Working with Children who have Co-Occurring Behavioral Health and Developmental Disabilities

Cynthia Mueller, PhD
J.J. Gossrau, MSW, LCSW
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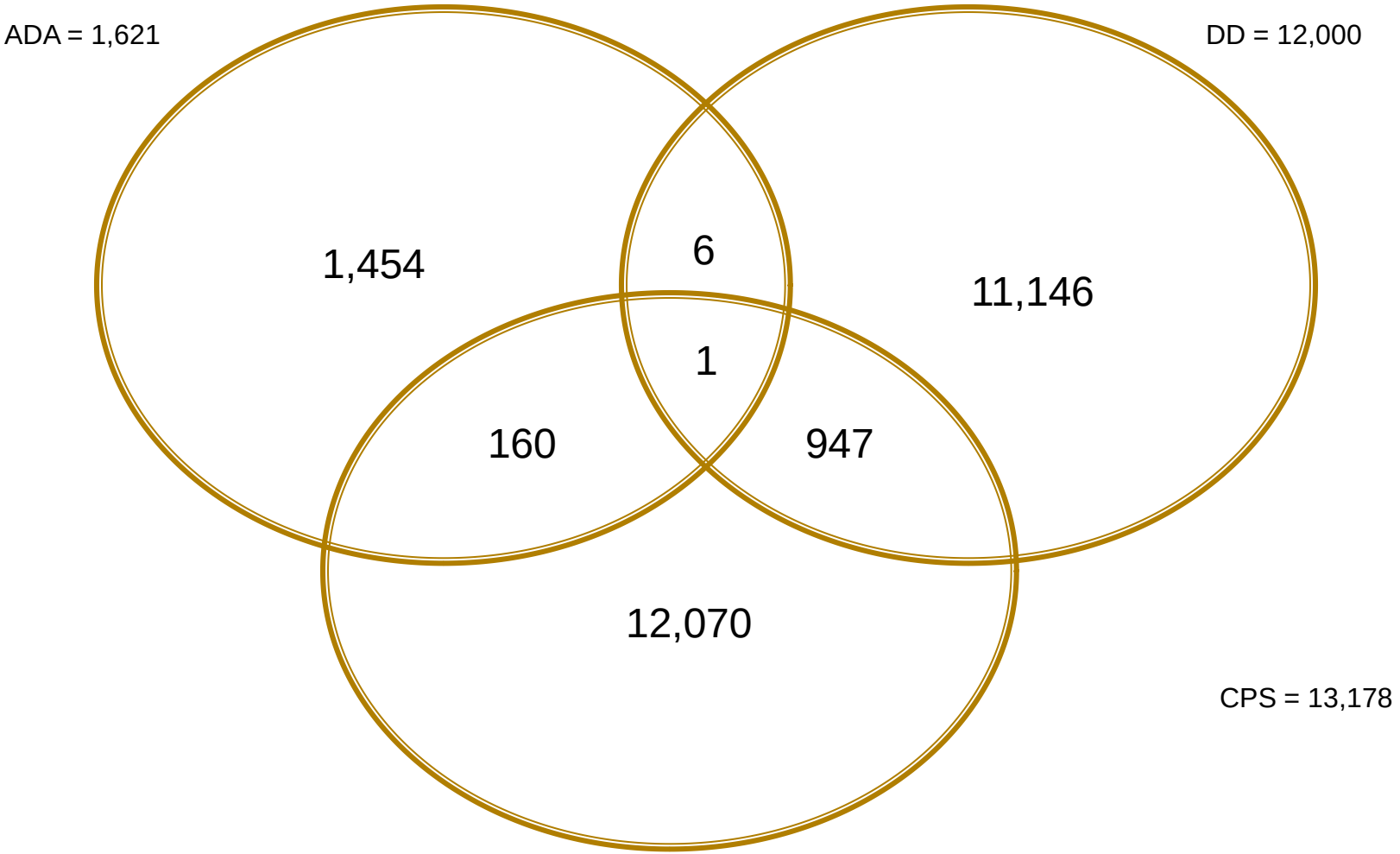
History

- Until deinstitutionalization began in the 1970's and 1980's, the issue of behavioral health health (both mental illness and substance abuse) occurring to people with DD was generally ignored.
- Many psychiatrist felt that people with intellectual impairments did not experience mental illness; symptoms were often attributed to learned behavior.
- Following deinstitutionalization when supports were provided in smaller settings, it was more obvious that people with DD were having symptoms of mental illness
- The fields developed community services separately, with competition for federal, state, and local funding

Prevalence

- Research in the last two decades has shown that 30-35% of people with DD, of all ages, have a psychiatric disorder as compared to 25% of adults and 20% of youth in the general population
- Mental illness effects people with DD
  - ✓ of all ages, and
  - ✓ of all levels of intellectual and adaptive ability
- People with DD can experience the full range of psychiatric disorders

Distribution of Consumers with Co-Occurring Disorders as of 12/2013



Why is there an increased prevalence?

Possible factors of co-occurring disorders:

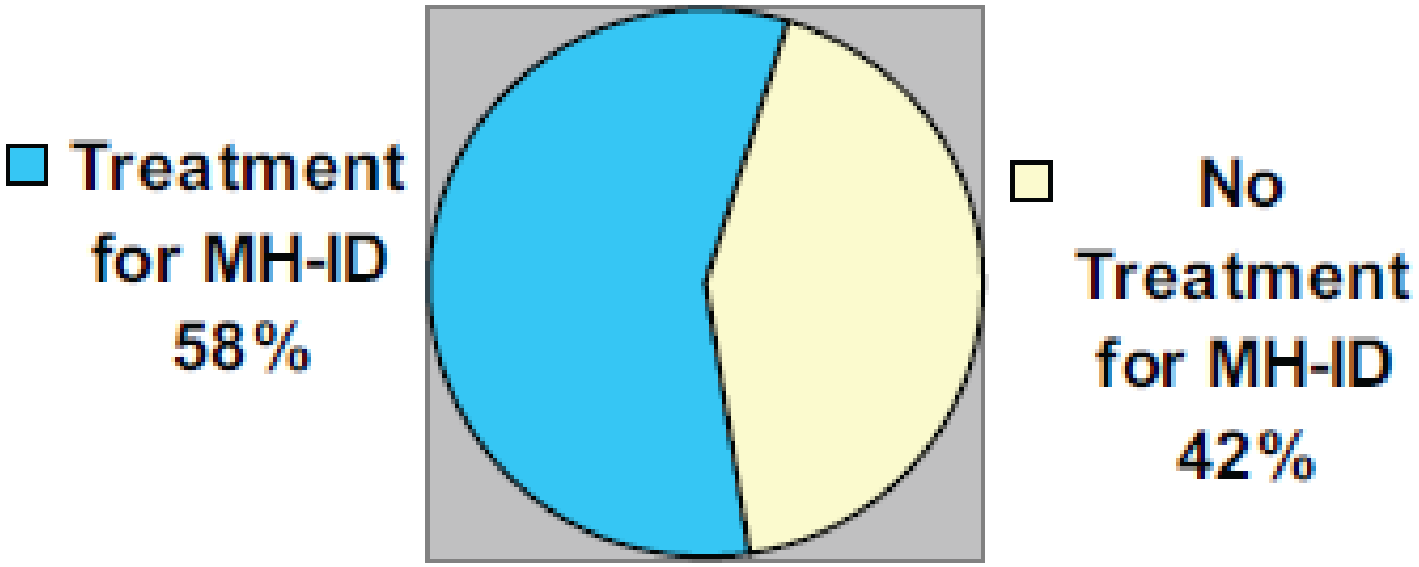
- stress, i.e., social rejection, ridicule, isolation
- limited coping skills
- language problems
- lack of social support
- central nervous system impairment
- behavioral phenotypes

If this is true, why is it still overlooked?

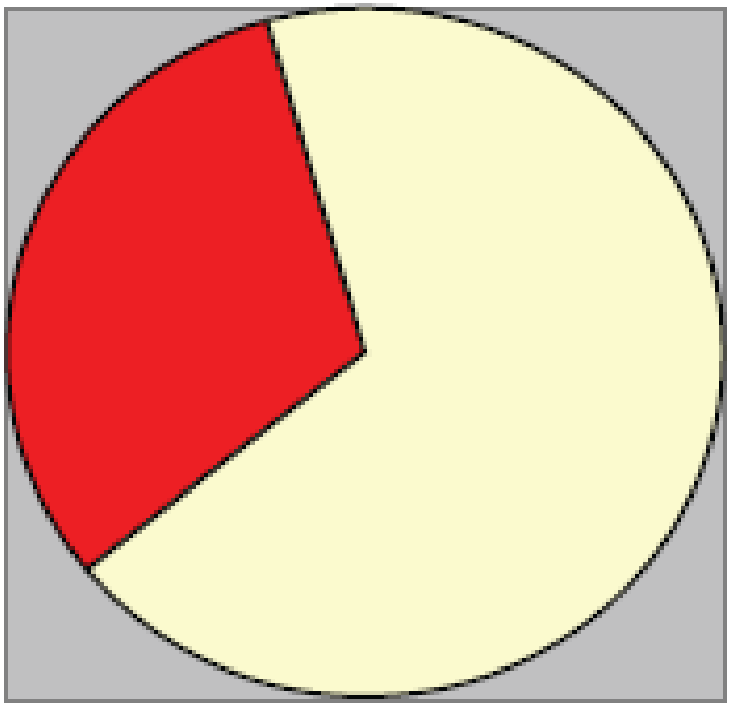
- Diagnostic Overshadowing-overlooking or minimizing signs of mental illness
- DD is considered more debilitating and therefore should be the focus of treatment
- DD failed to acknowledge the individuals with MI that were also DD
- No consensus yet on how to diagnosis BH in people with DD
- Professionals are often pressed to assign a "primary" diagnosis as Mental Health and DD services have historically existed in "silos", separated into two administrative processes

Why is MH/DD overlooked? Continued

Clinicians Currently ProvidingTherapy to People With MH-ID



Why is MH/DD overlooked? Continued



Education for MH-ID

No MH-ID Education

Different Systems

BH System	ID Systems
Rehabilitation	Habilitation
Recovery	Self-Determination
Medical Model	Development model
Clients	Consumers
Short Term Approach	Long Term Approach

Time for a Paradigm Shift

- ***Paradigm****-a philosophical or theoretical framework*
- ***Shift****-to move one place to another*

OLD

NEW

"No problem can be solved using the same consciousness that created it."
Albert Einstein

Similarities

- **Just like individuals with DD/BH concerns are more alike others than they are different, so are the systems supporting them. Both systems work with consumers to:**

1) Address and support healthy development
2) Promote EBP/Best practice guidelines
3) Support individual in securing employment, post-secondary education, stable housing
4) Support individual in the least restrictive environment
5) Support Independent living
6) Want the best for the consumer
7) Practice person centered planning

Similarities continued

- All children demonstrate similar signs at the onset of mental health concerns:

- ✓ Change in physical appearance
- ✓ Unusual sleeping habits
- ✓ Skipping normal activities or hobbies
- ✓ Change in friends
- ✓ Declining grades
- ✓ Missing school
- ✓ Mood changes
- ✓ Missing money or valuables

What the research says

To adequately provide services for children with Co-Occurring Disorders we must:

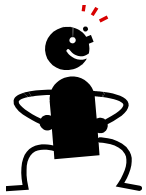
- Thoroughly evaluate the person's behavior
- Determine diagnoses based on complete psychiatric evaluation including behavior observations by those who care for the person
- Develop a COORDINATED support/treatment plan

In Missouri

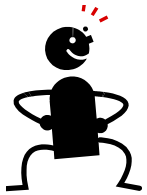
- 2005-establishment of the Office of Comprehensive Children's Mental Health via RSMO 630.097
- DMH developed the Protocol for Planning for Children with Co-Occurring Disorders
- Treatment/Support planning includes all the professionals and natural supports that a person has in their life
- Planning is based on the person's needs at that time and is updated as changes occur for that person

Protocol Continued

Instead of one DMH agency always taking the lead, the family and the person's needs dictate which agency becomes the lead…



Mental Health



DD

"Weakness of attitude becomes a weakness of character."
Albert Einstein

Protocol Continued

- Planning occurs jointly with each team member contributing to the supports/treatment as needed.
- Every attempt is made to share the cost of planning/treatment.
- Barriers to planning are taken to administrators for resolution

How do we get there?

- Cross training
- Cross systems crisis planning
- Cross system dispute resolution
- Cross system data base
- Cross system quality assurance and case review

How do we get there? continued

Stay Informed!

- ask informed questions,
- gather pertinent information,
- identify EBP, which have been adapted to address issues concerning youth with co-occurring disorders.

Case Scenarios

Scenario 1

Tim is a 10 year old with Mild Intellectual Disability. He is in the 4nd grade and receives special education services. Tim lost his father in a car accident a little over 2 years ago. Slowly over time, Tim has begun to have difficulty focusing at school, doesn't sleep well, and has been aggressive with his mom. After seeing his pediatrician, who finds no medical problems, the RO SC refers Tim to the CMHC for an evaluation. Through the evaluation, it is determine that Tim is experiencing clinical depression.

Scenario 2

Joan is a 12 year old who has been diagnosed with ADHD, Oppositional Defiant Disorder, Pervasive Developmental Disorder, NOS, Alcohol/Cannabis Abuse, and R/O Bi-Polar Disorder. Her parents, who have not sought state services until this time, have contacted both the RO and CMHC. Joan has been found eligible for services by both agencies. Joan's parents have indicated that can no longer stand the stress of caring for Joan and want placement for her.

Resources

National Association on Dual Diagnosis (NADD), Washington DC

www.nadd.org

Diagnostic Manual-Intellectual Disability (DM-ID)

Journals: *NADD Bulletin*

Journal of Mental Health Research on Intellectual Disabilities (JMHRID)

American Association on Intellectual and Developmental Disabilities (AAIDD) Washington, DC

www.aaidd.org

Journals: *American Journal on Intellectual and Developmental Disabilities (AJIDD)*

Intellectual and Developmental Disabilities (IDD)

More resources

National Alliance on Mental Illness (NAMI), Missouri Chapter
www.mo.nami.org
3405 W Truman Blvd, Ste 102
Jefferson City, MO 65109-5861
Phone: (800) 374-2138, **Fax:** (573) 761-5636

AAIDD, Missouri Chapter
www.moaaidd.org

US Department of Health and Human Services (DHHS)
Substance Abuse and Mental Health Services Administration(SAMHSA
www.samhsa.gov

More resources

National Association of County Behavior Health and Developmental Disabilities Directors (NACBHDD)

Washington, DC

www.nacbhdd.org

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