PSYCHIATRY IN MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES: A TRAINING PROGRAM FOR PSYCHIATRY RESIDENTS

Stephan A. Schwartz, Ph.D., Stephen L. Ruedrich, M.D. & Johnathan E. Dunn, M.D.

1Cuyahoga County Board of MR/DD
2Case Western Reserve University School of Medicine

This article describes a program that was initiated in 1995 in Cleveland, Ohio to train psychiatry residents in intellectual disability and developmental disabilities. The article provides a brief review of the literature on training psychiatry residents in developmental disability and an extensive description of our program. The training program was based in part on 1995 curricular recommendations advanced by the American Psychiatric Association Committee on Psychiatric Services for Persons with Mental Retardation and Developmental Disabilities. The article concludes with an informal appraisal of the program.

Keywords: developmental disability, diagnosis, intellectual disability, mental retardation, psychiatry, psychiatric disorder, training

The “Psychiatry in Mental Retardation and Developmental Disabilities” (MR/DD) program is designed to train psychiatry residents in this specialty area as part of their general psychiatry residency. This program is jointly operated by the Department of Psychiatry at the MetroHealth Medical Center in Cleveland, Ohio, and the Cuyahoga County Board of Mental Retardation and Developmental Disabilities.

“We should not rest until the Departments of Psychiatry and the Departments of Pediatrics in every medical school collaborate on a course in intellectual disability for third and/or fourth year medical students. We must see to it that all residents in psychiatry are oriented in the overall nature and problems of intellectual disability, including acceptable modalities of treatment, care, education and habilitation.” (p. 545)

Unfortunately, only a handful of medical schools and residency programs have embraced Potter’s recommendations, and even fewer have reported on their program’s successes and failures in educating medical students and residents about intellectual disability/developmental disabilities. Of those available, a few describe training programs5,7; others report surveys of practitioners for their opinions about their education in developmental disability.10,19

Beginning in the 1970’s, two reports from the United Kingdom described the medical curriculum in developmental disability as minimal27 and corresponding beliefs of physicians that their education in this area was inadequate.15 In similar fashion, Willer and colleagues40 surveyed US medical schools in the 1970’s, and found that only half offered any curriculum in developmental disability.

In the most comprehensive report in this area, in the late 1980’s the American Psychiatric Association Task Force on Psychiatric Services to Persons with Mental Retardation surveyed all state departments of intellectual disability and mental health, as well as residency programs in psychiatry. Both educators and students tended to view their educational programs as less than satisfactory, and almost 100% of state departments responding described difficulty recruiting physicians to serve persons with developmental delay. A recent publication also stresses the need for training psychiatry residents in developmental disabilities,2 and there is a new study that examines the impact of such training on the attitudes of senior psychiatry residents toward persons with developmental disabilities.24

To address this void, several authors have outlined rotations and/or instructional activities4,8,12,26,29 or programs21,22 to meet this
need. Menolascino and his colleagues have written extensively on both the importance and format for providing psychiatrists instruction regarding persons with mental retardation and developmental disabilities.

More recently, the APA Committee on Psychiatric Services for Persons with Mental Retardation published a complete set of guidelines, essentially outlining in a detailed, tiered system how to provide instruction to psychiatric trainees regarding developmental disability. This tiered approach by King and his colleagues describes three “levels of expertise,” and provides a framework for residency training programs to choose the extent and intensity of instruction that will best fit student and programmatic needs.

An overview of the available literature produces the following conclusions:

1. Most medical schools offer poorly organized and/or inadequate instruction regarding persons with developmental disability.
2. Perhaps as a result, physicians in practice often report feeling inadequately prepared to care for these persons in their practices.
3. Agencies and organizations responsible for ensuring medical and psychiatric care for persons with developmental disability often have difficulty recruiting and retaining qualified physicians to practice in this area.

To address the serious need for psychiatrists with specialty training in developmental disabilities, a program was jointly developed by the Department of Psychiatry at the MetroHealth Medical Center and the Cuyahoga County Board of Mental Retardation and Developmental Disabilities in 1995. Below, we describe the development of the program, its goals, and offer an appraisal of its effectiveness to date.

**Program Description**

**History and Goals**

The Psychiatry in MR/DD training program was launched in the latter part of 1995, beginning with an agreement by both sponsoring entities detailing the roles and responsibilities of the respective organizations. The Cuyahoga County Board of Mental Retardation and Developmental Disabilities provides funding to help sustain the training program, while the Case Western Reserve University School of Medicine supplies the trainees, clinical supervision, and academic instruction. The second author is the primary clinical supervisor for the psychiatry residents; the first author is the lead field instructor. The third author is the Director of Psychiatry Residency Training at the MetroHealth Medical Center’s Department of Psychiatry. The sponsoring organizations initiated the program to achieve the following goals:

1. It is recognized that there is a national shortage of psychiatrists providing services to persons with developmental disability. In the short term, our training program aims to address the issue at a local level, and in the long term the program seeks to increase the supply of psychiatrists interested in working with persons with intellectual disability and developmental disabilities.
2. Because psychiatry residents generally have little experience or training in serving persons with developmental disability, our program aims to enhance the competency of psychiatrists who will provide services to these persons.

**Program Format and Structure**

Training program participation is restricted to third and fourth year postgraduate psychiatry residents. The residents are generally assigned for rotations of three months. Residents may devote up to twenty hours per week to this training program, though the typical resident averages about twelve hours per week of participation. One to two residents have typically participated in this rotation at any given time. As of this writing, more than thirty residents have completed the developmental disability rotation.

The rotation generally follows the outline described in the training curriculum developed by the American Psychiatric Association. The rotation also reflects some of the content of the American Academy of Child and Adolescent Psychiatry’s recently published “practice parameters” for children, adolescents and adults with autism and other pervasive developmental disorders, as well as the practice parameters for children, adolescents and adults with intellectual disability and comorbid mental disorders. Residents split their training time between a mental health clinic at MetroHealth Medical Center and community-based experiences at the Cuyahoga County Board of Mental Retardation.
and Developmental Disabilities. The clinic-based experiences revolve around the provision of psychiatric services to persons with mental retardation and developmental disabilities who present at MetroHealth Medical Center, while the community-based experiences provide an introduction to the structure, function, and philosophy of the community-based developmental disability system.

**Clinic-Based Experience**

The Dual Diagnosis Clinic at MetroHealth Medical Center provides psychiatric evaluation and treatment for a significant number of adults with developmental disability and mental health needs. Each week, the clinic provides a comprehensive initial evaluation of a newly referred patient, and follow-up visits for a variety of others. During the first two weeks, the psychiatric resident is primarily an observer, sitting in with an attending psychiatrist in clinical contact with people with a disability, their families, and caregivers. This observation phase provides the resident with a model of physician behavior for (a) a systematic approach to gathering information and interacting with adults with developmental disability, their families, and caregivers; (b) a basic format for diagnostic assessment; and (c) methods for conducting mental status examination particular to individuals with developmental disability. By the third week, the resident is assigned several individuals with a disability who are seen for stable psychopharmacology maintenance. To check the accuracy and completeness of the resident’s assessment, the resident obtains and presents to the attending psychiatrist an evaluation of the individual’s status in the interval since the previous visit. The psychiatrist appraises the assessment and may visit with the resident and patient together. During these initial clinic experiences, modifications of the role of physician with individuals with developmental disability with respect to diagnosis, treatment, and interaction with caretakers are outlined and discussed.

By the fifth or sixth week, the resident engages in follow up visits with more complicated individuals with a disability, whose treatment phase is one of active medication adjustment. At this point, all visits are still presented verbally to the attending psychiatrist, who progressively reduces the degree of patient observation and supervision. In this fashion, residents ultimately are granted autonomy in clinical practice. The goal is that, by the end of the three to four month rotation, a resident will be able to perform a comprehensive initial diagnostic evaluation, arrive at a provisional diagnosis, and initiate a treatment program. During the rotation, each resident typically has clinical contact with fifty or sixty adults and has performed initial evaluations of six to eight individuals.

**Community-Based Experience**

The community-based experience takes place at the Cuyahoga County Board of Mental Retardation and Developmental Disabilities, and is concurrent with the clinic-based experience at MetroHealth Medical Center. At the start of the rotation, each resident confers with the community-based field instructor to establish individualized training goals. For example, some popular training goals have included learning how to assess informed consent for people with developmental disability, learning about the role of behavioral interventions in the field, and becoming acquainted with various types of residential supports. The field instructor then arranges learning experiences designed to fulfill the resident’s goals. While the next section of this article describes the common core content provided to virtually all residents, this section reviews the general format of the community-based experiences. The goal here is to portray the process and the more individualized aspects of the training.

During the initial meetings with the resident, the field instructor offers an overview of the community-based developmental disability system, including its history, philosophy, role, and function. The field instructor usually describes selected learning goals of previous residents to expose the trainee to the available options. For example, residents expressing a particular interest in learning about interdisciplinary team processes will be offered an opportunity to observe team meetings, often in the form of a “guided tour” facilitated by experienced staff members.

Each resident has a weekly meeting either with the field instructor or a staff member, depending upon the content planned during various phases of the rotation. The residents spend this time interacting with staff members representing a range of interest areas (e.g.,
psychological testing, human sexuality education), observing various residential and day programs, and sometimes doing some consultations on behalf of individual clients. The typical time commitment for the community-based segment is one-half day per week, and the training occurs in both office and community settings.

At the conclusion of the rotation, residents are usually asked to give a case presentation to interested staff at the Cuyahoga County Board of Mental Retardation and Developmental Disabilities. This presentation is prepared under the guidance of both the field instructor and the clinical supervisor, and it provides a good opportunity to integrate both biological and psychosocial approaches to assessment and treatment. The presentation also provides a forum for modeling interdisciplinary collaboration, as well as affording a forum for the exploration of legal and ethical issues that a particular case may highlight.

**Core Competencies Emphasized in the Psychiatry in MR/DD Rotation**

Although the “Psychiatry in MR/DD” rotation provides considerable flexibility, it is also clear that a core or common set of competencies must be developed. King and his colleagues recommended a curriculum that includes seven core content areas; our adaptations of these core content areas are described in this section.

This APA curriculum describes three levels of competency or expertise. Level I includes a basic ability to appreciate the spectrum of developmental disabilities, the co-morbidity of mental illness and other phenomena, and the ability to make appropriate referrals. Level II competency involves basic proficiency in performing initial diagnostic evaluations, case formulation and initial treatment plans, and obtaining consultation as necessary for ongoing care. Level III expertise includes the ability to provide definitive diagnostic formulation and treatment planning, trainee supervision, and consultation to psychiatrists and interdisciplinary teams.

The APA Task Force viewed their proposed curriculum as a fluid set of guidelines rather than a highly prescriptive program, and this section describes some of the competencies that our developmental disability rotation has emphasized. This section also provides a composite illustration of the specific types of content generally covered during the rotation, with the understanding that the emphasis varies depending on the needs and interests of each resident. Didactic content is provided via informal lectures given by the field instructor or clinical supervisor, reading assignments, field observations, and clinical experiences. This section also describes some references or resources that we would consider adding to the curriculum; a number of these references have appeared after the APA Task Force curriculum was published. These supplemental references expand upon the psychosocial aspects of the curriculum, providing additional coverage of behavioral interventions, the social ecology of intellectual disability, and clinical decision-making.

We view our rotation as imparting a combination of Level II and Level III competencies as depicted in the APA curriculum; we do not see the rotation as falling exclusively within one level or the other. However, we would not necessarily assert that completion of our rotation invariably equips a psychiatrist with the ability to either provide definitive diagnostic formulations or to supervise trainees. The attainment of Level III competency may also depend upon the resident’s prior training and experience, as well as the overall level of resident’s interest and commitment.

The following table outlines the content areas addressed in the American Psychiatric Association Curriculum and adapted in our training rotation:

<table>
<thead>
<tr>
<th>Table 1. Content Areas Addressed in the Psychiatry in MR/DD Rotation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic concepts and definitions</td>
</tr>
<tr>
<td>Historical and modern context of psychiatry in intellectual disability</td>
</tr>
<tr>
<td>Patterns of care</td>
</tr>
<tr>
<td>Laws pertaining to treatment and services</td>
</tr>
<tr>
<td>Biomedical aspects of intellectual disability</td>
</tr>
<tr>
<td>Approaches to the patient with intellectual disability</td>
</tr>
</tbody>
</table>

1. **Basic concepts and definitions.**

Our rotation emphasizes an understanding of psychological tests to a greater degree than basic
definitions, although it is possible to address both definitions and testing equally. Residents are introduced to the basic techniques of psychological assessment, and they may become acquainted with interpretive problems in testing such as floor and ceiling effects. Information about adaptive behavior is also provided, and residents are frequently introduced to psychopathology screening tools such as the Reiss Screen and the Psychopathology Inventory for Mentally Retarded Adults. Tools for assessing treatment effectiveness, such as the Aberrant Behavior Checklist, are also typically reviewed. Epidemiology is addressed in an introductory presentation describing who people with developmental disability are, where they live (i.e., the range of residential options that are available), how they are identified (or not), and how they may or may not receive services. Topics cover the basics of epidemiology, age and locus of diagnosis and identification, issues of medical co-morbidity, and the evolution of these circumstances in the last 25 years.

2. Historical and modern context of psychiatry in intellectual disability.

This section focuses on the interdisciplinary team process. Specifically, we review the advantages afforded by multiple perspectives, as well as the frustrations and challenges that may result when team members provide input based on opinion or bias rather than assessment information or empirical data. The guidebook emanating from the 1995 International Consensus Conference on Psychotropic Medications for Persons with Developmental Disabilities contains some excellent chapters on the role of physicians on interdisciplinary teams, and we often acquaint residents with the chapter by Kalachnik et al. on guidelines for the use of psychotropic medications. In addition, consistent with APA Task Force we emphasize the role of the psychiatrist as a consultant and teacher, stressing the importance of delivering service to caregivers and through caregivers.

3. Patterns of care.

This section emphasizes trends that are reshaping the developmental disability service delivery system. Residents are introduced to the concept of person-centered planning, and a brief article by Pfadt and Holburn serves as a useful resource in this respect. We review the current emphasis on social ecology implicit in the 2002 AAMR definition of intellectual disability, and this emphasis is contrasted with a deficit-based perspective. The evolution and maturation of the community support system for people with developmental disability is illustrated, with particular emphasis on the more recent development of individualized services and supports in contrast to congregate patterns of care. Residents typically request the opportunity to view a range of residential settings, frequently leading to a “guided tour” of several different types of residential arrangements. The concepts of normalization and mainstreaming may also be covered at this point, as per the recommendations of King et al. We note with interest that a number of the residents begin the rotation with an expressed desire to view institutional settings, perhaps as a result of initial comfort with their medical background and previous medical models of developmental disability. However, if the institutional option is pursued, we balance it with exposure to community-based settings. In addition, residents have the chance to learn more about early intervention services, which are often delivered in home settings, and they also gain knowledge about vocational and habilitation services for adults. With regard to vocational alternatives, residents may learn about individualized and community-based options such as supported employment programs, in addition to observing sheltered work settings.

4. Laws pertaining to treatment and services.

Residents often desire information about eligibility regulations governing community-based developmental disability services; this information is typically supplied during initial meetings with the community-based field instructor. In addition, residents are provided with rather extensive coverage of legal competency issues, such as competency to consent to treatment or to govern one’s own financial affairs. Informed consent concepts are reviewed in considerable detail, including fundamental elements of informed consent (e.g., disclosure of full information, capacity, and voluntariness), as well as various standards for the determination of competency (e.g., expression of preference, understanding, appreciation, and reasoning). The American Association on Mental Retardation Consent Handbook is a valuable resource regarding basic informed consent concepts, and Grisso and

Mental Health Aspects of Developmental Disabilities

January/February/March 2005 Vol. 8, No. 1
Appelbaum\textsuperscript{11} offer an informative review of competence standards and the manner in which these standards can be assessed.

5. Biomedical aspects of intellectual disability.

This segment emphasizes the overall utility of the biopsychosocial approach in working with people who have intellectual disability or developmental disabilities. Gardner and Sovner's\textsuperscript{9} volume on a multimodal approach to self-injurious behavior nicely illustrates a specific application of the biopsychosocial perspective. In particular, we stress (a) the way in which a behavioral or psychiatric disorder may represent the final common pathway for a multitude of causes, and (b) how this perspective offers multiple avenues for intervention. Other areas of coverage include many commonly under-recognized health problems that occur in persons with developmental disability, which may not be adequately addressed by the individual with developmental disability, their families, caregivers, or primary care physicians. Such problems may include sensory impairments, nutritional disorders, chronic or recurrent infections, diseases of the oral, gastro-intestinal, cardiopulmonary, endocrine, and musculoskeletal systems, neurological conditions such as headaches and seizures, and adverse medication side effects or drug interactions.\textsuperscript{38} In addition, we also address the need for preventative health care services, which should include inquiry and counseling about diet, lifestyle issues such as smoking and substance use, and sexual, reproductive and contraceptive issues. In another vein, residents are introduced to some literature on behavioral phenotypes,\textsuperscript{13,14} a topic that has intrinsic appeal and relevance to medically trained practitioners.

6. Approaches to the patient with intellectual disability.

This area typically is the most substantial content segment, because it addresses the vital areas of assessment of psychopathology, the range of treatment approaches, and issues in working with families. Information on psychopathology customarily deals with problems in making an accurate diagnosis. We include consideration of the pathplastic effects of intellectual disability on the expression of psychiatric symptoms,\textsuperscript{35} diagnostic overshadowing,\textsuperscript{32} and developmental versus deviance approaches to understanding various disorders.\textsuperscript{39} The paraphilias are presented as an illustration of the ways in which developmental factors and deviance may coexist. Residents have an opportunity to meet with a human-sexuality educator to learn about techniques for teaching persons with developmental disability about typical and appropriate forms of sexual expression. This opportunity is especially useful in emphasizing the contribution of developmental factors to apparently disordered behavior.

We highlight a number of features in our coverage of treatment approaches. Residents learn about psychosocial approaches that might be applied to the treatment of a variety of disorders, especially behavioral approaches and counseling interventions. The goal is to develop a basic appreciation of the contribution of environmental, learning, and personality factors in clinical work, as well as the array of interventions that are available for a variety of problems. We do not expect residents to attain a high level of expertise in designing or implementing these psychosocial interventions, but we anticipate they will acquire enhanced sophistication with regard to treatment selection. Residents are usually given a copy of the Konarski \textit{et al.}\textsuperscript{18} Manual for the Assessment and Treatment of the Behavior Disorders of People with Mental Retardation. This manual contains concise summaries of research literature on an assortment of behavioral, pharmacologic, and other approaches to behavior problems and psychiatric disorders in people with intellectual disability.

Our review of treatment approaches also includes information on clinical decision-making. Specifically, we review an article providing a framework for identifying and selecting outcomes of clinical services to people with developmental disability.\textsuperscript{33} We also explore issues such as phases in the clinical decision making process, multiple vantage points for the selection of outcomes, and the importance of person-environment fit. Perhaps the most important point here is that residents learn the importance of distinguishing between a problem that is primarily rooted in the caregiver expectations or the environment, as opposed to a problem that primarily reflects the patient's endogenous psychopathology.

Finally, we may cover issues involved in supporting families. Here, we stress that families can serve as sources of competence and strength,
in contrast to more traditional medical models that tend to view families as victims of psychopathology. This distinction is consistent with the shift from "pathology-oriented" to "stress-and-coping-oriented" perspectives in recent literature on work with families of people with disabilities. Residents often express an interest in observing early intervention programs, which obviously are intensively family-focused. In addition, observations of early intervention programs help residents learn more about tertiary prevention, as well as the important areas of home and community-based services.

Since its inception in 1995, nearly 40 residents have completed the program. All residents evaluate their experience at an annual retreat, where they provide anonymous feedback that can be utilized to modify the rotation for future participants. In the most recent sets of evaluations (2001-2003), both the clinical experience and didactic instruction received superior ratings from the resident consumers. Several strengths of the rotation were identified by senior residents, including:

1. Gaining clinical experience with persons with developmental disabilities.
2. The opportunity to experience and learn about community support services for people with developmental disability.
3. Increased knowledge about psychopathology in persons with developmental disability, as well as treatment approaches.
4. The high level of supervision of the clinical experiences.

The only weakness identified was that the rotation was too short in duration. With a three-month rotation, resident participants are often unable to observe, over extended periods of time, the effects of their clinical interventions for assigned patients. This is a common problem in many areas of psychiatry residency education. In future revisions of the rotation, attempts will be made to integrate the experience into a broader ambulatory clinical rotation, in order to allow residents to participate in the treatment of individuals and their families over more months, or perhaps years, of contact with the program.

**Conclusions**

We have presented a program of instruction and experience with persons with developmental disability for residents in psychiatry. Most residents participating have reported an increased interest in working with persons with developmental disability following completion of their residency training, and several graduates have taken consultant positions fulfilling that interest. Those not able to work directly in this specialty field after graduation have increased their knowledge and appreciation for the difficulties faced by persons with developmental disability, and the challenges they face in obtaining medical and psychiatric care. As a result, when they are asked to evaluate and treat patients with developmental disabilities in future outpatient clinics, emergency departments, or hospital settings, they will be more prepared to provide appropriate psychiatric care. An additional benefit of the program was the establishment of a specific liaison position between the County Board of MR/DD and the hospital, which has helped in transitions for persons with developmental disability in and out of the hospital, facilitating medical and psychiatric admissions when necessary, and coordinating aftercare. As a result, there has also been a higher level of positive familiarity and comfort for medical and nursing personnel working with persons with developmental disability on the inpatient and outpatient services.

In the community, the residents have become a familiar fixture in the vocational and residential settings in which they receive instruction, and provide consultation to these programs and individuals. The residents have been able to increase the level of sophistication of community staff in the area of psychiatric illness and psychopharmacologic therapies, and have gained new knowledge in the psychosocial approaches more common in community settings. Finally, the program has made psychiatric evaluation possible for a number of individuals who had been unable or unwilling to come to the hospital for evaluation, by providing consultation/evaluation in their homes or work settings.

**References**


27. Reiss S, Aman M. The International Consensus Handbook: Psychotropic Medications and


**Correspondence:** Stephan A. Schwartz, Ph.D., Chief Clinical Officer, Cuyahoga County Board of MR/DD, 1275 Lakeside Avenue, Cleveland, OH 44114; tel.: 216-736-2693; fax: 216-861-0253; e-mail: Schwartz_s@ccbmrd. org.