ASK THE DOCTOR

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SYSTEMS SUPPORTS FOR INDIVIDUALS WITH INTELLECTUAL DISABILITY AND SUICIDALITY

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Individuals with intellectual disability and significant suicidality need comprehensive community support systems. Psychiatry is an essential component to assist in the diagnostic formulation, treatment plans, and pharmacotherapy. Staff must have extensive training and ongoing 24-hour clinical support. Environmental modifications, such as alarms, are also typically necessary. Lastly, family members, all community agencies and providers must participate in a collaborative support plan.
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Q. Dr. Luiselli, in this issue you reported two cases of individuals with intellectual disability and significant problems of suicidality.[5] Because of the nature of risk associated with their mental health and behavioral problems, your agency provided a comprehensive support system. Can you please describe what the essential elements are for successful community placement of people with such challenges?

A. In these two cases, as well as similar adults we have served, it is essential to closely monitor and supervise all elements of community support.[5,6] Day-program and residential staff must receive comprehensive training for working with at-risk individuals. This means that staff are able to implement therapeutic procedures properly, follow safety guidelines, and be aware of conditions that could exacerbate clinical problems. On-line staff also need to have a 24/7 administrative on-call protocol so that they can access crisis services if warranted. Building a strong alliance with family members and mental health agencies is another fundamental component when working with people who threaten or have attempted suicide.[4]

Q. What is the role of community providers such as psychiatrists or psychotherapists?

A. Psychiatry plays a vital role in community support to assist with the diagnostic formulation, psychosocial treatment recommendations, and medication management. Several individuals we have served benefited from cognitive-behavioral therapy with community providers. Various state agencies often help with case management responsibilities, risk review, and hospitalization should it arise.

Q. Is it difficult to find such professionals with training in mental health and intellectual disability?

A. My experience is that few professionals have sufficient knowledge about treating mental health problems, including suicidality, among people with intellectual disability. However, there are more training opportunities through continuing education events and more specialty programs available than ever before. Journals such as *MHDD* are also a valuable resource for disseminating clinical and research information.

Q. Typically, major problems arise when a person with intellectual disability is brought to the emergency department of a hospital for a psychiatric evaluation—most staff will have little or no experience with such patients. As a result, they may be dismissed as just being "developmentally delayed" or as having a "behavioral problem" and will be sent home. If this is not a problem, and hospitalization is necessary, then the lack of specialized inpatient services and beds available for such patients may be a significant barrier. Have you faced these problems?

A. As seen in the two cases we presented, hospitalization was required to treat physical injury and health threats caused by each persons'

self-harming behavior. We have had experience with both general psychiatric hospital settings as well as specialized inpatient programs for adults with intellectual disability. It is true that most hospital admissions are brief and concentrate on stabilization before discharge. A specialized setting appears to be the best option in that the senior staff have expertise with individuals who have cognitive challenges and usually require therapies that are different from typical clinical populations. I don't think effective community support for adults with intellectual disability and risk of suicide are possible without the availability of emergency hospitalization but certainly, it is not efficacious in isolation.

Q. How were staff trained to be confident with a person who presents with suicidality ?

A. There are several approaches to training. It helps, I think, to recruit staff who are motivated to work with at-risk individuals and understand the intensity of support that must be provided. Not everyone is so inclined. Having written procedural guidelines in the form of a behavior support plan also is essential because it tells staff what to do under specific conditions. Supervising clinicians must have a routine presence in the service setting, meet regularly with staff, and be available for consultation and advice at any time. These and related methods of training seem to build confidence among staff.

Q. You have mentioned behavior support plans several times. What goes into such a plan?

A. A behavior support plan should specify the clinical problems being addressed, the conditions that seem to provoke and maintain the problems, and detailed intervention procedures. There should be an emphasis on preventive and skill building strategies as well as methods to positively reinforce the consumer's acquisition of treatment objectives. Plans also should feature objective documentation of behavior through data collection, something that is essential for evaluating progress or the need to revise procedures.

Q. These supports you described are expensive to provide. In addition, the state government must help assure cross-system collaboration among their case managers, your agency, other agencies involved, the crisis teams, and mental health partners. Can you comment on this?

A. Yes, there is a cost associated with hiring more staff, making environmental safety modifications, and seeking additional therapeutic services. As other agencies and treatment team members increase, there is a critical need to have comprehensive program monitoring and oversight. Each agency on a treatment team also must work within its scope of responsibility, be it allocating necessary funds, securing services, family case management, and the like. In dealing with seriously at-risk individuals, a collaborative partnership among agencies and personnel is critical.[1,2,3]

Q. What advice do you have for others who work with individuals presenting with significant suicidality?

A. The treatment setting certainly must have the necessary staff resources and administrative support. One or more senior clinicians should have expertise with individuals who pose health threats and potential lethality. Inevitably, there will be a need for comprehensive psychiatric and pharmacologic services. I advise establishing a fully dedicated treatment team responsible for all elements of service delivery, documentation, and coordination with "outside" agencies. To provide adequate care to such individuals, a specialty team that provides treatment beyond routine clinical care is critical to success.

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