Section I, P. 11).

BEST PRACTICES: ASSESSMENT Con't

5. The individual is experiencing excessive mood or unusual mood patterns.

6. There are changes in the individual's appearance and a decline in their independent living skills, such as diet, hygiene and exercise.

7. They may start to engage in purposeful self-harm (cutting, hitting, scratching, pulling out hair).

8. They may start to show signs of hallucination, such as staring to the side or corners and not appearing to track conversations. They may begin to cover their ears or eyes.

Source: Behavioral Practices in Regional Centers (Draft 2, Section I, P. 11).

BEST PRACTICES: ASSESSMENT Con't

9. There may be changes in eating patterns such as eating less or more. They may develop fears around food or refuse foods.

10. The individual has a history of a psychiatric disorder that was in remission.

11. There is an acute onset of the behavior.

12. There is an unusual change in behavior patterns.

Source: Behavioral Practices in Regional Centers (Draft 2, Section I, P. 11).

BEST PRACTICES: DIAGNOSIS

- Diagnostic Manual – Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability

- Developed by the National Association for the Dually Diagnosed (NADD) in association with the American Psychiatric Association (2016).

BEST PRACTICES: INTERVENTIONS

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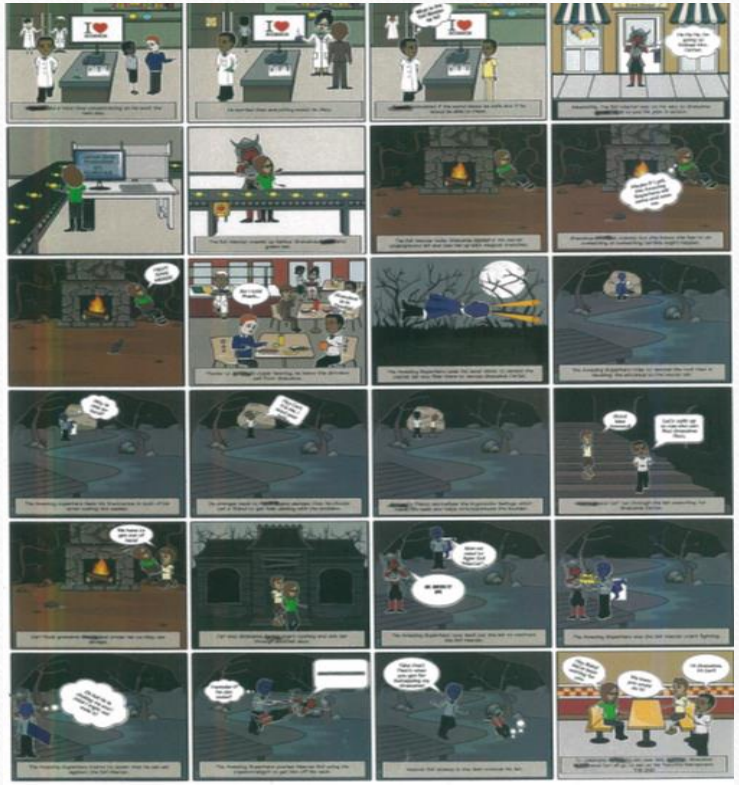

BEST PRACTICES: INTERVENTIONS

CLINICIAN'S EXPERIENCES

Cross systems collaboration and why it was so important.

- ✓ Kept goals consistent/Prevented mixed messages
- ✓ Provided common language/Understanding of the needs
- ✓ Individuals were able to learn from the successes of others
- ✓ Appropriate diagnosis

OUTCOMES FOR JOHN

Why did it work?

- ✓ Client arrests decreased to zero during that time.
- ✓ School staff felt more supported.
- ✓ Client was able to get more restrictive IEP plan and eventually be referred to Educationally Related Mental Health Services (ERMHS).
- ✓ Client was referred to Regional Center

TRAINING REFERENCES

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Teresa Celada-Dalton, Ph.D.

tceladadalton@chla.usc.edu

Lorraine Viade, Psy.D.

Lviade@dmh.lacounty.gov

Amanda Seon-Walker, Psy.D.

Aseon-walker@dmh.lacounty.gov

Karin Woo, LMFT

Karin.Woo@pathways.com