



Robyn Woods

Behavioural concerns

Assessment and management of people with intellectual disability

Background

General practitioners often care for people with an intellectual disability, and challenging behaviours are a common presentation, whether the patient lives with their family or in a group home.

Objective

This article aims to give practical advice on the assessment and treatment of behavioural issues in patients with intellectual disabilities.

Discussion

General practitioners can make a significant contribution to improving the quality of life of intellectually disabled persons. Collecting a careful description of the behaviour, assessing for physical causes and considering specific psychiatric diagnoses will help the GP target appropriate intervention. Psychological support under the Better Outcomes in Mental Health Care program can assist in developing behavioural strategies. The role of medication is also discussed.

Keywords: disability, intellectual; behavioural symptoms, emotions



General practitioners often care for patients with an intellectual disability. These patients may live with their family or in a group home. People with intellectual disability experience the same range of mental illnesses as the rest of the community, however they may express it differently. With poor verbal skills they may be easily frustrated and act out or withdraw.

Challenging behaviours are 3–5 times more common in the intellectually disabled population than in the general population.¹

Challenging behaviours can include:

- aggression toward others
- self injurious behaviour
- inappropriate social and sexual behaviour, and
- self stimulating behaviour such as excessive rocking, extreme withdrawal or noncompliance.²

Assessment

Careful assessment of behaviour

An accurate description of the behaviour is an important starting point. This includes triggers and patterns of escalation so that behavioural intervention can be started early. The behaviour may be a response to the living environment. The intellectually disabled person may simply be bored, reacting to noise or overcrowding, or attempting to communicate a normal emotion, such as sadness or anxiety, with limited vocal skills. Does this person have meaningful activities in their life? It is important to consider a change in behaviour as against the background of the person's normal behaviour patterns.

Some syndromes can be associated with a behaviour pattern that is linked to that syndrome. It is worth seeking out a list of features when dealing with a patient who has a syndrome you are unfamiliar with.

Understanding the communication from a person with poor verbal skills may involve signing and the use of communication aids. A family member or staff member familiar with the patient can be of great assistance.



Consider physical causes of pain

The next most important aspect of assessment is to screen for physical causes.

- Is this unrecognised pain? Easily missed causes of pain include reflux, otitis media, fractures, urinary tract infection and dental pain. Simple things such as constipation can cause significant behavioural changes
- Is there an endocrine cause? Check thyroid function and B12, calcium and sodium levels
- Is there a prescribed medication that is making things worse?
- Is there excess caffeine being consumed?
- Could this be seizure activity?

Consider specific psychiatric conditions

After excluding physical causes assess the patient for specific psychiatric conditions. Depression may present as agitation/aggression or as withdrawal. Loss of sleep or appetite, reduced motivation and loss of pleasure are common features of depression.³

If depression is present look for mania and consider bipolar disorder. Anxiety disorders are common in the general population, and in people with intellectual disabilities as well. Assess for generalised anxiety symptoms, and obsessive compulsive disorder symptoms and phobias. Ritualistic behaviour may indicate anxiety or autism.³

Psychoses characterised by loss of touch with reality or bizarre behaviour may be difficult to diagnose, especially in people with poor verbal skills. Self talk, if present, may simply represent the patient processing their day in an auditory way.³ It may also represent a response to auditory or visual hallucinations so the content of the self talk is important.

Management

Environmental modification

Issues for people with intellectual disability in the home environment can include:

- an over- or under-stimulating environment
- social isolation
- confusing or inconsistent communications, or
- excessively demanding situations or expectations.²

Modifying the home environment can include simple changes to reduce overstimulation, such as turning off the television or radio. Conversely, providing games and activities and opportunities to engage with others can help reduce behavioural issues related to under stimulating environments.

Communication can be improved by keeping sentences short and simple. Short, simple instructions can also reduce anxiety symptoms that arise from performance pressure and unrealistic expectations. The use of sign, visual and communication aids can also optimise successful communication by those who have speaking difficulties.

Family care and group home care

Families caring for a child with intellectual disability are often tired and have limited access to respite. As the child grows, the damage caused by physical outbursts also grows. Support for the family from both the GP and allied health professionals is critical. Encourage tenacity in families in their pursuit of funded services.

The challenge in group homes is to obtain adequate history from staff. Persist. Issues that arise in group homes often include loss of control and grief: staff members change; service providers change as contracts are renewed; clients are moved, residents change and family is missed. Enlisting the help of a psychologist to help the person process these emotions and implement behavioural strategies is very useful.

Under the Better Outcomes in Mental Health Care program, the Medicare Benefits Schedule gives a list of referable disorders that allow access to a psychologist. Intellectual disability is excluded as a sole condition for referral. If you have assessed the patient as having anxiety or depression, or any other recognised disorder, then they may be referred under this scheme.⁴

Group home patients may also have access to a behavioural practitioner who can liaise with the psychologist and staff.

Drug management

If you have a specific psychiatric diagnosis, use the appropriate psychotropic medication that you are familiar with for that condition. The principal is to start low and go slow.⁵

It is important to obtain consent before prescribing. Be aware that a number of psychotropics lower the seizure threshold and can increase the frequency of epileptic fits. Monitor these patients for an increase in fit frequency.

If the diagnosis is unclear, consider referral or telephone discussion with a psychiatrist. If the patient performs repeated and serious acts of aggression, discuss this with a psychiatrist. Medications used in these scenarios include antipsychotics, beta blockers, and selective serotonin reuptake inhibitors (SSRIs) and mood stabilisers.⁵

If the patient is on a regular atypical antipsychotic and needs an 'as required' (PRN) dose, the PRN is usually an 'extra' dose of the routine medicine. Always monitor the frequency of PRN use.

Autism is the most common indication for antipsychotics in the paediatric intellectually disabled population.⁶ Where there is severe aggression and injuries to self or others, risperidone is available on the Pharmaceutical Benefits Scheme (PBS). The PBS Authority criteria includes that the patient is under the supervision of a psychiatrist or paediatrician and that nonpharmacological methods of control have been unsuccessful.^{6,7}

If certain activities always bring on extreme agitation, such as a hospital outpatient clinic or the taking of bloods, a PRN may be used. Benzodiazepines may be used with caution, being aware of their ability to cause respiratory depression and addictive potential.⁸ They can also cause a paradoxical agitation reaction.⁸ Prescribe a test



dose, during office hours, to assess its effect and duration. Dosing depends on the patient's age, weight and concurrent medications. For example, a small elderly woman with Down syndrome will need a smaller dose than an otherwise healthy adult who is on multiple psychotropic medications. Charting benzodiazepines as 'pretest' or 'prespecialist' visit on the stat sheet is a way of avoiding overuse. Always monitor the frequency of PRN medications.

Case study

John, 54 years of age, has cerebral palsy, an intellectual disability, anxiety and bipolar disorder. He has a long history of anger outbursts. He lives in a group home and was hospitalised when he put his arm through a plate glass window. He also punched a staff member at the group home.

At the time of being hospitalised he was on paroxetine, lorazepam, and olanzapine, both regular and PRN. These medications were supervised by a psychiatrist. John was able to answer simple questions with slightly slurred speech, but was easily understood. He liked to please the questioner and would answer questions with what he thought they wanted to hear. As such, questions to assess his mental state needed to be clear, simple and open ended. John was referred to a psychologist with experience in disability. Sessions targeted grief and loss: his mother dying a number of years ago; his wanting to be with family; and issues from the group home including staffing and activity scheduling, and issues with other clients at his group home.

Under the Better Outcomes in Mental Health Care program, John had six (plus six) sessions, which was extended to 18 sessions under extenuating circumstances, as he was clearly benefiting from seeing a psychologist. His issues of grief and loss were communicated to the staff at the group home to assist them in responding more appropriately to his feelings of sadness, irritability and anger. The psychiatrist also noted PRN use on seven occasions over several months, so John's olanzapine dose was increased from 15 mg/day to 20 mg/day. This reduced his PRN use.

Summary of important points

- Challenging behaviour may present as acting out or withdrawing.
- Loss of function – is it organic, dementia or depression?
- Look for pain/physical causes.
- Check that new medications have not made things worse.
- Always ask about sleep and appetite changes when checking for depression. Anhedonia is a particularly important and useful clue to depression.
- Look for specific psychiatric diagnoses.
- Refer early to a psychologist under the Better Outcomes in Mental Health Care program when possible.
- Refer/telephone a psychiatrist for advice regarding drugs.
- Judicious use of PRN medications can be helpful in specific situations.

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