Adults with Developmental Disabilities: The Series

Psychotropic Medications: Considerations and Concerns

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Disclaimer:

- Please be advised that I am not attempting to represent myself as a medical doctor or as someone who can prescribe medication. The information and observations contained within this webinar are based upon my 35 years of experience in working with "dually diagnosed" (mentally ill/DD) adults. I have had the extreme pleasure and benefit of working collaboratively with several **outstanding** psychiatrists, and many of my opinions and beliefs are based upon what I have learned from some of these brilliant practitioners. Studying and staying current with the field of psychopharmacology has been, and continues to be, a lifelong passion of mine.

Diagnostic Issues:

- As a general rule, it can be EXCEPTIONALLY DIFFICULT to diagnosis non-verbal, lower-functioning individuals who cannot directly contribute to the evaluation and assessment process; many psychiatrists are not adequately trained and/or "comfortable" serving this population
- It has been **well established** that individuals with developmental disabilities are more susceptible to developing some form of mental illness as compared to adults in the "general" population
- Personally, I believe one of the most "overlooked" diagnoses in our population is DEPRESSION; this can include forms that I refer to as "agitated depression"
- We need to be very careful when recording/maintaining data which impacts prescribing of psychotropic medications; are we simply treating "behaviors" or are we treating symptoms of a suspected mental illness that may have a behavioral expression/manifestation? This is a very important distinction!

Diagnostic issues

- BPD (Bipolar Disorder) is likely over-diagnosed; this diagnosis justifies the administration of many different classifications of medications
- BPD (Borderline Personality Disorder) is likely under-diagnosed; one of the reasons is that individuals with BPD oftentimes do not respond to psychotropic medication treatment/intervention; from my experience, characteristics may include:
- A. History of family abuse/dysfunction/pathology
- B. Can be **extremely** polite, friendly, respectful but can also be **extremely** rude, hurtful, and demeaning; never share personal information!
- C. Sexual "confusion" or displaced emotions/feelings (frequently towards staff), inability to initiate/maintain healthy intimate relationships
- D. Superficial "cutting" or other forms of self-injury
- E. Extreme egocentricity, or need to be "center of attention"

Diagnostic Issues

- F. Frequent need/desire to go to the "emergency room"
- G. Sense of "entitlement", belief that they should be able to go "straight to the top" with their issues, complaints, and concerns
- Bipolar Disorder is oftentimes ascribed when practitioners see significant fluctuations in behavioral data; exacerbations and/or fluctuations of behavioral presentation **do not** necessarily equate to a diagnosis of Bipolar Disorder
- Adults diagnosed with Bipolar Disorder **rarely** exhibit features of the "depressive" phase of the disorder; rather, the focus is almost always on what appears to be "manic" symptoms
- Be wary of diagnoses that contain "NOS"
- Poll Question #1

Medication Issues

- Generally speaking, monotherapy is almost always the most desirable, though seems to be quite rare
- Be extremely careful when prescribing medications that need to be monitored via blood levels; questions to be asked include the following:
- A. Does the person receive adequate hydration?
- B. How often will blood levels be done? (I prefer Q 3 months)
- C. Does the person have an aversion to blood draws/needles?
- Blood levels required for mood stabilization purposes (i.e. Depakote, Tegretol) can be significantly higher than therapeutic levels recognized for seizure control; avoid "WNL", get the actual **number!**

Medication Issues

- Be extremely careful if/when prescribing Lithium as individuals are quite prone to toxicity due to inadequate hydration!
- Try to identify the "threshold dose" where you can achieve optimal clinical results at the lowest possible dose of medication
- When titrating medications, WITH RARE EXCEPTION, make one change at a time to avoid conflicts and confounding variables!
- When a medication has been discontinued, give the person 6 to 8 weeks to get "acclimated" before making a decision or determination that the person needs to be placed back on the medication
- When titrating medications, sometimes they need to be made **very slowly** (i.e. 5% increments) for the person to successfully tolerate the reduction

Medication Issues

- Psychotropic medications should not be viewed as a "quick fix", unless there is evidence that a person would not/could not benefit from proper behavioral and environmental interventions (which is rare). Medications should not typically be the "first" thing that is considered by the person's support team.
- Many psychotropic medications can have potentially serious side-effects (i.e. weight gain, agranulocytosis, development of type II diabetes, lethargy) so these should be monitored **very carefully** constantly utilizing a risks/benefits type of analysis
- It would be nice to see more collaboration between the various medical disciplines when an individual is being treated, psychiatrically
- Poll Question #2

Pre-Sedates

- Medication is oftentimes given to individuals prior to any type of medical appointment and/or invasive medical procedure (i.e. dental, gynecologic)
- Be aware that many individuals have fear or apprehension that is based on prior REAL LIFE EXPERIENCES!
- The definition of a phobia typically includes “irrational fear”
- Pre-sedates prior to medical appointments/procedures oftentimes have a paradoxical effect; it actually makes the individual WORSE, not BETTER!

Data-Related Issues

- What are the exact symptoms that staff are expected to track/monitor? If we are ONLY interested in reduction or elimination of aberrant behaviors, aren't we prescribing medications, frequently including anti-psychotics, primarily if not solely for the purpose of behavioral suppression?
- When analyzing data, can we reasonably account for some of the fluctuations of the data based on reasonable identification of external variables that might be solely responsible, if not at least contributory, rather than attributing everything "to the meds"?
- Remember, it is not uncommon for many individuals to get worse, not better, on psychotropic medications; also, look out for possible paradoxical effects (similar to the pre-sedate phenomenon).
- Poll Question #3

Thank You!

- Questions and Answers

- Please consider attending the other webinars that comprise Adults with Developmental Disabilities: The Series

- For more information, please contact me via my website: premierbehavioralsolutions.com