Psychiatric Evaluation of Patients with IDD in Crisis

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Psychiatric Evaluation of the IDD Patient in Crisis: OVERVIEW

- In the past 25 years, care has shifted from state hospitals to the community setting, increasing the need for medical and psychiatric care in the community.
- Adequate services are typically lacking and the specific training of medical and psychiatric professionals is often insufficient, creating additional barriers to proper intervention and treatment.
- In a survey by Werner and colleagues,90.2% of psychiatrists felt they lacked specific training in treating and diagnosing problems in the IDD population. [1]

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Psychiatric Evaluation of the IDD Patient in Crisis:
OVERVIEW

- Prevalence of psychiatric disorders in individuals with IDD is estimated to be between **32%-40%.**[2]

- Persons with IDD: frequency of co-occurring psychiatric disorders:

Autism Spectrum Disorders	Mild IDD: 5-10%, Moderate-Severe IDD: up to 30% [3]
ADHD (Children)	Estimated 8.7-16% vs. 5% in general pop.[4]
Major Depression	1.5-2 times higher than in general pop. [3]
Schizophrenia/Bipolar	2x higher than in general population [3]
Anxiety	Very Frequent, especially with autism spectrum -phobias, stereotypies, compulsions [5]

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Psychiatric Evaluation of the IDD Patient in Crisis: OVERVIEW

- **Challenging behaviors** (i.e., aggression toward others, self-injurious behavior, inappropriate social and sexual behaviors, self-stimulating behaviors such as rocking, withdrawal, or noncompliance) ***are 3 to 5 times more common in the IDD population***. [6]
- About **12% to 46%** of individuals who have IDD receive **psychotropic medication for treatment of behavioral problems**. [4]
- Rates are higher among adults and those living in institutions. [4]

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Psychiatric Evaluation of the IDD Patient in Crisis: Most Common Presenting Problems

- **AGGRESSION, SELF INJURIOUS BEHAVIOR, OR BOTH,**
  -either *new onset* or *escalation from baseline frequency*
- **CHANGES IN MENTAL STATUS, including, but not limited to:**
  -hyperactivity, irritability, agitation, withdrawal/isolation,
  -confusion, disorientation,
  -severe changes in mood, sleep, or energy
  -psychotic symptoms
- **MEDICATION RELATED PROBLEMS**
  -examples include dystonic reactions, akathisia, paradoxical disinhibition
- **PHYSICAL COMPLAINTS or BEHAVIOR DISTURBANCES THAT MAY BE MANIFESTATIONS OF UNDERLYING MEDICAL PROBLEMS**

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Psychiatric Evaluation of the IDD Patient in Crisis: Most Common Presenting Problems

- ***AGGRESSION TO SELF OR OTHERS*** is by far and away the most common presenting issue by IDD patients in crisis
- **For the *caregiver*** bringing the person with IDD to the evaluation, ***aggression is the problem.***
- While evaluating the patient with IDD in crisis, ***professionals see aggression:***
  1. As a form of communication,
  2. The starting point for determining the cause of the problem.

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Psychiatric Evaluation of the IDD Patient in Crisis: Most Common Presenting Problems

- **When AGGRESSION is viewed as a *form of communication*, the entire treatment philosophy shifts from a desire to 'medicate the aggression away' to a desire to further explore**

- **Adaptive *'BENEFITS'* of aggression for the IDD PATIENT:**
  1.) exerting control in the environment (e.g., get someone to stop doing something)
  2.) something that is seen as beneficial for the patient (e.g., removal from unpleasant task, a way to get attn.)
  3.) an expression of *emotional* discomfort(depression, mania, paranoia)
  4.) an expression of *physical* discomfort (constipation, dental abscess, infection)

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Psychiatric Evaluation of the IDD Patient in Crisis: DIAGNOSTIC CHALLENGES

- By definition, a ***CRISIS*** represents a ***'significant turn for the worse'*** or ***'an unstable change from baseline'. To***

TO UNDERSTAND A PERSON'S 'CRISIS',ONE HAS TO HAVE SOME UNDERSTANDING OF THEIR BASELINE FUNCTIONING

- **In DSM-5, the diagnoses of mental disorders are:**
  -Based on a person's symptoms in comparison to normative data about the way most people behave, feel, perceive, or think, and
  -There is a strong emphasis on a person's verbal description of their symptoms and degree of distress

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Psychiatric Evaluation of the IDD Patient in Crisis: DIAGNOSTIC CHALLENGES

Patients with intellectual and developmental disabilities have tremendous variability in baseline functioning and health status.

Persons with IDD have a broad range of cognitive skills, physical abilities, verbal skills, communication skills, associated medical conditions, and social supports. The potential combinations of attributes are so great, that even if normative data does exist, it is difficult to apply to any individual patient. (Example: consider the range of traits present in Autism Spectrum Disorder.)

Deficits in verbal fluency are a hallmark of IDD.

'VERBAL FLUENCY' is a cognitive function that facilitates information retrieval from memory. Successful retrieval requires executive control over cognitive processes such as selective attention, selective inhibition, mental set shifting, internal response generation, and self-monitoring.

Psychiatric Evaluation of the IDD Patient: DIAGNOSTIC CHALLENGES

Are the patients symptoms due to the DEVELOPMENTAL DISABILITY, PSYCHIATRIC ILLNESS, or *Something Else?*

DIAGNOSTIC OVERSHADOWING: **symptoms common to psychiatric illness such as agitation, social withdrawal, disturbed sleep, poor impulse control, inability to focus, and abnormal motor movements may or may not be baseline features of the patient's neurodevelopmental disorder.**

Awareness of DIAGNOSTIC OVERSHADOWING encourages a *broad based diagnostic approach* that emphasizes looking for multiple potential sources for those presenting symptoms.

'COGNITIVE COMPLEXITY OF THE PHYSICIAN', which refers to the tendency of the clinician to view a presenting problem in a multi-dimensional fashion. Clinicians who have greater cognitive complexity have been reported to be more likely to detect comorbid psychopathology…*and comorbid medical issues presenting as psychiatric or symptoms.*

'Diagnostic overshadowing: worse physical health care for people with mental illness'; Acta Psychiatr Scand 2008: 118: 169–171.

Psychiatric Evaluation of the IDD Patient: ADDITIONAL DIAGNOSTIC CHALLENGES

- IDD patients have often lived in ***multiple placements***, with ***multiple caregivers***, and seen ***multiple doctors***.
- The most recent caregiver, or the person bringing the patient to the evaluation may have little or no knowledge of their medical and psychiatric history.
- IDD PATIENTS OFTEN PRESENT IN CRISIS PRESENT WITH:
  -MULTIPLE PSYCHIATRIC DIAGNOSES & no information as to how they were derived,
  -MULTIPLE PSYCHIATRIC MEDICATIONS and no information as to their effectiveness, how long they have prescribed to the patient, and their side effects.

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Psychiatric Evaluation of the IDD Patient in Crisis: UTILIZES A TEAM APPROACH

- When evaluating persons ***WITHOUT IDD*** there is a strong emphasis on VERBAL REPORTING and NORMATIVE DATA (working assumptions based on age, education, occupation, etc.)

- With this population, the psychiatrist ***'goes it alone'*** in arriving at a diagnosis, and directing treatment.

- When evaluating the crisis patient ***WITH IDD***, the psychiatric approach is:
  1.) to avoid premature attribution of symptoms to a psychiatric illness, &
  2.) avoid use of psychotropic medications that may interfere with finding root causes for symptoms, or have side effects that worsen the condition

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Psychiatric Evaluation of the IDD Patient in Crisis: UTILIZES A TEAM APPROACH

- **That approach begins with CAREGIVERS:**
  -guardians, family members, case managers, home care providers, workshop therapists, teachers, etc.
  -see the person with IDD in the community regularly when not highly stressed or in crisis,
  -they are typically the best source of information for *understanding baseline functioning*.

- **BASELINE FUNCTIONING** **-mood, social interaction, appetite, sleep patterns, toileting, constipation**
  -aggression toward self or others,
  -recent changes in the household or workshop,
  -health issues including new medications,
  -medication compliance,
  -infections, injuries, pain complaints,
  -seizures, blood sugars.

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Psychiatric Evaluation of the IDD Patient in Crisis: ***Caregivers are Partners***

- **CAREGIVERS** can help **calm a patient** with IDD in a new setting, or one that is potentially frightening such as the clinic or emergency room.
- They can be used as **interpreters** of various gestures, sounds, etc. that nonverbal patients use to communicate.
- **Questions for CAREGIVERS about the patient:**
  "How can you tell when something is hurting?"
  "How do you know when he's scared?"
  "How can you tell when worried about something?"

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Psychiatric Evaluation of the IDD Patient in Crisis: UTILIZES A TEAM APPROACH

- The **INTERDISCIPLINARY TEAM** should include thorough exams by **internal medicine** and **dentistry**, When indicated, it may include consultations with **neurology, psychology, gynecology, speech therapy, audiology, behavior specialists, occupational therapists, physical therapists**.
- **Schools are often good sources for neuropsychological testing**, especially when recent testing has not been done or is not available.

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Psychiatric Evaluation of the IDD Patient in Crisis:

- **The goal of the emergency evaluation *IS NOT* to reach a definitive diagnosis.**
- **The primary goal** of the evaluation is to assure patient and caregiver **safety**.
- **<u>The emergency evaluation</u>:**
  1. Begins the diagnostic process and makes arrangements for the various components of a thorough assessment.
  2. Develops a plan to insure safety, at least in the immediate future.

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Psychiatric Evaluation of the IDD Patient in Crisis: TAKING A HISTORY

- **Evaluate the patient in a safe, private, quiet place.**
- **Seeing, hearing, and being seen and heard by other patients and staff can be frightening, distracting, or over stimulating.**
- **Whenever possible, invite familiar staff, family, or both to keep the patient company and provide history.**
- **Individuals with IDD benefit from predictable, reassuring stimuli. Verbal and nonverbal patients benefit from calm and soothing 'energy' from the doctor,& worsen when the doctor is rushed, getting interrupted with phone calls, etc.**
- **So, FIRST CALM YOURSELF. Then calm the patient and the caregivers. Caregivers often have anxiety around doctors, clinics, hospitals. Their anxiety may be contagious to the patient.**

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Psychiatric Evaluation of the IDD Patient in Crisis: TAKING A HISTORY

- **Patients and caregivers may have fears or poor expectations based on prior experiences with health care professionals (as do all of us).**
- **Sometimes fears about mental health (eg, frightening side effects from medications) or resentment about those negative experiences (eg, doctor didn't return phone calls) *must be addressed first*, in order to have enough trust to move forward with the evaluation.**
- **Be aware that some crises are 'situation specific.' Just because the patient isn't acting out in the examining room or clinic, it doesn't mean that they weren't acting differently elsewhere. This may well point to environmental triggers as a source of the problem.**

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Psychiatric Evaluation of the IDD Patient in Crisis:

Taking a History-*Beware of Hidden Agendas*

Case managers, guardians, and family members may bring the IDD patient for a crisis evaluation under the appearance of 'requesting an evaluation'. However, the real purpose may be to move the IDD person to another living arrangement. Focusing more on the '*hidden agenda*' may be in the patient's best interest.

Beware of the *'QUEST FOR THE MAGIC PILL'* that will remove all anxiety, make everyone happy, and eliminate all conflict. (This one typically doesn't exist. However, it actually might exist if the caregiver, and not the patient for whom it's prescribed, takes the benzodiazepine).

Beware of the *'QUEST FOR THE MAGIC PILL'S COUSIN'* that will make the aggressive or IDD patient with challenging behaviors sleep most of the time, or be too tranquilized to put up any fuss. This one does exist, most commonly prescribed as 2nd GENERATION ANTIPSYCHOTICS.
Sometimes, family members and caregivers become quite upset when these medications are *not prescribed.*

Psychiatric Evaluation of the IDD Patient in Crisis: MEDICAL SOURCES OF PSYCHIATRIC SYMPTOMS

- Physical illnesses are often missed in patients with IDD.
- In one study, 75% of persons with IDD referred for psychiatric assessment had untreated or undiagnosed medical conditions, and 45% received nonpsychiatric medications that could produce psychiatric symptoms.[7]

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Psychiatric Evaluation of the IDD Patient in Crisis: MEDICAL SOURCES OF PSYCHIATRIC SYMPTOMS

- EXAMPLE: Hyperthyroidism can present with anxiety, depression, or manic symptoms.
- Medical problems can result in psychiatric symptoms or exacerbate preexisting ones. EXAMPLE: head banging in a nonverbal patient with an untreated earache.
- It is not uncommon for the medical illness to initially cause the problematic behavior, and **SECONDARY GAIN**, such as increased attention, may maintain the behavior even after the illness is treated.

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PSYCHIATRIC SYMPTOMS from Psychiatric Medications:
'Sometimes the CURE can cause the ILLNESS'

MEDICATION CLASS	EXAMPLES	SIDE EFFECTS
Benzodiazepines with long half-lives	Valium (diazepam), Klonopin (clonazepam)	ACCUMULATE->drowsiness, mental clouding, unsteady gait, paradoxical disinhibition
Benzodiazepines with short half-lives	Xanax (alprazolam)	Interdose 'rebound' with worsening of anxiety just before next dose
Anticonvulsants (prescribed for seizures, migraine HA, bipolar disorders)	Depakote (valproic acid), Tegretol (carbamazepine) Lamictal (lamotrigine) Topamax (topirimate)	Sedation, unsteady gait, blurred vision, agitation, spinning sensation, confusion, shortness of breath, chest tightness
Antihistamines (allergies, congestion, insomnia, itching)	Benadryl (diphenhydramine) Vistaril (hydroxyzine) Claritan (loratidine) Allegra, Zyrtec	Drowsiness, agitation, blurred vision, dry mouth, constipation
Selective Serotonin Re-Uptake Inhibitors (SSRIs) (treat depression, anxiety, panic attacks)	Prozac (fluoxetine) Zoloft (sertraline) Celexa (citalopram) Paxil (paroxetine) Luvox (fluvoxamine)	Akathisia, aggression, dizziness, insomnia, nausea, vomiting, diarrhea, SEXUAL SIDE EFFECTS (erectile dysfunction, anorgasmia) SUICIDAL IDEATION

Be Vigilant for MEDICATION WITHDRAWAL SYMPTOMS Triggering a Crisis

- All medications have some potential for withdrawal syndromes, ***especially when stopped abruptly***.
- ***This can happen accidently*** when a caregiver forgets, or a person with IDD skips or misses a few doses.
- Even when the prescribing physician gives a tapering schedule to wean off of a medication gradually, some medications, e.g., Paroxetine &Venlafaxine, can be very difficult to stop.
- Withdrawal symptoms can range from ***flu-like symptoms to severe agitation.***
- The list of psychiatric symptoms from medications is far too long to be included here. For an extensive list, see: **The Medical Letter Volume 50 Issue 1301/1302, December 15/29, 2008**.

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Research in Developmental Disabilities

Antipsychotic medication prescription patterns in adults with developmental disabilities who have experienced psychiatric crisis

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ABSTRACT

Antipsychotic medication rates are high in adults with developmental disability. This study considered rates of antipsychotic use in 743 adults with developmental disability who had experienced a psychiatric crisis. Nearly half (49%) of these adults were prescribed antipsychotics. Polypharmacy was common with 22% of those prescribed antipsychotics taking 2 or more antipsychotics at once. Predictors of multiple antipsychotic use included gender, residence, psychiatric diagnosis and previous hospitalizations. Implications of medication prescriptions to this vulnerable population are discussed.

'Atypical' or '2nd Generation' Antipsychotics: SIDE EFFECTS triggering a Crisis

- **AKATHISIA, or 'Restless Leg Syndrome'**
  -a most uncomfortable sensation of needing to move, especially the legs; persons often describe it as **'feeling like I have ants in my pants',**
  -degree of discomfort ranges from 'annoying' to 'full-blown rage'

- **AKATHISIA IS OFTEN MISTAKEN FOR THE ORIGINAL AGITATION FOR WHICH THE ANTIPSYCHOTIC MEDICATION WAS INITIALLY PRESCRIBED ALL TOO OFTEN, A 2ND LARGER DOSE IS THEN GIVEN, WHICH ONLY MAKES THE PROBLEM SO MUCH WORSE!!!**

- **TREMORS,TICS** -involuntary movements or jerks, often in the hands or face
  -can occur sporadically, wax & wane, and can be very upsetting

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‘Atypical’ or ‘2nd Generation’ Antipsychotics: SIDE EFFECTS triggering a Crisis

- **DYSTONIC REACTIONS: muscle spasm or cramp-like reaction** to antipsychotics **ranging from ‘uncomfortable’ to ‘painful’**
  - more commonly involves muscles of the head, neck, and face, eg, ‘tongue feeling thick’
  - –occurs more frequently with high potency antipsychotics, e.g., Haldol
  - **-can be quite frightening**, especially for someone who doesn’t know what is causing the ‘cramp’

- **TARDIVE DYSKINISIA:** abnormal, involuntary movements that may include facial grimacing, tongue thrusting, repetitive chewing
  - -may or may not go away when the antipsychotic is DC’ed

- **Note: WITHDRAWAL DYSKINISIAS:** can occur when an antipsychotic med is abruptly stopped
  - –may take weeks or months to fade away

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ANXIETY: The CRISIS of the IDD patient may involve an INTOLERABLE EXPOSURE TO A FEARED SITUATION

- Persons with Mild IDD may be able to verbally express their anxiety, typically with a more concrete worry, such as fears a relative may die or get hurt in an accident.

- For those with more severe impairments, especially nonverbal persons, **look for physical signs of anxiety** such as sleep disturbance, palpitations, diarrhea, sweating, trembling, body aches, irritability, co-occurring depression, and aggression.

- **OCD: OBSESSIVE fears typically aren't verbalized; OCD is diagnosed based on observation of COMPULSIVE behaviors** such as hoarding, frequent wiping of hands, refusal to touch certain objects, etc.
  OCD symptoms are especially common in persons with Autism Spectrum Disorders.

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An IDD Patient's CRISIS may be Precipitated by an INTOLERABLE EXPOSURE TO A FEARED SITUATION

- **SPECIFIC PHOBIAS**: behavior manifestations include 1.)an ***obvious response*** to the feared object (spiders), 2.)a ***less obvious response*** (refusal to enter clinic due to a fear of needles for a blood draw), 3.)to ***the 'What in the heck is going on?' response*** (aggression at home when getting ready to leave for the clinic), **PERFECT OPPORTUNITY FOR CALLING THE BEHAVIOR ANALYST AND YELLING, "HELP!!!"**

- **The IDD population is extremely vulnerable to physical and sexual abuse.**

STAY VIGILANT for these phobic avoidant responses to sites of, or representations of sites of, places where the IDD patient has been TRAUMATIZED

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IDD Patients in Crisis: MOOD DISORDERS

- **MOOD DISORDERS** are probably ***underdiagnosed*** in the IDD population, as ***most referrals are made for disruptive behaviors.***
- **In persons with mild IDD**, depressive symptoms are similar to those in persons without IDD, but the **complaints may be more concrete**, eg, saying "I feel sick" as opposed to, "I feel sad."
- **When diagnosing mood disorders:**
  -DSM-V places an emphasis on a patient's verbal reporting of internal states.
  -For IDD patients, the evaluation focuses on observable changes relative to that person's baseline emotional state

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PSYCHIATRIC SYMPTOMS from Psychiatric Medications:
'Sometimes the CURE can cause the ILLNESS'

OBSERVABLE BEHAVIORAL CHANGES FROM BASELINE FUNCTIONING	MOOD DISORDER
Inability to find pleasure in things that previously were enjoyable	Depression
Excessive engagement in pleasurable activities	Mania
Hypersexuality, as manifested by *new onset or compulsive* masturbation or self stimulation	Mania
For nonverbal persons, decreased vocalization or no sound production	Depression
Notably increased or nonstop vocalizations in a previously quiet nonverbal person	Mania
Excessive sleeping or interrupted sleep with early morning wakening in combination with pervasive low energy and slowed movements	Depression
Decreased need for sleep combined with boundless energy and nonstop movement	Mania
Pervasive irritability or a dramatic increase in aggressive behaviors	Depression or Mania
New onset of rages, destructiveness, hostility	Mania

Psychiatric Evaluation of the IDD Patient in Crisis: EVALUATION OF PSYCHOSIS (*can be quite difficult*)

- **Sensory Impairments are common in persons with IDD**; an evaluation of vision and hearing are indicated when psychosis is expected
- Symptoms that may appear to be 'psychotic' are often part of the developmental disability, e.g., 'imaginary friends in persons with autism'
- Schizophrenia is probably impossible to diagnose in persons with an IQ<45 due
- Evaluators need to be aware that persons with limited verbal ability might use behavior that is odd or unusual as a means of communication

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Psychiatric Evaluation of the IDD Patient in Crisis: EVALUATION OF PSYCHOSIS

- **Schizophrenia**: an illness characterized by **delusions, hallucinations, and disorganized thinking**; it *should not be diagnosed in the emergency or crisis evaluation*
- **DELUSIONS** (paranoia)-new onset of tremendous fear and a belief that others are out to harm the person.
- **DISORGANIZED THINKING**-a significant deterioration from baseline comprehension & expression skills.
- **HALLUCINATIONS**- easiest way to diagnose is to observe a person hearing or seeing things not present.

(After that, it gets tricky.)

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Psychiatric Evaluation of the IDD Patient in Crisis: EVALUATION OF PSYCHOSIS

- **AUDITORY HALLUCINATIONS**:
  -the person may hold hands over their ears with a pained expression on face,
  Relatively concrete diagnostic questions to ask are, ***"Are you hearing that with your ears, or is it only in your head? Do you think can hear the same thing?"***

- **VISUAL HALLUCINATIONS**: almost always have 'medical' causes such as intoxication, medication side effects, illness, delirium, etc.

- **ALWAYS LOOK FOR MEDICAL ILLNESS OR MEDICATIONS CAUSING PSYCHOTIC SYMPTOMS**

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The IDD Patient in Crisis:
Delirium, or Acute Confusional State:

- a ***medically-caused*** decline from a previously attained baseline level of cognitive functioning,
- Is typified by a ***fluctuating course***, attentional deficits and severe disorganization of thinking and behavior,
- involves ***changes in arousal*** (hyperactivity, hypo-activity, or mixed), altered sleep-wake cycle, and ***psychotic features*** such as delusions and hallucinations (auditory, visual, tactile).
- symptoms include ***autonomic abnormalities*** (flushed, sweating, shaking, etc.) and ***abnormal vital signs*** (elevated pulse & temperature).

DELIRIUM IS A MEDICAL EMERGENCY WITH A HIGH MORTALITY RATE!

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The IDD Patient in Crisis:
Environmental Interventions

- **On the basis of the crisis evaluation, any of the following dispositions may be agreed on:**
  - -Return to current living situation
  - -Respite care or increased monitoring at home
  - -Inpatient psychiatric hospitalization

- **Emergency Inpatient Psychiatric Hospitalization:**
  - -indicated when a patient is ***of imminent danger of harm to themselves or others***, and ***cannot be kept safe in the community***, or,
  - -is so ill that ***outpatient care is inadequate to prevent further decompensation***, or,
  - -has an illness that has gotten so severe that they ***cannot function in a less restricted setting***

THERE CAN BE SIGNIFICANT VARIATION IN INPATIENT PSYCHIATRIC UNITS AND THEIR WILLINGNESS TO ACCEPT & TREAT PATIENT'S WITH IDD (DISCUSSION TOPIC)

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Psychiatric Evaluation of the IDD Patient: MEDICATION INTERVENTIONS

The most frequent targeted symptoms are:

AGGRESSION, INSOMNIA, ANXIETY, AGITATION, & SELF-INJURIOUS BEHAVIOR.

A VERY COMMON SCENARIO: **The doctor may prescribe an atypical antipsychotic medication during an '*office emergency*' with the intention of short term use, only to find that 3 years later, the patient is still taking that same med, along with a 2nd antipsychotic. In addition, that patient now is *obese with diabetes and hypertension*, and is also taking medicines for those conditions.**

Atypical Antipyschotics have been *overprescribed in the IDD population* for the symptoms listed above & *have potentially harmful short term & long term side effects.*

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Psychiatric Evaluation of the IDD Patient in Crisis: INTERVENTIONS with MEDICATION

- **In the Crisis Evaluation Setting, medicines with a quicker onset of action are prescribed:**
- **Sleep**: short term benzodiazepines or Trazodone,
- **Agitation**: short term medium potency benzodiazepine, e.g., lorazepam; monitor for disinhibition, (Short acting benzos can have 'rebound', long acting benzos can accummulate with sedation, gait problems, decreased cognition),
- **Impulsivity, Aggression, Self-Injurious Behavior**: consider buspirone, beta blockers, oxcarbazepine

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Psychiatric Evaluation of the IDD Patient in Crisis: INTERVENTIONS with MEDICATION

PRESCRIBERS:

Remember the adage: "Stay low, go slow."

1.) *Start with lower doses*, 2.) *allow adequate time to observe effect of med change*, 3.) *monitor frequently*.

Consider the potential complications of monitoring discontinuation of one medication while starting another at the same time.

Consider the fact that our patients have multiple medical problems and are seeing multiple doctors, each of whom may be making medication changes; the risk of medication interactions increases with every new medicine added.

Psychiatric Evaluation of the IDD Patient:
MEDICATION INTERVENTIONS
'SOMETIMES LESS IS MORE'

- **At the LEE SPECIALTY CLINIC, our guiding philosophy as physicians treating the IDD population:**
  "We can often make the best and most effective medication interventions by…
  -*discontinuation* of a medication that is unnecessary or is causing the patient problems,
  -*lowering medication doses,* or
  -*switching to an alternative medicine that is better tolerated, & more safe in the short term & long term."*

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Thank You for Your Attention

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