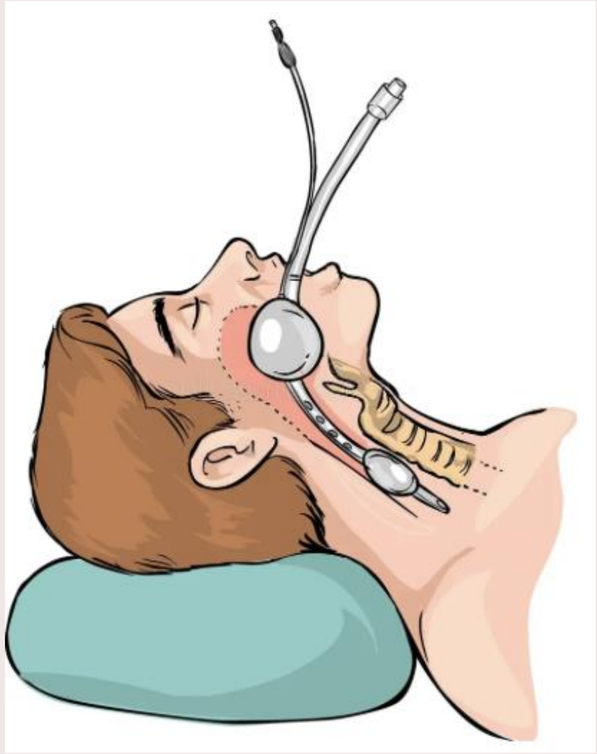
Chemical restraint, health & mental health

Human Rights at our Doorstep conference- 06.04.2024

Bahman Zarrabi- Psychiatrist (SAIDHS, LMH Psychiatry Consultation Liaison Service)

Jake

- 21 yo, ASD (L3) and ID (moderate), non-verbal. Generally settled but more recently randomly goes to foetal position and clutches his tummy. Can occur anywhere. This time in car, when carer didn't stop, he attacked the carer. Then lied down in the road. Mum too k him to hospital. Agitated in ED > code black > ICU intubated purely for sedation



Ben

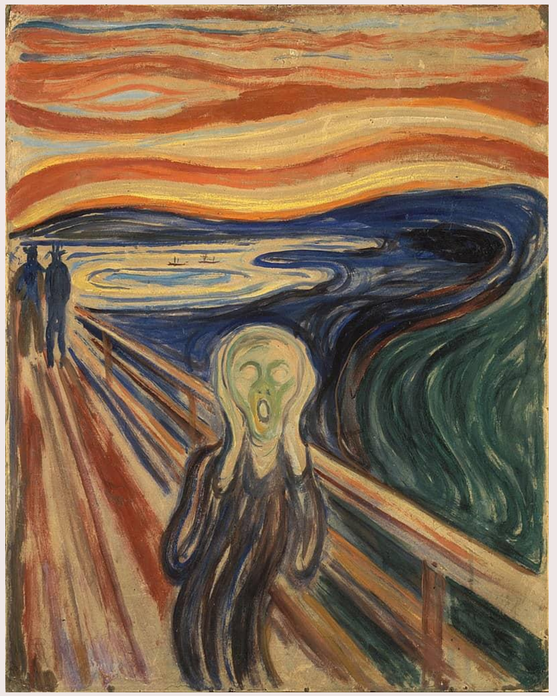
19 yo, severe autism and ID. On risperidone by paediatrician for behaviours. Gained significant weight, in wheelchair. Significant aggression when taken to day option and when returns home, mainly targeting mum. She is at her wits end, pushing for additional medication

Charlie

- 44 yo man, ID, lives in shared SIL. Forensic hx: perpetrator of sexualised behaviour towards minors: required constant supervision. In a complex same sex relationship with another resident, difficult to establish if consensual. Frequent episodes of aggression.

Aidan

- 32 yo male, ID (moderate to severe), increased agitation, not settling down, was taken to hospital and some changes made to his medication. When arrived, carer didn't feel safe to let him out of the car. I saw him in the carpark. He was beside himself. Screaming head banging and running around the back of the van



Evidence Base

- In the psychiatry of ID, the evidence base for the use of psychotropic medications is extremely limited
- Reasons:
  - Very few well-designed randomised controlled trials (RCTs)
  - Adults with ID frequently have additional health problems that preclude them from being recruited into studies.
  - Measurement tools for symptoms and outcomes vary, not standardised, and prone to rater bias
  - Mixed results
- On the basis of current evidence, the use of psychotropics could neither be supported nor be refuted

Aggressive Behaviour

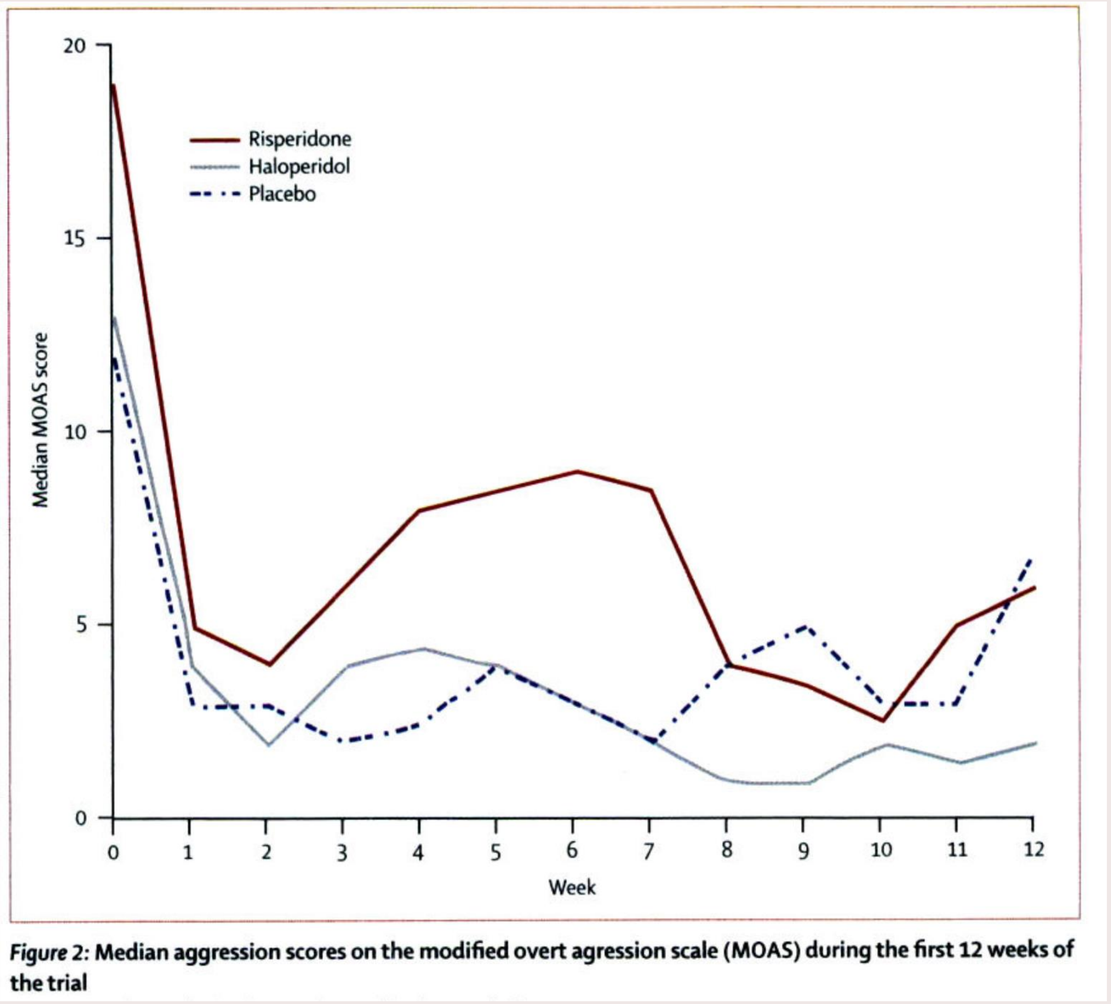


Figure 2: **Median aggression scores on the modified overt agression scale (MOAS) during the first 12 weeks of the trial**

- *Tyrer P, Oliver-Africano PC, Ahmed Z, Bouras N, Cooray S, Deb S, et al. Risperidone, haloperidol, and placebo in the treatment of aggressive challenging behaviour in patients with intellectual disability: a randomised controlled trial. The Lancet (British edition). 2008;371(9606):57–63*

Does this data inform the practice of prescribing psychotropics for people with ID?

- 32%-85% of the ID population are prescribed antipsychotics for behavioural disturbances
- UK primary care data 1999-2013 : 49% prescribed, only 21% had a psychiatric diagnosis
- Off-label prescription for problem behaviour
- Polypharmacy and using high dose is common

Why?

- Pressure from professionals/carers for immediate resolution of a problem
- Limited resources available for changing the environment
- Lack of appropriately trained staff in private residential homes
- Shortfall of psychiatrists
- Lack of input from clinical psychologists, specialist, clinical pharmacists and speech therapists

New	Cholecalciferol capsule; 25microgram	25 microg, Oral, daily	
New	Azithromycin tablet;500mg	500mg, Oral, daily	
New	Nystatin oral susp;100,000 units/mL	1ml, Topical, qid	
New	Doxycycline tablet;100mg	100mg, Oral, daily	
Active	Risperidone tablet (soluble quicklet);4mg	8 mg, Oral, BD	320%
Active	Paliperidone tablet prolonged release;6mg	12 mg, Oral, mane	200%
Active	Benztropine tablet;2mg	1 mg, Oral, BD	
Active	Lithium carbonate tablet (SR); 450mg	675 mg, Oral, nocte	
Active	Ziprasidone capsule;80mg	80mg, Oral, BD	200%
			Total: 720%

Follow Up Management Plan: See clinical synopsis
Services on Discharge: None
Future Hospital Appointments: None
Other Appointments: None

Challenges in assessment

- Cognitive and communication impairments: Difficult to achieve understanding of subjective experience
- Difficult to ascertain degree of subjective distress and impairment in function necessary for defining a psychiatric disorder
- Baseline exaggeration
- Characteristic symptomatology can be significantly altered by the nature of ID syndrome, e.g. neurovegetative symptoms, interpersonal relationships, etc. (Diagnostic overshadowing)
- Intellectual distortion
- Developmental biases: mismatch between chronological age and developmental stages
- Psychosocial masking
- Expression of psychopathological symptoms as behavioural equivalents
- Cognitive disintegration: lack of cognitive reserve

Assessment

Environment

- Environment:
  - Big space
  - Not too medicalised, not childish
  - Safety issues
  - Sensory tools
  - Communication tools

Assessment

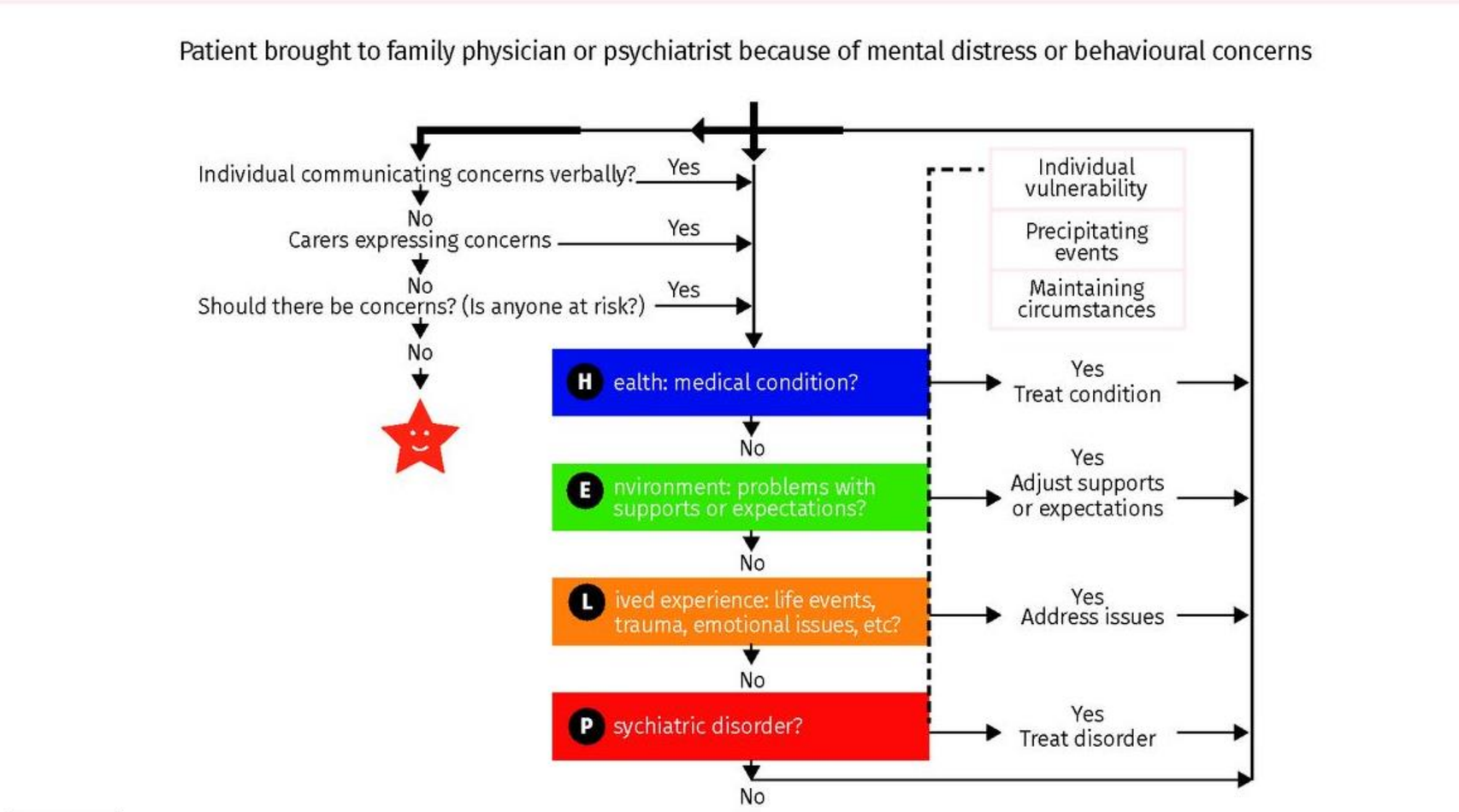
Assessor

- Do your research first
- Allocate adequate time
- Note the affect/body language and decide about direct approach or talking to informant first
- Explain the process
- Frequently provide positive feedback and remind them they are not in trouble
- Be flexible with the format
- Tailor your communication
- Collateral information
- Pay attention to patient through the review

Integrated, multidimensional assessment

- Done by different professionals working together to build up a shared project with person and his/her family, looking at
  - ID assessment (cognitive and adaptive behaviour)
  - Medical and personal Hx
  - Language (communication assessment profile: CASP)
  - Emotional development (Scheme of Appraisal of Emotional Development: SAED, SED-R, SED-R2, SED-S)
  - Physical/ functional assessment
  - Psychiatric and Mental state assessment
  - Assessment of problem behaviour (ABC, ABA, CATS)
  - Assessment of support needs (Support Intensity Scale: SIS)
  - Assessment of quality of life, should be the main outcome measure, (QoL)

Assessment



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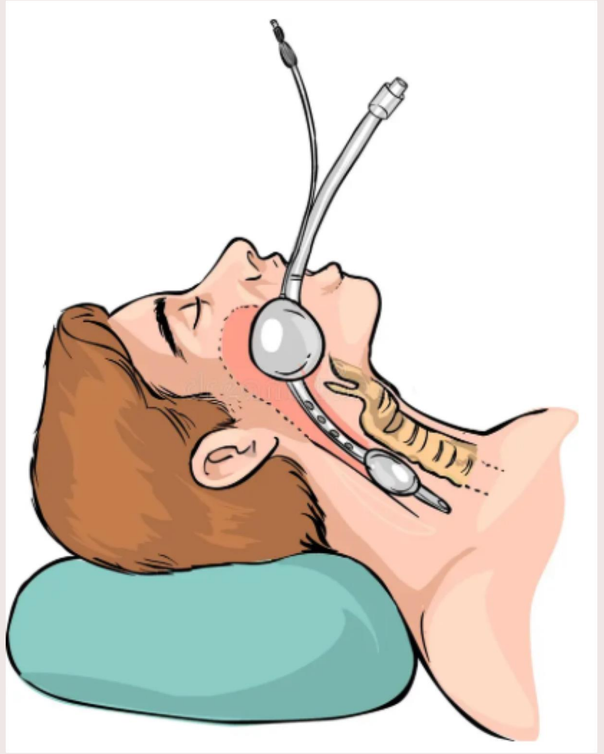

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Environment

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Lived Experience (Trauma)

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