

**Webinar 11**

**Working to support the mental health of children with an intellectual disability**

7:15 pm to 8:30 pm AEST  
Thursday 13<sup>th</sup> February 2020

**Emerging Minds.** National Workforce Centre for Child Mental Health





Emerging Minds and MHPN wishes to acknowledge the Traditional Custodians of the lands across Australia upon which our webinar presenters and participants are located.

We wish to pay respect to the Elders past, present and future for the memories, the traditions, the culture and hopes of Indigenous Australia.



## Welcome to series two

This is the third webinar in the second series on child and infant mental health, presented by Emerging Minds and the Mental Health Professionals' Network.

Upcoming webinars in this series are:






- **Supporting trans and gender diverse children and their families**
- **Aboriginal children and the effects of intergenerational trauma**
- **Engaging children and parents affected by child and sexual abuse**

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## How to use the platform

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-  open the chat box
-  ask the panel a question
-  access resources including the case study, panel biographies and supporting resources
-  open the survey
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## Learning outcomes

At the webinar's completion, participants will be able to:

- Identify the risk and protective factors for children where they have an intellectual disability.
- Describe best practice of collaboration with families and children that achieve positive social and emotional wellbeing outcomes for children with intellectual disability.
- Describe tools and tips for assessing, recording and reporting the mental health concerns in children with intellectual disability.



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## Tonight's panel



**Dr Janina Szyndler**  
Clinical, Educational and  
Developmental  
Psychologist, NSW



**Emeritus Professor Stewart Einfeld**  
Psychiatrist, NSW



**Facilitator: Dan Moss**  
Workforce Development Manager,  
Emerging Minds, SA



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## Concepts and classification



Emeritus Professor Stewart Einfeld

- Confused history especially around the relationship between "behaviour problems" and "psychiatric disorders" of people with intellectual disability.
- Bottom-up and top-down approaches to classification:
  - Top down e.g. Diagnostic and Statistical Manual of Mental Disorders (DSM), International Classification of Diseases (ICD).
  - Bottom-up e.g. syndromes derived from factor analysis of behavioural questionnaires, e.g. Developmental Behaviour Checklist: disruptive, self-absorbed, anxiety, social relating, communication.



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## Presentations of psychopathology



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- Mild intellectual disability
  - similar to TD, but simpler in ideational content
  - externalising/disruptive problems are common
- Moderate/severe intellectual disability
  - unusual behaviours, e.g. self-injury, stereotypes, rituals
- Profound intellectual disability
  - not much behaviour
- Increased rate of behavioural problems start very early, decline slowly through young adulthood but remain increased



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## Assessment of behavioral and emotional disturbance



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- Use multiple sources of information.
- Use structured and unstructured techniques.
- Language at level of mental age, plus visual tools e.g. COOP pictograms.
- Remember impairments may vary across domains, e.g. William syndrome expressive language > receptive > visuospatial.



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## Some causes of mental health problems in people with intellectual disability



Emeritus Professor Stewart Erfeld

- **Biological** - brain dysfunction, including behaviour phenotypes of genetic syndromes, epilepsy
- **Psychological** - reduced capacity to find adaptive solutions to problems, increased experience of trauma, learned maladaptive behaviour patterns
- **Social-stigma** - exclusion, poverty, family dysfunction



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## Some behaviour assessment questionnaires



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- **Aberrant Behaviour Checklist**
  - Informant-based 58-item questionnaire suitable for people with moderate to profound levels of intellectual disability aged 5 and over. Frequently used in drug studies to measure the effects of interventions and levels of maladaptive behaviour. The checklist consists of five subscales.
- **Developmental Behaviour Checklist** (DBC; Erfeld & Tonge, 2002)
  - The DBC-Parent/Primary Carer and DBC-Teacher versions are used with young people aged 4–18 years, measure the Total Behaviour Problem Score as well as scores on five subscales: disruptive/antisocial, self-absorbed, communication disturbance, anxiety and social relating.
  - Cases of disorder can be determined by a score of 46 or more on the Total Behaviour Problem Score. The instrument is designed to supplement clinician assessment for use in treatment studies. Norms available Australia, the UK and the Netherlands.
  - Other forms: short form, adult form, monitoring form.



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## Some aspects of assessment



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- Psychosis is often over diagnosed
  - People with intellectual disability may have audible conversations with no-one as a social training deficit, not a delusion.
  - Paranoia may be real!
- Depression underdiagnosed
- Epilepsy-related behaviour notable



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## Protective factors

- Parents appear to have a good relationship with Noah and have tried their best to prioritise his needs and provide a stable routine for him.
- Noah has an appropriate educational placement. He has engaged with speech therapy to build his communications skills. Also linked in with paediatrician or child psychiatrists who is prescribing medication.
- History of appropriately managing Noah's behaviour and understanding that all behaviour has communicative intent.
- Awareness of the impact of mental health on their own functioning (Amy - Post Natal Depression, Jesse - Anxiety) and willingness to engage with services around this.



Dr. Janina Snyder



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## Risk factors

- Noah is a child with complex long term needs - his moderate intellectual disability, ADHD and epilepsy which places him at increased risk of long term behavioural and mental health challenges (e.g. Dekker et al 2002).
- Amy, as the primary carer does not work outside the home, and also has another child with anxiety and an ageing mother, which will increase the demand on her. She also has a history of post natal depression.



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## Need to consider multiple factors in intervention

Already aware of:

- management of Noah's environment
- developing predictable routines
- working on developing Noah's communication skills
- consistent responses to his behaviour.

Also need:

- review of his medications and physical health especially any factors impacting on his sleep (apnoea) changes in epileptic activity?
- to review support for family, parents individually or as a couple, sister and additional in home support, respite care?



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## As a psychologist

- Family support: Meet with parents to talk about their views and expectations of themselves and Noah. Look at what they would like to prioritise. Individual support for Amy? Exploring beliefs, expectations and pressures.
- Behavioural support: ABC chart to monitor behaviour at home and at school - establish if there are any particular triggers or reinforcers for behaviour.
- If triggers identified - how can these be modified?
- If reinforcers - how can these be modified?



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### Behavioural intervention

- Identify circumstances which make behaviour more and less likely.
- Assess antecedents and consequences.
- Challenging behaviours rarely occur without a precipitant.
- Identify gains of behaviour problem ("functions").
- Minimise reinforcers and reward more adaptive solutions.
- Simple reward program done properly.



Dr. Janina Snyder



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### Simple Guide to Behaviour Reward Programs.

- Step 1: Select one behaviour at a time, usually the behaviour which is causing the most concern.
- Step 2: Behaviour must be easy to understand by the child and the parent and described in specific not general terms.  
(e.g.: 'not kicking his sister' would be okay whereas 'doing what he is told' is not okay).
- Step 3: Pick a reward that matters to the child. (Reward may need to change over time).
- Step 4: Time between behaviour and reward has to be close enough to be within the child's time concept.
- Step 5: Try to find a more adaptive way for the child to achieve what he/she wants.



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### DBC-M

Behaviour	Date							Weekly Total
	21/10	22/10	23/10	24/10	25/10	26/10	27/10	
Eats non-food items	2	2	1	2	0	2	1	10
Smells, tastes or licks objects	0	1	1	0	2	0	0	4
Panics	0	0	0	0	1	0	0	1
Has temper tantrums	2	2	2	1	2	1	2	12
Scratches or picks skin	2	1	0	1	0	0	2	6

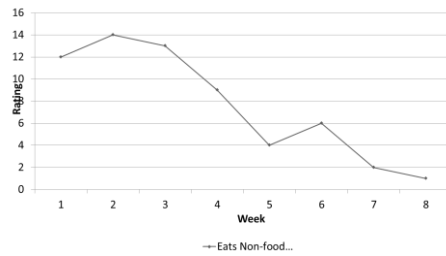


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### DBC-M



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## Multidisciplinary intervention essential

- Providing support for NDIS applications.
- Identifying other services family can access e.g. Stepping stones-Triple P.
- Carers Australia - information, advocacy and individual counselling for carers (free). *There may be some changes in this service - not sure exactly what will be on offer in 2020.*



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## Pharmacological treatment of behaviour problems

- Informed consent, viz Guardianship Act.
- Tranquilisers overprescribed.
- Use a systematic approach
  - identify clear targets of treatment, maximum doses, systematic effect and side-effect monitoring
  - unpredictable side-effects or dosage sensitivities more common
  - withdraw slowly.



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## Pharmacological treatment of behaviour problems

- Antipsychotics
- Anxiolytics
- Mood stabilizers
- Antidepressants
- Stimulants
- Anticonvulsants
- Antilipidals



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## Q&A Session



Emeritus Professor Stewart Einfield  
Psychiatrist, NSW



Dr Janina Szyndler  
Clinical, Educational and Developmental Psychologist, NSW



Facilitator: Dan Moss  
Workforce Development Manager, Emerging Minds, SA



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## Resources and further reading

Other supporting resources associated with this webinar can be found by clicking on the light blue supporting resources icon.

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### Upcoming webinars:

- Mental illness, terrorism and grievance-fuelled violence: understanding the nexus on Tuesday 18th February. [Learn more and register here](#)
- Responding to the needs of a person who presents with suicidality Monday 23rd March. [Register here](#)
- Supporting Trans and Gender diverse children and their families Thursday 23rd April. Registrations open soon.



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## Thank you for participating



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- Statements of Attendance for this webinar will be issued within four - six weeks.
- Each participant will be sent a link to the recording of this webinar and associated online resources within four – six weeks.



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This webinar was co-produced by MHPN and Emerging Minds for the Emerging Minds: National Workforce Centre for Child Mental Health (NWCCMH) project. The NWCCMH is led by Emerging Minds and delivered in partnership with the Australian Institute of Family Studies (AIFS), the Australian National University (ANU), the Parenting Research Centre (PRC) and the Royal Australian College of General Practitioners (RACGP).

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