

NON-RESTRICTIVE CARE FOR MENTAL HEALTH PAEDIATRIC INPATIENTS WITH CO-MORBID INTELLECTUAL DISABILITY AND/OR AUTISM SPECTRUM DISORDER

PRACTICE GUIDELINE[®]

DOCUMENT SUMMARY/KEY POINTS

- NSW Health Child and Adolescent Mental Health services are committed to the Creating Positive Cultures of Care initiative, whose aims include the reduction of seclusion and restraint practices in inpatient units. The use of seclusion and restraint with patients should only be implemented as a last resort, where the patient poses danger to either themselves or others.
- Individuals with mental health and *comorbid intellectual disability and/or autism spectrum disorder* can pose a particular risk of escalated behaviours, due to vulnerabilities such as poorly developed communication skills, social relating and emotion regulation deficits, intellectual handicap, limited problem solving skills, and sensory sensitivities.
- Proactive management for inpatients with these developmental disabilities is therefore essential, to ensure their rights to non-coercive, least-restrictive inpatient care are promoted, upheld, and protected.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1 st March 2016	Review Period: 3 years
Team Leader:	Clinical Psychologist	Area/Dept: Psychological Medicine CHW

CHANGE SUMMARY

- N/A – new SCHN guideline

READ ACKNOWLEDGEMENT

- All clinical staff currently (or anticipated to be) working with an inpatient young person with intellectual disability and/or autism spectrum disorder are to read and acknowledge they understand the contents of this document.
- All other clinical staff are to be aware of this document.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

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Purpose and Scope

This document provides guidelines for facilitating least-restrictive care for inpatient children and young people who have comorbid intellectual disability and/or autism spectrum disorder.

It has been developed to support implementation of NSW Health *Policy Directive PD2012 035 Aggression, Seclusion & Restraint in Mental Health Facilities in NSW*. It should be considered in the context of this and other NSW Health policy, and applied in conjunction with existing practice guidelines that have been developed for the general population (without developmental disabilities).

For policy information relating to the use of seclusion and restraint, refer to The NSW Health policy directive titled *Aggression, Seclusion and Restraint in Mental Health Facilities in NSW (PD2012 035)*.

For more general practice guidelines refer to The Children's Hospital at Westmead Practice Guidelines on "Seclusion (Hall Ward)", and "Restraint of a Young Person for Safety Purposes".

For further information and practice guidelines specific to children and young people with an intellectual disability, refer to the Intellectual Disability Mental Health Core Competencies Framework auspiced by MH-Children and Young People and the Department of Developmental and Disability Psychiatry (3DN) at the University of NSW.

Policy and Rationale

Child and Adolescent Mental Health Services In Patient (CAMHS IP) Units are committed to the reduction in use of involuntary management practices with patients, including working towards the elimination of the use of seclusion and restraint. This is in keeping with the National Mental Health Commission National Report Card (2012) recommendations.

CAMHS IP Units are also committed to promoting, upholding, and protecting the rights of individuals with a disability, in keeping with the National Disability Strategy.

Individuals with mental health and comorbid intellectual disability and/or autism spectrum disorder can pose a particular risk of escalated behaviours, due to vulnerabilities such as poorly developed communication skills, social relating problems, emotion regulation deficits, intellectual handicap, limited problem solving skills, and sensory sensitivities.

Best practice in management for inpatients with intellectual disability and/or autism spectrum disorder requires proactive and pre-emptive intervention, to foster an inpatient environment that is safe, respectful, and minimally restrictive.

Intellectual Disability

The term intellectual disability (ID) is used to describe people who have a general delay or deficit in their intellectual functioning and adaptive skills, with onset during the developmental period. To meet formal criteria for intellectual disability, the diagnosis must be determined by both clinical evaluation and a standardised individual intelligence test (with scores falling in approximately the lowest 2% of the general population).

Individuals with ID have difficulties with cognitive tasks and daily living skills, including understanding abstract concepts, performing complex tasks, and with learning and evaluating new information as quickly or effectively as other people their age. Intellectual disability can be classified as mild, moderate, severe, or profound, depending on the level of impairment, and the extent of the functional support needs of the individual.

A mild level of intellectual disability may be quite subtle to detect, especially on a first or brief meeting. Skills in areas such as personal care, conversational language, and routine social activities may appear fine. However, the individual is likely to have difficulty with abstract reasoning, problem solving, and planning skills, and may be poor at detecting risk, or generalizing skills from one situation to another. Social immaturity or naivety is common.

An individual with a moderate level of intellectual disability presents with more marked difficulties, for example, may need ongoing assistance with elements of personal care, may have only very elementary language skills, and generally requires persistent and repetitive teaching to master basic skills. Socially, capacity to form strong attachments with family and friends is evident, but the quality of these relationships may be less nuanced, and social judgment and decision-making skills are limited.

Individuals with severe and profound levels of intellectual disability have limited capacity to acquire conceptual skills, and tend to experience their world in a very concrete, function-oriented way. Spoken language, if present at all, comprises only single words or short phrases, and comprehension is similarly limited. Language use is predominantly action- or object-oriented. The individual requires substantial support from carers to achieve most activities of daily living (eg dressing, bathing, toileting, feeding). Maladaptive behaviours (such as aggression and self-injury) are present in a significant minority.

Autism Spectrum Disorder

Autism Spectrum Disorders (ASDs) are developmental disorders characterized by a pattern of persistent, qualitative impairments in social interaction and communication, and the presence of restricted and repetitive interests and behaviours. These difficulties are present from early childhood and interfere with everyday functioning. The term ASD subsumes the previous diagnoses of Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS).

Individuals with ASD face challenges with social relationships (such as forming friendships, reading social cues, and adjusting behavior to social norms). They can show strong insistence on routines and experience difficulties coping with change, and may have sensory sensitivities.

While these particular characteristics are diagnostic of ASDs, their expression varies markedly across individuals. Communication skills can range from non-verbal through to superior verbal expression skills. Social interaction can range from aloof and self-preoccupied, through passive, to highly socially motivated yet 'odd'. Restricted and repetitive interests and behaviours can manifest as all-encompassing obsessions, or all-absorbing repetition of movements, through to relative mild preferences for sameness and adherence to routine. Sensory processing can range from hyposensitivity through to hypersensitivity, even within the individual for different stimuli. Intellectual functioning in autism spectrum disorders ranges from severe to profound levels of intellectual disability through to intellectual giftedness.

Autism spectrum disorders can be classified as mild, moderate, or severe, depending on the level of functional impairment experienced by the individual as a consequence of both their social-communication difficulties, and their restricted and repetitive interests and behaviours.

Developmental Considerations

General Principles

When considering the support needs of an individual with ID/ASD, it can be helpful to adopt a developmental approach. Conceptualising skills in reference to that of (younger) typically-developing children can help to frame appropriate behavioural expectations. For example, the significance of 'inappropriate' tantrums in a 10 year old with moderate-severe intellectual disability may be re-considered as a developmentally appropriate progression for an individual with social, communication, and impulse-control skills at a 2-2½ year developmental level.

Accurately assessing the mental state of an individual with ASD and/or ID can be very challenging. Clinicians must be flexible, and ensure ongoing re-evaluation of their initial assessment as new information emerges. Clinicians will often need to hold several competing hypotheses in their formulation, and capacity to tolerate working with an ongoing degree of uncertainty is important. Information provided by parents, carers, teachers, or other individuals who have a pre-existing relationship with the patient can be invaluable.

Self Help Skills

The patient may need more support than other young people of a similar age, to complete routine activities of daily living such as for personal hygiene, toileting, dressing and feeding.

The patient may demonstrate less awareness of, or capacity to comply with, domestic and community routines, such as with taking care of their belongings, assisting with chores, and observing organisational protocols

The patient may demonstrate a naivety or reduced appreciation of potential environmental dangers, such as when around kitchen facilities, with other patients, or in the dispensing of medications.

Communication

Verbal expression (speech) may be significantly impaired, or even absent.

Verbal comprehension may be significantly impaired.

Reading and writing skills can be limited; the patient may be illiterate.

A patient's expressive capacity may be vastly and unexpectedly discrepant from their verbal comprehension. In cases where speech exceeds understanding, patients can give the impression of being more able than they actually are. This can lead to inappropriately high expectations of carers and peers in terms of behaviour and self-regulation capacity. In cases where understanding exceeds expressive capacity, there can be issues with patient frustration and indignation, as a consequence of feeling 'talked down' to, or being excluded from developmentally appropriate activities and interactions as a consequence of carers or peers underestimating the patient's capacity to participate.

Non-verbal communication skills may also be significantly impaired. This can range from poor integration of use of skills such as eye contact, gesture, facial expression, and body language, through to their absence. Capacity to interpret non-verbal communication of others may also be significantly impaired.

Social and Emotional Development

The patient may present as socially immature, with skills more consistent with that of a younger child. Conversational skills and use of language may be very concrete. The patient may seem impervious to social cues from peers and may lack capacity to accurately judge or manage a situation where they are being manipulated or taken advantage of.

The patient may have great difficulty with regulating their emotions and controlling their behaviour.

Sensory issues

The patient may have difficulty processing and regulating information from any/all of the sensory systems i.e. auditory, visual, touch, movement, taste and smell.

Some patients may be over-responsive to certain sensory experiences i.e. sensitive and/or avoiding behaviours. For example; sensitivity to loud noises, fussy eating, distress during grooming tasks.

Some patients may be under-responsive to certain sensory experiences i.e. decreased awareness of sensations and/or seeking out certain sensations. For example; not hearing their name when called, humming and making sounds, seeking out touch experiences, putting objects in their mouth.

Difficulty processing and regulating sensory information can impact on learning and play skills, body awareness, regulation of emotions and behaviour, and ability to participate in daily tasks and activities.

Behaviour

Maladaptive behaviours are present in a significant minority of individuals with ID and/or ASD. This can include self-injury (e.g. head banging), aggression directed at others with or without intent (e.g. biting, hitting, kicking, yelling etc), destructive or disruptive actions, tantruming, and absconding.

In part due to the communication impairments common to both ID and ASD, individuals may commonly use behaviour to express a range of issues including anxiety, frustration, confusion, fear, distress, tiredness, overload of information, overload of stimulation, boredom and pain. Behaviour can also be a means through which to express likes and dislikes, to communicate wants or needs, or to gain social attention. Establishing the communicative function of a behaviour is a critical step in the process of reshaping it.

Common learning characteristics for individuals with ASDs

- **Visual Learning Style**

Researchers report that on average, children with ASDs tend to have superior visual skills, as compared to their skills in other cognitive domains. This means that they tend to show a preference for visually presented information, for example, in understanding and responding to visual communication more readily than spoken language, and in learning more effectively where concepts are visually represented.

- **Concrete and literal thinking**

Children with ASDs tend to be very concrete in their style of thinking. This can include a very literal interpretation of language such as to understand idioms and metaphor, or difficulties with grasping multiple labels or meanings (e.g. that an eggplant may also be referred to as an aubergine, or that a particular word can hold more than one meaning). Individuals with ASD will often need explicit explanation of these concepts to grasp them, though once explained, many young people with Asperger's can develop a strong interest in understanding the nuances of language and metaphor.

- **Creative and Unconventional World View**

Due to their often idiosyncratic perspectives people with autism often think of ideas that others do not. This results in them being often very creative thinkers with ideas that are outside the box.

- **Passionate About Their Interests**

Restricted patterns of interests of high intensity are part of the diagnosis, however this can also be viewed as a strength. Children with ASD can derive great pleasure and satisfaction from their interests. Using these interests can be a way to engage and motivate these children when under unfamiliar and stressful circumstance of a hospital admission

- **Rule-governed and rote-based learning**

Children with ASDs tend to have a strength in rote memory skills, though may not always attend to or process the meaning of what they remember. They can also learn

information as 'chunks' (e.g. sections of dialogue from a film). This characteristic can also present in individuals in terms of their preference for routine and familiarity.

- **Weak Central Coherence**

The concept of central coherence is captured in expressions such as 'grasping the whole', or 'having a sense of the bigger picture'. This is often difficult for individuals with an ASD, who may pay close attention to details, but have difficulty in seeing how it all fits together, or may focus overly on irrelevant or minor details, rather than being able to recognize what is most relevant for them to focus their attention on.

- **Poor executive functioning**

Executive functioning refers to skills such as planning and organisational abilities, ability to hold and manipulate information in memory, inhibition and impulse control, attention, and flexibility and problem solving. Impairments in executive functioning can be observed in people with ASD in characteristics such as difficulties in shifting attention from a current focus to something different, difficulties in sustaining attention when there are external distractors, difficulties in coping with change or unpredictability, and seeming to 'respond without thinking'.

- **Responsiveness to Structure**

Children with autism are characterised as creatures of routine and structure. Through structure the world becomes a more predictable and calm place for the individual with ASD. As a result, hospital admissions with a timetable or treatment with a set plan or program is likely to be adhered to and responded to well.

Management Strategies

General Management Principles

Team work and collaboration

Emotional and behavioural disturbance in young people with intellectual disability and or ASD need to be assessed from a multidisciplinary perspective as each discipline can contribute to understanding different contributions to the disturbance and to approaches to skill building to enable improvement. For example consider input from a speech therapist to review communication capacity or an occupational therapist for review of sensory processing issues. Functional impairment is often due as much to emotional and behavioural disturbance as it is to underlying intellectual disability. All cases should be considered from both a behavioural (challenging behaviour) as well as a psychiatric perspective. More often than not challenging behaviours are associated with significant psychiatric disorders (often more than one) and therefore need multimodal approaches to intervention.

Family members, carers, and other service providers can provide invaluable information to support a patient with ID/ASD during an inpatient admission. This can include information about; their likes, dislikes and preferences; their communication skills and strengths; common antecedents for challenging behaviours; strategies for self-soothing. Family and service providers are also well placed to give feedback about how typical or not particular behaviour or responses are, and how generalizable any inpatient strategies will be when applied to the patient's environment outside the hospital.

Positive Behaviour Support

Positive behaviour support involves proactive management of a patient's environment to minimize the risk of challenging behaviours, and maximize patient engagement with the appropriate activities of the ward. This includes having a good understanding of common antecedents and triggers of a patient's challenging behaviours, and use of a range of strategies to preempt recurrence of these triggers in other environments.

- **Structured teaching**

This is an approach to supporting individuals with ID and/or ASDs that involves structuring the environment so that this itself acts as a way of enhancing a patient's participation. This is achieved through incorporating structures such as the use of schedules, tasks & work/activity systems, and routines. Examples of incorporating structured teaching into an inpatient environment could include:

- Using visual markers in the environment (e.g. a chair to indicate that the patient needs to sit, a footprint template to show where to stand, colour-coding of materials to show that they 'go' together, use of mats or other floor markings to create visual boundaries for different areas (e.g. the green mat is where you can watch TV, the red mat is where we sit for meals, the lino floor shows where we do painting and craft)
- Using the environment to communicate the duration and/or nature of a task (e.g. keep all the materials required for a particular activity in a labeled box or folder; use of strategies such as templates with empty spaces, or worksheets with drawn lines - to represent visually where a task starts and ends).
- Use of 'natural' environmental cues to help patients identify important elements in their environment to attend to (e.g. a clock face as a visual indicator of when visiting times start or end)

- **Teaching of effective skills**

This involves teaching the 'what *to* do' as a management approach for reducing the 'what *not* to do'. This is important because for many individuals with ID and/or ASD, they are not aware or attuned to what behaviour is expected or appropriate for a given circumstance. Feedback to stop a behaviour can create a behavioural 'vacuum', because the individual does not know what behaviour they should demonstrate to replace the behaviour they have been asked to stop. Teaching effective skills addresses this issue by equipping patients with ASD with clear and explicit information about what behaviours and skills are appropriate.

- **Establishing the communicative function of behaviour**

This involves establishing what message the patient is trying to convey through their behaviour. It is important to remember that this message can often be unintentional. Once there is a sense of what function a behaviour is serving, this can guide what adjustments or supports can be put in place to enable the patient to communicate their needs in a more appropriate way.

- Positive feedback and encouragement to reinforce desired behaviours
 - What does the patient like –what is reinforcing for them (this will likely be different for different patients, and often different for patients with ASD. Special interests can often be used as motivators/reinforcers (e.g. an interest in trains)
 - Use of reward charts –where patients can be allocated points for their participation in activities or cooperation with routines. A small reward (e.g. an inexpensive toy, computer time, time off the ward) to be offered after accrual of an agreed number of points.
 - Enable success – ward staff should monitor & ensure that the patient has success with at least parts of their program on a daily basis. Being able to do something successfully helps to build confidence, and boosts their enjoyment in the program, both of which are motivating and aid learning. For patients who are finding the admission more challenging, consider:
 - Scaffolding* – which involves providing extra prompts until the patient is able to perform a routine task successfully or to engage with an activity appropriately
 - Using graded questions/instructions* - which involves ensuring opportunity for all patients (& particularly those who are less capable) to engage appropriately with staff. This may include simplifying questions/instructions as necessary.
 - Attending to and using ‘unintended’ contributions as teaching opportunities.* This involves acknowledging and incorporating the comments made by the patient into the program, even if on the face of it they may seem rude or disruptive. For example, John complains that an activity is too difficult and he is not going to take part. Staff could turn this into a teaching example; “*John is showing us one strategy that can be helpful for managing stress –removing ourselves from the stressful situation. What is good about his strategy? What might be not so good? What is another way he might deal with the problem...*” etc.

Environmental adjustments

Planned admissions

Before a planned admission, in addition to information provided to the patient and their primary carers about the unit, reciprocal information should be sought about the patient, particularly, what accommodations or supports would be helpful in facilitating their hospital stay. Where practicable, existing supports (such as communication systems, reward charts, feelings toolkits etc) from the home/school environments should be adopted (or adapted) into the hospital setting. Full medication reconciliation should be done prior to any planned admission, by the referring team.

Emergency admissions

In the case of emergency admissions where such preparations have not been possible; basic information should be sought from the primary carer (e.g. about likes/dislikes, common triggers, effective reinforcers). Any existing supports from home/school should be introduced soon after admission. As full a medication history as possible should be compiled, based on information provided by the primary carer, and the patient's medical records.

Resources

A general resource kit kept permanently on the ward could include materials such as materials for a visual schedule, or to convey ward rules (with common ward activities, depicted at several levels of visual literacy – eg in words, in photos, in line drawings), several styles of reusable reward charts, a 'sensory bag', a basic social story about day-to-day life on the ward, and an ipad (or other technological aid device) preloaded with applications that can provide these resources. The kit could also include a 1-2 page form/template for a carer to complete, providing structure and prompts to gather information about interests, preferences, triggers, and strengths.

A safe withdrawal space on the ward for 'down time' should be identified collaboratively with the patient (eg for them to withdraw from an environment in response to sensory overload)

Routine and structure

A key environmental consideration is to provide as much consistency and predictability as is practicable. This is best achieved through a combination of familiar routines, and a clear and effective method for communicating change (be it unexpected disruptions, or regular events such as staff changeovers).

During an admission; the patient's activities for the upcoming time period should be communicated to them at a level that is accessible/meaningful (e.g. for a highly verbal patient, this may be via a written schedule for the whole day; for a less verbal patient this may be via a set of 4 photos showing the morning's sequence of activities, for a non-verbal patient this may be a "first→then" board using real objects (e.g. hairbrush to depict brushing hair, followed by toothbrush and paste to depict tooth brushing; first it is time to brush your hair, then it will be time to brush teeth) etc.

Daily Programming

Patients with a developmental disability should be given opportunity to participate in all activities (as is, or a customised version thereof) as available to other inpatients on the ward. This would typically require an individualised program that incorporates person-centred versions of these activities into their daily schedule. Examples may include watching preferred TV programs, playing preferred computer games, participating in outings off the ward, engaging in physical activity (e.g. 'gym' activities, swimming, ball games)

Communication Strategies

Patients should at all times be treated with respect, such that communication strategies used should not be too complicated to be understood, and where simple, presented in a way that they are not perceived as patronising.

A patient's communication skills should be gauged as early as possible in the admission process (including in advance, where feasible). When in doubt, adhere to the principle that too simple is rarely a problem, but too complicated almost always will be (e.g. use of a pictogram versus a written word; ♀♂ vs 'toilet').

Verbal communication

Verbal information can be simplified by presenting it at a slower speed, with fewer, less complicated words, and in fewer parts (e.g. reduce a multipart instruction to just two-parts, or a two-part instruction to just one etc). Use of jargon, idioms, colloquialisms, and other figures of speech should be avoided.

Visual supports

Where needed, verbal information should be augmented by visual supports; these can range from use of gestures and written language through to provision of concrete objects, depending on the individual's comprehension level. Visuals can be used in a range of scenarios, including to provide forewarning, to sequence tasks, to show a planned timetable for the day, to prepare for change, to convey 'no', and to label key places.

Social stories

Social stories can be another vehicle for conveying important social information in a format that is accessible to the patient. Generic social stories about life and routines on the ward can be developed as a general resource, while some patients may need individualised stories developed around their particular needs while inpatients.

Sensory strategies

Information should be sought from the patient and carers relating to the patient's sensory preferences; what sensorimotor activities they like/dislike and find calming/distressing. Incorporating sensory based approaches into the management strategies can help prevent or quickly resolve escalation. Each patient is individual; has different preferences and will all respond differently to sensory based activities. What one patient may find calming another patient may not, so it is important to gain as much information from patient, carers and observation as possible.

Assess the sensory environment i.e. identify any environmental stressors, in particular lighting, sounds. Modifying the physical environment may help in managing the patient and helping the patient regulate their arousal. For example providing regular time throughout the day for the patient to have 'down time' in a safe space such as a quiet, darkened room thereby reducing sensory stimulation.

Patients should be given opportunities for sensory breaks regularly throughout the day. For example this may include spending time in a quiet space alone, playing with sensory box items, or having a movement break.

“Heavy work” sensorimotor activities have the benefits of being able to both increase and decrease arousal. Incorporating activities such as exercise, sport, stretching, weight-baring, pushing/pulling activities into regular daily routine is extremely beneficial.

Other sensory based activities include a sensory bag and trialling the use of weighted modalities such as weighted blankets, lap/ shoulder bags, and vest may be useful for some patients.

Medication

There are a number concerns that are more likely to need consideration in young people with intellectual disability and or ASD. First there is a greater likelihood of medical comorbidity that may need investigation, management or consideration in prescribing. The developmental profile needs to be considered against which to understand behaviour. Be aware that the presence of one area of disability or developmental delay/disorder raises the risk of another, such a sensory disability (eg deafness) or specific learning problems (eg Semantic Pragmatic Language Disorder).

There are additional difficulties in diagnosis in young people with intellectual and developmental disabilities. There are additional manuals available to help provide guidance (refs: DM-ID; DC-LD). There are some difficulties in the reliability of diagnoses, as these young people may have difficulty describing their internal mental state (as often applies to younger children). Particularly people with intellectual and developmental disabilities have difficulty describing their level of anxious and depressed moods and other more abstract concepts. These may need careful consideration, from several informants, especially those who know the patient well. Young people with intellectual and developmental disability may well give answers to please the interviewer, or fail to understand the significance of the question (eg do you hear voices?). Be aware of their developmental capacity and abilities in theory of mind for understanding a question and influencing the answer they provide. They are more likely to be able to describe changes in their functioning, such as sleep, appetite, losing interest in something or forgetting events or routines. In particular those with limited capacities of theory of mind may have difficulty distinguishing delusions, hallucinations and flashbacks from concrete thoughts, stereotypic thoughts and memories, or active pretend and imaginary thinking, dissociation or pseudo hallucinations. Pretend friends and eidetic memory are more common. The diversity of features (eg as stereotypic movements) that is characteristic of ASD need to be taken into account when considering psychiatric phenomena.

In those with limitations of cognitive capacity and communication, from both their developmental and their psychiatric disorders, there can be greater difficulty in providing psychological interventions and a greater need to use pharmacological intervention. However it must be remembered that intellectual disability and abnormality of brain development also increases the risk of medication side effects including serious side effects such as neuroleptic malignant syndrome or a serotonergic syndrome. Greater caution is therefore required in the introduction of medications and the monitoring of side effects. Further there is some suggestion that they may respond more slowly eg to a decline of hallucinations with major tranquillisers. The presence of several different psychiatric disorders may nonetheless

require an increased rate of using more than one medication, and 'polypharmacy' is required more frequently.

Those with intellectual and developmental disorders may find hospitalisation and an alteration of routines more stressful, and it may take longer for them to accommodate to their new environment and new staff relationships. Active management of their anxiety and distress may need to be anticipated. For example stereotypic thinking may predispose young people with ASD to a slow crescendo of anxiety and agitation, and a lesser capacity for asking for help.

The principals of medication management may require greater attention to the adage of 'start low and go slow'. However general principals are otherwise similar. Often there is limited literature on the use of medications in this special population, and also differences in considering medications, particularly in the presence of side effects from first line medications choices. For example it may be necessary to consider second and third line treatments for ADHD or Anxiety. Mood lability and aggression may benefit from mood stabilisers.

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