HEALTH CARE FOR PATIENTS WITH MENTAL ILLNESS AND INTELLECTUAL DISABILITIES – THE DUALLY DIAGNOSED POPULATION:

Utilizing Strategic Actions to Facilitate Communication and Improve Care

OBJECTIVES

- Assess your own attitudes toward individuals with mental illness and/or intellectual/developmental disabilities
- Discuss guidelines for communicating with patients who have mental illness and/or intellectual/developmental disabilities
- Assess causes of inappropriate behavior in patients with mental illness and/or intellectual/developmental disabilities
- Describe key components of the verbal de-escalation technique
- Facilitate support services for the patient with mental illness and/or intellectual/developmental disabilities

ATTITUDES MENTAL ILLNESS

- Healthcare professionals' assumptions about individuals with mental illness can result in poor communication
- Examples:
  - Assume patients with mental illness are aggressive
  - Assume complaints related to medical issues are psychiatric in nature
  - Assume a link between mental illness and level of intelligence
  - Assume individuals with mental illness are drug seeking

All of these individuals struggled with mental health

ATTITUDES INTELLECTUAL/DEVELOPMENTAL DISABILITIES

- Healthcare professionals' assumptions about individuals with intellectual/developmental disabilities may result in poor communication
- Examples:
  - Assume inability to communicate problems, thoughts, concerns
  - Assume inability to participate in care
  - Assume inability to comprehend discussions about healthcare topics
  - Assume too much time and effort to provide care to the individual
  - Assume poor quality of life – wasted resources

CASE 1

- A 45-y/o female with a history of I/DD, OCD, autism with SIB and epilepsy who is currently living in a group home in the community presents with increasing SIB and agitation. She has been on stable doses of medication including Depakote, Topamax for her seizures and mood stabilization as well as Abilify and Prozac.
- The recommendation to add increased behavioral support was made as well as to increase community outings. This individual thrived in a “classroom” type setting and enjoys outings that encouraged this.

GUIDELINES FOR COMMUNICATION MENTAL ILLNESS

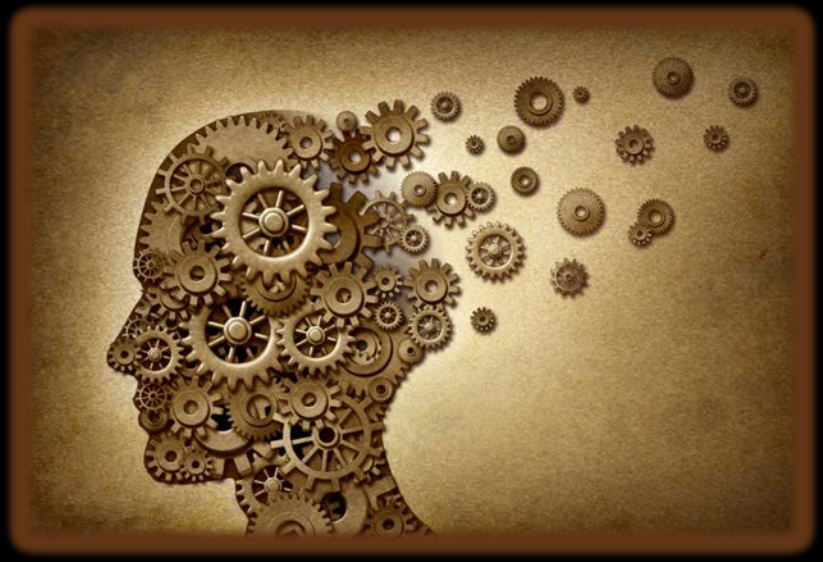
- Treat the individual with respect – as a unique person, not as his/her diagnosis
- Exhibit compassion and empathy through non-judgmental listening
- Reflect information back and ask questions so you can understand
- Avoid reactive listening (arguing, blaming, criticizing, or giving advice)

GUIDELINES FOR COMMUNICATION MENTAL ILLNESS [2]

- Be truthful – Not doing so will quickly erode rapport
- Allow the individual to participate as much as possible in his/her treatment. Try to find goals you can both agree upon
- Seek to maintain the focus of the interaction
- For those individuals experiencing hallucinations/delusions, communicate that you understand what he/she is experiencing but don't pretend that you are also experiencing them

CASE 2

- 46-y/o male with history of I/DD, epilepsy and psychotic d/o who presents for follow-up with the complaint of feeling drowsy and “twitchy”.
- Meds: VPA, Clozapine, Benztropine
- Labs: CBC – Nl; VPA – 106
- Plan: Decrease VPA dosage.
- He was previously placed on slightly higher VPA dosage due to being on psychiatric polypharmacy that had increased his risk for seizures. He is now at a lesser risk and is ok to come back down on the seizure coverage.



GUIDELINES FOR COMMUNICATION MENTAL ILLNESS [2]

- Provide more space for individuals who are paranoid or psychotic/delusional
- If the individual is suffering from extreme psychiatric symptoms, try to find out what reality based needs you can meet
- Set limits if the individual's behavior is inappropriate, unacceptable, or is otherwise disruptive
- Set limits on when and how long you can listen
- Maintain calm composure
- Get past language or criticisms hurled at you
- Seek consultation of colleagues as needed

GUIDELINES FOR COMMUNICATION INTELLECTUAL/DEVELOPMENTAL DISABILITIES [1]

- People with intellectual/developmental disabilities have diverse language comprehension skills and communication abilities.
- Healthcare providers need to know how well an individual can communicate and how much he/she can understand in order to promote effective communication

CASE 3

- 50-y/o female with profound I/DD, epilepsy, CP, autism with SIB and psychotic d/o who is followed by both psychiatry and neurology for her dually diagnosed issues and is well controlled on her medications. She tends to have behavioral problems (SIB) and vocalizations when she has a medical issue (pain).
- Meds: Lamictal, Keppra, Tegretol, Klonopin, Vimpat, Zonegran, Geodon, Cogentin

GUIDELINES FOR COMMUNICATION INTELLECTUAL/DEVELOPMENTAL DISABILITIES [3]

- Establish Rapport
  - Avoid directing all communication to the person's caregivers
  - Talk to the individual in an age-appropriate manner
  - Ask simple questions to break the ice (e.g. name, reason for visit)
  - Explain the process and purpose of visit in a manner the individual can understand
  - Gain eye contact, if possible, through the use of touch prior to sharing information or by calling the person's name
  - Utilize the individual's communication technique or device and ensure the caregiver participating in the interaction is able to assist.
  - Allow the individual to keep a favorite item, sit in a preferred spot, or to stand rather than sit
  - Some individuals may be uncomfortable with eye contact

GUIDELINES FOR COMMUNICATION INTELLECTUAL/DEVELOPMENTAL DISABILITIES [3]

- Make Thoughtful Language Choices
  - Ask clear, direct questions; Give clear, direct instructions
  - For example, “Are you sad?” instead of “How are you feeling?”
  - Avoid using a louder tone of voice to help the person understand you better
  - Use the same language as the individual, avoid medical terms
  - When discussing concepts that involve time, refer to familiar routines such as meals, bedtime, activities, etc.

GUIDELINES FOR COMMUNICATION INTELLECTUAL/DEVELOPMENTAL DISABILITIES [3]

- Actively Listen
  - Actively listen to what an individual says
  - Allow the individual enough time to communicate
  - Voice your understanding and lack of understanding of what the person is communicating
  - Nonverbal cues are as important as what the individual is communicating verbally
  - Some people may have problems with muscle tone which can make it difficult to interpret facial expressions and body language. Ask to be sure your perceptions are correct.

GUIDELINES FOR COMMUNICATION INTELLECTUAL/DEVELOPMENTAL DISABILITIES [3]

- Provide Clear Explanations
  - Review what you are going to do prior to starting
  - Demonstrate what you are going to do and explain the purpose
  - Ensure you speak in an appropriate tone and at an understandable pace
  - Provide breaks for the individual to digest information
  - Allow the individual time to process and respond to the information being shared
  - Be willing to restate the information in a different way if needed. If the person can read, writing the information down may be helpful
  - Avoid overloading the individual with information
  - Level of understanding should be checked frequently. This can be done by asking simple, direct questions

GUIDELINES FOR COMMUNICATION INTELLECTUAL/DEVELOPMENTAL DISABILITIES [3]

- Communicate without words
  - Visual aids
  - Demonstrations
  - Simple diagrams
  - Gestures
  - When possible and safe, allow the individual to handle and become more familiar and comfortable with the equipment
  - Point to body parts and describe or demonstrate procedures

CASE 4

- 64 y/o female with CP with left hemiparesis, mild I/DD, hx of seizures/status epilepticus, mood d/o, generalized anxiety, and severe pulmonary disease (COPD/asthma) requiring O_2. She is a “frequent flyer” in the ER due to her severe respiratory issues or recurrent infections due to severe peripheral edema and medical noncompliance with subsequent wound formation. She frequently refuses to take medication or to adhere to treatment plans often due to poorly communicated instructions.

VERBAL DE-ESCALATION [2]

- Used when a situation is potentially dangerous or threatening
- Goal is to prevent a person form harming themselves or others
- The use of physical force is never advocated – should only be used as a option of last resort to prevent injury to self and/or others – often results in injury to person and/or staff

VERBAL DE-ESCALATION STRATEGIES [2]

- Respect personal space
  - Space for the patient's comfort and for your safety
- Avoid provocation
  - Hands visible and relaxed
  - Calm presence and appearance
  - Avoid staring
  - Body language should match verbal communication – you will not harm the patient, you want to listen, you want everyone to be safe

VERBAL DE-ESCALATION STRATEGIES [2]

- Establish communication
  - Designate one person to communicate with the individual. Ideally, this person should be properly trained in de-escalation strategies.
  - Be respectful, introduce yourself, and explain that you are there to promote the safety of all involved
- Keep it short
  - Agitation reduces the individuals ability to process information (which may already be limited to some degree depending upon their level of IDD) – Use short sentences and concrete language to reduce the risk of escalation
  - Be consistent in your message and restate as necessary when requests, limit setting, choices occur

VERBAL DE-ESCALATION STRATEGIES 2

- Be aware of the person's needs/wants
  - Inquire about his/her needs; Be honest when you can't meet a need
  - Take notice of the person's body language, comments, and remember your past interactions. All of these may help you identify their needs.
  - Demonstrate to the individual that you care and are attentive to their feelings by acknowledging what you hear/observe, engaging in conversation with the person, and maintaining empathetic body language.
  - Use *Miller's Law* – "To understand what another person is saying, you must assume that it is true and try to imagine what it could true of" – Reduces our tendency to judge others and expresses to the individual that we are genuinely trying to understand where he/he is coming from

VERBAL DE-ESCALATION STRATEGIES 2

- Agree to agree or disagree
  - Fogging – finding something about which you can agree
  - Agree with the truth
    - “Yes, she has stuck you three times. Do you mind if I try?”
  - Agree in principle
    - After the individual complained of being disrespected: “”I believe everyone should be treated respectfully.”
  - Agree with the odds
    - After the individual complained about a long wait: “There are probably other patients who would be upset also.”
  - When you cannot agree – because of delusions, never had that experience, etc. – simply let the patient know that you believe he/she is experiencing what they are describing. In other situations, you can simply agree to disagree.

VERBAL DE-ESCALATION STRATEGIES [2]

- Clearly and firmly set limits
  - Describe acceptable behaviors and express your willingness to assist the individual be successful, but be clear that you will not tolerate mistreatment
  - In a firm but supportive way, advise the person that he/she may not injure him/herself and that assaulting others may result in arrest and prosecution
  - Consequences of limit violations must be:
    - Clearly related to the specific behavior
    - Reasonable
    - Presented in a respectful manner

VERBAL DE-ESCALATION STRATEGIES 2

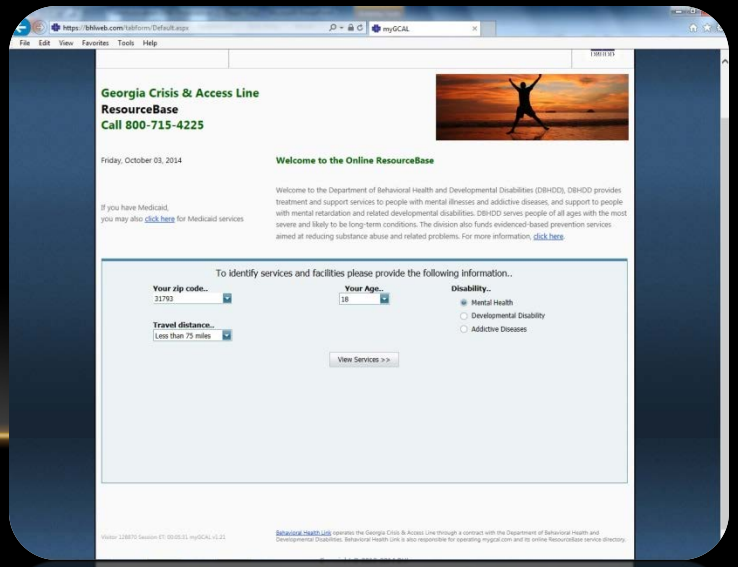
- Provide appropriate choices
  - When the individual is escalating toward aggression, offer alternatives
  - Compassion may delay aggression (blankets, magazines, access to phone, food, drink) – Never make promises you can't keep
  - Ask the individual what calming strategies work for him/her
  - When medication is indicated, offer the individual a choice
    - Medication choice – Can give individual a choice of medications by providing information about side effects
    - Route of medication – "Would you like to take this medication by mouth or by a shot?"

VERBAL DE-ESCALATION STRATEGIES 2

- After the incident, review with the individual (if possible) and staff
  - Allow the individual to discuss the event and explain his/her perspective. Discuss the actions taken and why they were necessary.
  - Devise a plan for managing aggression in the future
  - Allow staff recommendations for improvement based upon the successes and failures of the event.

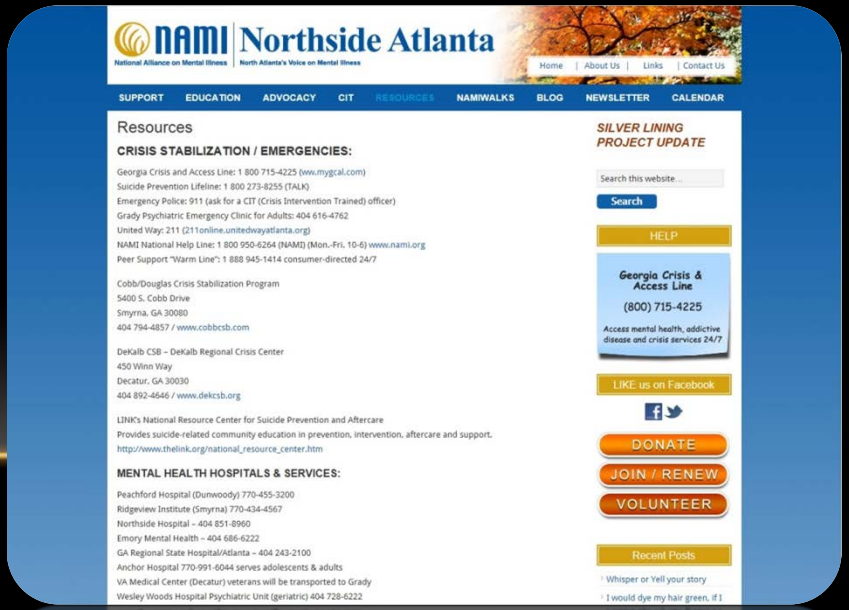
FACILITATE SUPPORTS

- GCAL – Georgia Crisis Access Line - 1-800-715-4225
  - Offers a statewide toll-free call center for consumers to access services
  - Operates 24/7 and has the capacity to screen and assess callers for intensity of service response
  - The website contains a resource database of service providers and contact information throughout the state. Using your zip code, you can identify a provider in close proximity.
  - Visit: www.mygcal.com



FACILITATE SUPPORTS

- Guide to services in Region 4
  - https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Region%204%20-%20SW_v2.pdf
- Facilities should develop a list of specific community resources that individuals can access upon discharge
  - Sample: http://naminorthsideatlanta.org/resources/



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