

Service, Support and Success

The Direct Support Workers Newsletter

Getting Psyched!

Psychiatric Consultation in Dual Diagnosis:
What Should Direct Support Workers Know?



By: Andy Wilson

Several years ago, I was working at an agency where I had consulted for several years. One of my appointments that day was with a woman who had extremely limited communication skills. I had not seen her in almost two years. The support staff member who accompanied her had only known this woman for just over a week. Not surprisingly, he was virtually unfamiliar with her - did not know why she was back to see me and had no knowledge of her course over the previous 1 ½ years. The combination of her severely impaired language and his lack of knowledge of her made it impossible to provide a useful opinion and the review had to be rebooked for the next available appointment - in several months.

This woman's needs were not served; with some forethought on the part of her direct support staff, the problem could have been prevented. Admittedly this is an extreme situation, but unfortunately it is not uncommon for support staff to arrive inadequately prepared for psychiatric consultations and reviews. Key roles for direct support workers are the provision of information which those they support cannot provide about themselves and advocacy for those they support.

Imagine if you were to go to your physician, unable to speak or write, accompanied by someone who knew little about why you were going to the doctor or how you were feeling. Would you expect useful interventions from your physician?

I realize that those of us who support people with developmental are sensitive to language. As a psychiatrist, I refer to all of the people I see in a professional capacity as patients which is the term I will use throughout this article.

What is the psychiatrist's role?

The psychiatrist's primary responsibility is to identify whether or not a psychiatric disorder is present and if so to recommend treatment. Unless presence of a psychiatric disorder can be established, what a psychiatrist can offer is limited. In physical medicine, diagnosis is determined through a combination of information provided by the patient (the history), findings from the doctor's examination (the physical), and results of investigations (blood tests, CT scans etc.). In psychiatry there are very few helpful investigations, so psychiatric diagnosis is established by what information the psychiatrist receives from the patient and/or others, and by what the psychiatrist observes during the consultation.

Psychiatric disorders all have a number of defining symptoms or criteria required for a diagnosis and the pattern of these symptoms over time is also important. Persons who have an intellectual disability may struggle with the often abstract nature of these symptoms, and may have poor time concepts as well. As a result, the psychiatrist must often rely heavily on what direct support workers have observed over time regarding the person they are supporting. Vague or inaccurate information is of little value – “Garbage In = Garbage Out.”

Psychiatric referrals may come about because of the presence of “challenging behaviour.” Direct support workers often come to the consultation with the expectation that the psychiatrist will provide medication to control this behaviour. It is important to be aware that challenging behaviour is *not* a psychiatric disorder, nor does psychiatric medication treat challenging behaviour. Psychiatric medication is of no value in treating self-injurious behaviour that results from unrecognized severe constipation, bladder infections, or side effects to other medication. Medication will be of no value if the challenging behaviour is related to frustration over communication deficits or when a person has learned that aggressive behaviour allows avoidance of stressful situations. The multiple factors contributing to challenging behaviour must be identified, and treatment directed at these causes.

Amongst the general population, there continues to be a mystique about psychiatry and what happens in a psychiatrist’s office. Because direct support staff may have limited awareness of what happens during the consultation, they may attend without necessary information. The remainder of this article will address how direct support staff can prepare both themselves and their clients for the consultation, and on information the psychiatrist will need to know.

What is the direct support worker’s role?

In the absence of an emergency, there is usually a significant waiting period from the time the consultation is booked to the time of the actual appointment. The good news is that this should provide ample time to be ready for the consultation when it does occur.

Direct support staff should give thought to who should attend the consultation with the person who has been referred. If there is a Substitute Decision Maker (SDM), it is probably wise for the SDM to attend if possible, as this person’s consent will be needed for any treatment and the SDM may have questions for the psychiatrist. At the very least, staff should ensure that the SDM knows of the consultation, and pass along the SDM’s questions or concerns to the psychiatrist.

Ensure that staff schedules allow for attendance at the consultation of the most appropriate support staff. Direct support workers who attend should have a good rapport with the person they are accompanying and need to be knowledgeable about the nature of the problems for which consultation is being sought.

Give some thought to what you, as a direct support staff / advocate, or you as a representative of your agency are hoping the psychiatrist may be able to help with. Try to be specific – not ‘we’d like a medication review,’ but why a med review is being requested at this time. Advise the psychiatrist if a particular psychiatric disorder is suspected. If there has been a change in the person’s overall functioning or challenging behaviour is a concern, be prepared to discuss this in some detail with concrete examples.

If the request for consultation originates with your agency rather than the family physician, it is important that the referral be discussed with the family physician. There may be recommendations from the consultation which the family physician will need to implement. A psychiatric report containing recommendations which arrives at the physician's office without awareness that there even was to be a consultation is not the best way to get the family doctor onsite.

Consider what your role as a direct support worker will be for the consultation. Some persons you support may be very capable of providing considerable information to the psychiatrist on their own behalf, while others may need more assistance. Remember, the psychiatrist does not know your client and you may need to advocate as well as presenting your own concerns.

Assist your client to give history to the best of his or her ability, using whatever communication strategies work for him/her. Should their speech be difficult to understand by those unfamiliar with it, you should help out. If you feel your client may not have understood a question from the psychiatrist, you can rephrase the question more concretely.

Preparing your client for the consultation

Give thought to preparation of the person you support for the consultation. How long in advance of the appointment should they know of it? – some may benefit from a long lead time during which they can ask questions and process what will happen. Others may become increasingly anxious, and may do best with less advance notice. Everyone (with rare exceptions) should have some knowledge about where they are going and the reasons for the consultation. To arrive in a strange situation unexpectedly can create significant anxiety.

At a level on par with the person's skills, tell them about the consultation. Talk about how the consultation may help. Empathically explain that the doctor may need to hear about certain problems, even if this might be upsetting – reassure if necessary, that troubling behaviour does not mean the person is bad. This preparation can also be an opportunity to explore how he/she feels about the assessment. I recall one man I saw who, when direct support staff brought up his aggressive behaviour, protested loudly, "I don't do that anymore!!" He had in fact not had any incidents in two weeks which, given his concept of time, meant to him that it was no longer happening.

Direct support staff may feel uncomfortable talking about certain problems in front of their client. This can lead to what I term, 'speaking in code.' In the hope that the client will not understand what is being said, sensitive topics are raised in extremely vague terms. Unfortunately, it is usually the psychiatrist who does not understand the code, while the patient probably understands full well. It may be important to consider in advance whether it would be best if direct support staff and indeed the person him/ herself each had some personal time with the psychiatrist. However, this should be a discussion with your client, not a unilateral decision by direct support staff.

What will the psychiatrist want to know from direct support staff?

If your client has had previous psychiatric assessments or relevant assessments from other professional disciplines, these may be very helpful for the psychiatrist to review. Ask the family doctor to provide these or, if they are in your agency's files, obtain consent for them to be sent to the psychiatrist.

It is essential to bring an accurate and up to date list of the all person's current medication, with dose, and time of administration. Far too often this crucial information does not arrive for the consultation. It is extremely helpful to the psychiatrist if a list of previous psychiatric medications is also provided if these are known. This can reduce the chances of a previously unhelpful or poorly tolerated medication being prescribed again.

On the Surrey Place Centre's website there are a number of very helpful forms which direct support staff can use to provide both family doctors and psychiatrists with a wealth of information. I would highly recommend that support staff review these forms and utilize them:

<http://www.surreyplace.on.ca/Primary-Care/Pages/Tools-for-care-givers.aspx>

It will be important for the psychiatrist to have a good sense of what the person you support is like at his/her "baseline." This is crucial in order to appreciate changes which may have occurred. What is "baseline?" It is a description of what the person is like during their usual state. My baseline is not when I have the flu, or after there has been a death in my family, but when I am feeling reasonably content, without excessive external stressors. The same principle applies to those who you support.

If challenging behaviour is present, a detailed description is important– what would the psychiatrist have seen if present?

- Is it a new behaviour? How long has it been present (weeks, months, years?) Has it worsened? How often does it occur? How long does it last? What factors seem to bring it on? When is it least likely to occur?

When providing information to the psychiatrist, describe what you see, not the conclusion you have reached about what you see. The psychiatrist's job is to decide what the behaviour represents. For example:

- don't say your client is anxious (people use 'anxious' to mean anything from worry to fear to anger to physical restlessness) - say:
 - she seems to be always worrying about things going wrong,
 - he is constantly seeking reassurance for minor things,
 - she is reluctant to go into places where there are crowds, etc.
- don't say your client is confused - say:
 - he no longer seems to understand directions that he could before, and give examples,
 - she no longer remembers where to put dirty dishes, etc.
- don't say your client is hallucinating – say:
 - he talks out loud to himself in his room,
 - he says he hears voices in the wall,
 - he says he hears voices ordering him to do things, or swearing at him,
 - he appears to be listening to something and, in response, angrily shakes his fist, etc.

Psychiatric consultation can be a challenge in persons who have an intellectual disability. Reaching an accurate diagnosis requires good information. I hope I have convinced you that direct support workers have a key role to play in this process and your contribution can be crucial to success. If we all work together, the lives of those we support can be substantially improved.

About the Author:

Dr. Andy Wilson graduated from medical school at Queen's University in 1969. He obtained a fellowship in the Royal College of Physicians and Surgeons in 1974. He worked at Oakville Trafalgar Memorial Hospital from 1976 to 1993 as a psychiatric staff member and was the head of the Department of Psychiatry for 6 years. Dr. Wilson has worked in the field of Dual Diagnosis for 25 years as he began providing psychiatric consultation to Huronia Regional Centre in 1989. He has provided specialized psychiatric consultation to community-based adults with both a developmental disability and psychiatric disorder for a variety of community and health agencies throughout Central / Northern Ontario. Dr. Wilson has been the Psychiatric Consultant to the North Community Network of Specialized Care since its inception and, in this role, has delivered a number of educational sessions on a variety of topics in person and by VC. He has a recent appointment to the faculty of the Northern Ontario School of Medicine.

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