COMPETENCY STANDARD 1:
Assessment of Medical Connection to Challenging Behavior

OVERVIEW

The brain behavior relationships that underlie both challenging behaviors and mental disorders are intimately connected to physical health and well-being. Medical illness can have a profound effect on brain functioning. These effects include: delirium (abrupt change in the brain causing mental confusion and emotional disruption); worsening of pre-existing mental status, target symptoms, or psychiatric symptoms; and emergence of new patterns of behavior that mimic mental disorders.

Medication side effects or iatrogenic causes can create similar problems. The differential diagnoses of these complications can require an extensive medical or neurological workup.

Being aware of these conditions can improve the quality of life for many individuals with IDD. It can also be helpful in minimizing psychiatric misdiagnosis and inappropriate pharmacotherapies.

The candidate needs to be able to recognize common medical/neurological sources of mental status change. The medical provider in concert with the treatment team can use this information to begin the medical assessment, refer to an outside specialist, or, in the case of an emergency, refer for acute medical care.

Culturally sensitive trauma-informed care is needed in medical assessment and refers to the capacity for health care professionals to effectually provide trauma-informed assessment and intervention that acknowledges, respects, and integrates patients' and families' cultural values, beliefs, and practices.

AREAS OF KNOWLEDGE AND SKILL

The following areas of knowledge and skill have been identified as benchmarks for satisfying the following

Benchmark 1A: Assessment of Medical Conditions
Benchmark 1B: Cultural Considerations in Assessing Medical Connections to Behavioral Issues

BENCHMARK 1A: Assessment of Medical Issues

The qualified clinician demonstrates knowledge about the connection between physiological or neurological disorders and behavioral problems or psychiatric symptoms.

Benchmark 1A Performance Indicators

The qualified clinician:

- Acknowledges that medical and neurological disorder can mimic most primary mental disorders.
- Demonstrate knowledge of common causes of cognitive/behavioral changes or the intensification or emergence of medical symptoms similar to those seen in primary mental disorders, including:
  - Behavior changes due to polypharmacy, medication side effects, or errors in dosing.
  - Rapid changes in level of consciousness. Behavior can occur in association with a seizure, stroke, or brain injury. It is important to be aware of a history of past seizures, current seizure medications, and side effects of these drugs. Abrupt changes can be related to stroke or intra-cerebral bleeding. A recent head injury, past history of stroke, paralysis, difficulty understanding or speaking, disorientation, and confusion are common symptoms. Brain tumors are rare but shunt failure in someone with hydrocephalus or degenerative disorders such as Parkinson's may present over an extended period of time
  - Elevated blood sugar and diabetic ketosis, electrolyte problems, acute oxygen deprivation, and liver failure are suspected when an individual has a current history of diabetes, kidney problem, liver disease, and chronic lung disease.
  - Age related or neurocognitive disorders such as Alzheimer's, vascular (stroke-related), and other types of dementia are at increased risk for agitation, aggression, and acute onset of psychosis. Vitamin B12 and folic acid deficiencies are associated with dementia, mood and anxiety disorders, and psychosis in some extreme cases. Urinary tract infections can cause a change in behavior in older people and people with dementia. Appearing as confusion, agitation, or withdrawal, UTI may actually be the cause of behavioral shifts.
  - Thyroid and other endocrine disorders can present with the gradual onset of mood and anxiety related symptoms. Lethargy, depressed mood, and loss of interest in activities due to hypothyroidism are common and may be exacerbated by some medications like lithium. Premenstrual changes in mood and behavior can be a challenge to sort out and the cyclical hormone changes along with the response to pain and discomfort can be mistaken for bipolar disorder or recurring depression.
  - Sleep deficiency such as sleep apnea can contribute to chronic mood and cognitive abnormalities, high blood pressure, worsening diabetes, and heart disease. Obesity and anatomical changes seen in Down syndrome are apnea risk factors. Children with enlarged adenoids and tonsils can also present with sleep apneas as well as worsening of hyperactivity, agitation, irritability, and in some situations contribute to increased self-injury and aggression.

BENCHMARK 1B Cultural Considerations

Culture is a pattern of ideas, customs, and behaviors shared by a particular people or society. The candidate recognizes the influence of culture on mental and physical health. Both health professionals and patients are influenced by their respective cultures. Culture and bias can affect perceptions of health, illness and death, beliefs about causes of disease, approaches to health promotion, how illness, pain and emotions are experienced and expressed, where patients seek help, and the types of treatment patients prefer. Cultural bias may result in very different health-related preferences and perceptions.

Cultural competence is the awareness of how issues of culture may be relevant and the ability to negotiate such differences. This perspective allows care providers to ask about various beliefs or sources of care specifically and to incorporate new awareness into diagnosis and treatment planning. The candidate uses this understanding not only when assessing the concern but also in identifying the treatment and determining how this information is communicated to the person in a way that promotes best possible outcomes.

The candidate is not expected to make diagnoses, but to have an elevated index of professional suspicion for various diagnostic possibilities. These observations and hypotheses should be raised with the treatment team to promote appropriate medical assessment.

References:

Bostic, J.Q., & Rho, Y. (2006). Target-Symptom psychopharmacology: Between the forest and the trees, *Child and Adolescent Psychiatric Clinics of North America*, *15*(1), 289-301.

Bregmann, J.D., Zager, D., & Gerdtz, J. (2005). Behavioral interventions. In F. R. Volkmar, R. Paul, A. Klin A, & D.J. Cohen (Eds.), *Handbook of autism and pervasive developmental disorders* (pp. 897-924). Hoboken: John Wiley and Sons.

Foxx, R.M. (2008). Applied behavioral analysis: State of the art, *Child and Adolescent Clinics of North America*, *17*(4), 821-834.

Harris, J.C. (2006). I*ntellectual disability: Understanding its development, causes, classifications, evaluation and treatment*. New York: Oxford University Press

Juckett, G. (2005). Cross cultural medicine. *American Family Physician*, *72*(11), 2267-74.

King, B.H., & Bostic, J.Q. (2006). An update on pharmacological treatments for autism spectrum disorders*. Child and Adolescent Psychiatric Clinics of North America*, *15*(1), 161-76.

Kodjo, C. (2009) Cultural competence in clinician communication. *Paediatric Review*, *30*(2), 57-64.

Mayhew, M. (2018) *How culture influences health, caring for kids new to Canada*. The Canadian Paediatric Society, https://www.kidsnewtocanada.ca/culture/influence

McDougle, C.J., & Pose,y D.J. (2003). Autistic and other pervasive developmental disorders. In A. Martin, L. Scahill, D.S. Charney, J.S. Leckman (Eds.), *Pediatric psychopharmacology: Principles and practice* (pp. 563-579). New York: Oxford University Press.

Parikh, M.S., Kolevzon, A., & Hollander, E. (2008). Psychopharmacology of aggression in children and adolescents with autism: A critical review of efficacy and tolerability. *Journal of Child andAdolescent Psychopharmacol*ogy*,* 18(2), 157–78.

Reiss, S, & Aman, M. (Eds.), (1998). *Psychotropic medications and developmental disabilities: The international consensus handbook*.

Silva, A.J., & Ehninger, D. (2009). Adult reversal of cognitive phenotypes in neurodevelopmental disorders. *Journal of Neurodevelopmental Disorders*, *1*(2), 150-157. Published online 2009 June 17.

Tsiouris, J.A. (2010). Pharmacotherapy for aggressive behavior in persons with intellectual disabilities: Treatment or mistreatment. *Journal of Intellectual Disability Research, 54*(1), 1-16.