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TREATMENT OF MENTAL ILLNESS CO-OCCURRING
WITH INTELLECTUAL DISABILITIES

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Natalie Nevarez
June 2016

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ABSTRACT

Past literature has showed that there have been several misdiagnoses of mental illness due to clients' delays in speech or introspection caused by an intellectual disability. It is believed that the intellectual disability is either interfering with the proper mental health diagnosis or a mental health diagnosis is unnecessarily being added to an intellectual disability. The study used a qualitative design that asked four psychiatrists how they are treating their clients with an intellectual disability in addition to their mental illness. The interview guide asks about the difficulty in diagnosing individuals with a mental illness and a co-occurring intellectual disability. The proportion of clients also having an intellectual disability and co-occurring mental illness ranged from 5 to 20%. The problems that psychiatrists are running into are the fact that patients are not being correctly diagnosed before the age of 18 and not able to get the resources that are needed, such as through Inland Regional Center.

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DEDICATION

I dedicate this work to the people that have had to struggle the most while I was in school, my daughters: Jocelyn Berlynn Nevarez and Madison Sloane Nevarez. My mother, Maria Ofelia Medina, who has supported me mentally and helped be a second mother to my children.

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CHAPTER ONE

INTRODUCTION

As the mental health field is growing, we as a society and as mental health providers are becoming more aware of the complexities of dealing with mental health individuals and families suffering from mental illness. It has become more and more apparent that unsuspected underlying mental illness such as intellectual disabilities (i.e., Autism Spectrum Disorder, Asperger's, Mild Mental Retardation, etc.) is often overshadowed by Axis I diagnosis (According to the DSM-IV TR). This has unfortunately has led to incorrect primary diagnosis by mental health providers which has subsequently led to improper treatment emphasis.

Research has shown that the intellectual disability often interferes with the proper mental health diagnosis or a mental health diagnosis is unnecessarily being added to an intellectual disability. While discussing this topic with a psychiatrist, he expressed to me that in his experience he has noticed that when a child with Autism is not properly and promptly diagnosed with Autism Spectrum Disorder before the age of 18, that they are much more likely to be misdiagnosed with Schizophrenia or another Axis I mental illness as an adult. A qualitative study needs to be done to see what treatments are currently being used in order to better assist the clients with this dual diagnosis. Currently, Autism Spectrum Disorder cannot be diagnosed after

the age of 18 and many people are falling through the cracks and not obtaining the proper resources needed. Some children are not being diagnosed at a young age because of stigma and parents refuse to accept that their children are having issues. When the issue becomes out of control it will be too late for these people to be diagnosed. The diagnosis is necessary in order to obtain benefits, resources and to properly treat.

Problem Statement

Currently DSM-IV TR does not allow mental health providers to apply certain diagnosis such as Autism Spectrum Disorder after the age of 18 if there is not substantial pre-existing documentation suggesting intellectual disability or delay. This in itself is very limiting and can have lifelong effects on the individuals and families. This issue needs to be addressed because research and clinical data shows that there is a high rate of misdiagnosis in mental illness due to the interference of the intellectual delay. Research in this area is much needed and extremely lacking, increasing the difficulty in treating children and adults with a psychiatric disorder along with an Autism Spectrum Disorder (ASD) diagnosis and other intellectual disabilities. Thus, further research must be done in the matter.

People that are receiving or not receiving services will be impacted and so will the mental health system in the way that they provide services. There

might be resistance from agencies because they do not like to see that there are any deficiencies in their agencies.

It is believed that mental illness is not addressed in treatment among individuals with intellectual disabilities and so the question is... How is mental illness addressed among individuals with intellectual disability?

Purpose of the Study

The purpose of the study is to examine Psychiatrists' views on diagnosing clients with a co-occurring mental illness and an intellectual disability. An incorrect diagnosis or a late diagnosis can lead to lack of resources and lack of correct treatment at a crucial time of a person's life, which will be accentuated and examined in this study.

The sample of this study will be psychiatrists who treat adults ranging from 18 years of age to 59 years of age. Men and women will have to be included and hopefully a variety of cultures. The sample will be drawn from Riverside University Health Systems, Behavioral Health.

The four mental illnesses that will be looked at will be schizophrenia disorder, schizoaffective disorder, bipolar disorder and depressive disorders. The types of intellectual disabilities that will be looked at will be autism spectrum disorder and mental retardation (intellectual disabilities). Since the county has not transferred to the DSM V, the study will be using the DSM IV-TR to use as criteria for the diagnosis.

This study is qualitative research study. The quality of services is being looked at to see where services can be improved. There is a lack of treatment targeting both illnesses. Riverside University Health Systems, Behavioral Health focuses on mental illness and the Inland Regional Center focuses on only the intellectual disabilities. Both agencies are currently not working together. This study is being conducted to see how these two agencies can either work together or if a new agency has to be developed.

Significance of the Project for Social Work

Research in this area is very important due to the lack of resources that clients with an intellectual disability and mental illness have. There are misdiagnoses; therefore, inability to properly diagnose and treat. Studies have shown that psychiatrists only treat the negative behaviors such as aggression because most of the time they cannot get to the underlying issue. The lack of communication from the client to the psychiatrist makes it very difficult to properly diagnose. The similarities between autism and childhood schizophrenia have also led to misdiagnoses.

Finally, the results and findings of this study could potentially lead to changes in policy and practice in the mental health field for Riverside County. By bringing attention to this it increases the awareness of difficulty in diagnosing and make some organizational changes. Require more training in co-occurring mental illness and intellectual disabilities. Since, client's with an intellectual disability are not able to get the resources that they need if

diagnosed after the age of 18 then maybe an expansion to that age limit can assist these clients to obtain resources such as Inland Regional Center.

Summary

Research has shown that an intellectual disability often interferes with a proper mental health diagnosis or a mental health diagnosis is unnecessarily being added to an intellectual disability. Research in this area is very important due to the lack of resources that clients with an intellectual disability and mental illness have. Finally, the results and findings of this study could potentially lead to changes in policy and practice in the mental health field for Riverside County, now known as Riverside University Health Systems, Behavioral Health.

CHAPTER TWO

LITERATURE REVIEW

Introduction

There is little research on how clients with a mental illness and intellectual disability are treated. There is literature on the extensive misdiagnosis in mental illness due to an intellectual disability. Due to the misdiagnosis in co-occurring mental illness and intellectual disabilities, this population is not being properly treated and is not getting the proper care and resources that they need.

Misdiagnosing

Past literature has showed that there have been several misdiagnosis of mental illness due to client's delays in speech or introspection caused by an intellectual disability. Research was conducted by Swenson (2012) on the inaccurate psychiatric diagnosis when paired with adolescents that already have a diagnosis of autism. They studied several high functioning Caucasian adolescents and looked at several different psychiatric diagnoses. It was hypothesized that there would be a misdiagnosis of the mental illness or a comorbidity of psychiatric diagnosis because of the interference of the ASD diagnosis and the difficulty of interviewing this population. Results showed that prior diagnosis by parents did not correlate with ACI results. Also, ACI was

showing that most children had some type of depression disorder that that parents had not previously seen. There was a poor correlation between ACI and prior diagnoses. It is in according to the hypothesis that “the psychiatric diagnoses they received were mislabeling of ASD-related concerns” (p. 521).

Psychotropic medications are being used on people with autism and it is believed to not be working properly because the brain works different for someone with autism. Some research was conducted on how psychiatrists used psychotropic medications. In the study by Tsiouris (2013):

[R]esults indicated that the major psychiatric disorders, except anxiety disorder and autism, influenced the use of psychotropics and the number of medication used. These findings imply that although practitioners still rely too heavily on the use of antipsychotics in this population, there is a welcome shift in the prescription patterns relative to other studies. The practitioners appeared to use psychotropics primarily to treat diagnosed psychiatric disorders and not just to control aggressive behavior, which suggests that evidence-based practice of psychiatry is playing an increasing role in the ID population. (p. 719)

If a misdiagnosis occurs then the care and measure being taken is not accurate such as incorrect medications. They are just treating the behavior and not the underlying problem.

Similarities in Diagnosis

Several mental health diagnoses can look very similar to several different kinds of intellectual disabilities. One study shows that schizophrenia can look very similar to childhood schizophrenia. Hommer and Swedo (2015) suggest that “[g]iven the share clinical manifestations of SCZ and ASD, it is not surprising that the 2 disorders co-occur frequently” (p.1). In this editorial they talk about how ASD (Autism Spectrum Disorder) and SCZ (schizophrenia) have a “risk gene” and derive from similarities. The diagnosis is almost identical besides except that childhood schizophrenia has psychotic features.

According to Mazefsky et al., (2012) some children with autism spectrum disorders can have behavioral and emotional dysregulation and because of those dysregulation, it can be difficult to diagnose the child with autism spectrum disorder and because of it will get the incorrect treatment.

Treating the Behavior

When there is a co-occurring mental illness and intellectual disability, mental health professionals only are expected to treat the aggressive behavior through medication. They are brought to psychiatrists when attempts at treating behaviors are not successful and medication is the last resort. “Aggressive behavior represents a frequent symptom in people with intellectual disabilities (PWID).

Despite uncertain evidence of effectiveness, the use of antipsychotics (Aps) drugs to treat aggressive behavior is very common” (Amore et al., 2010, p. 210).

Theories

This research emphasized on how cognitive behavioral therapy intervention is used with the intellectually disabled population and how they adapt in social settings.

Current evidence concerning the use and effectiveness of psychosocial interventions for people with intellectual disabilities and mental health problems is then outlined. Particular attention is paid to cognitive-behavioral interventions. Finally, issues concerned with adapting psychosocial interventions for people with intellectual disabilities and mental health problems are discussed, focusing on issues of informed consent and assessment of suitability for CBT. (Hatton, 2002, p. 357).

CBT is the intervention being used to assist with outbursts and aggression but when there is a dual-diagnosis, they are treated with medication.

The psychiatrists at Riverside University Health Systems, Behavioral Health use the biopsychosocial theory to obtain their psychiatric assessments and diagnose a patient. They look at the client’s history and family history to see if there are any genetics involved. They also look at the social environment to see if there is anything in their social life that could have

encouraged the behavioral issues that they are now experiencing. They also look at health and trauma. The patient is looked to as a whole to assist with the psychiatric assessment and diagnosis.

Summary

There is vast literature about how several different mental illnesses co-occur with different types of intellectual disabilities but little research on how it is being treated at its core. Several psychiatrists have turned to just treating the behavior such as aggression but cannot communicate with the client to get to the root of the issue. Many psychiatrists are not well trained in this area and intellectual disabilities co-occur so often.

CHAPTER THREE

METHODS

Introduction

This study was a qualitative study on how psychiatrists in the mental health system are addressing individuals with a dual diagnosis of a mental illness and intellectual disability in order to create new programs to better assist this population. The study took place in Riverside University Health Systems, Department of Behavioral Health through an interview guide which was given to four psychiatrists in one of the clinics.

Study Design

The study used a qualitative design that asked four psychiatrists on how they are treating their clients with an intellectual disability in addition to their mental illness. The interview guide asks about the difficulty in diagnosing individuals with a mental illness and a co-occurring intellectual disability. In addition to the difficulty in diagnosing, the psychiatrists were asked what types of problems are psychiatrists running into when diagnosing individuals who have mental health issues and a dual diagnosis with an intellectual disability. They were also asked what types of problems could occur if an individual with co-occurring intellectual disability does not receive the correct diagnosis and

What are the most common misdiagnoses that occur with an individual with intellectual disability.

Sampling

The population that will be sampled was four psychiatrists at Riverside University Health Systems. Three of the participants were psychiatrists and one was a psychiatric physicians assistant. Two of the participants were Hispanic, one was mixed and one was Indian. Age range was from 30 years of age to 56 years of age. Initially, at least ten psychiatrists from the adult clinics and ten psychiatrists from the children's clinic were supposed to be interviewed in order to compare and contrast the difficulties that they are having diagnosing an individual with a co-occurring mental illness and intellectual disability. Only four interviews could be conducted due to time constrains and availability of the psychiatrists.

Data Collection and Instruments

An interview guide and a demographics questionnaire were used (see Appendix A and Appendix B). The interview guide consists of 10 questions on the difficulty with diagnosis with individuals who have a mental illness with a co-occurring intellectual disability.

The interview guide asked the psychiatrists what type of population they served and how many of their client's had a co-occurring mental illness and intellectual disability. It also asked what types of problems are psychiatrists running into when diagnosing individuals who have mental health issues and a dual diagnosis with an intellectual disability. Because previous research suggests that there is a misdiagnosis with this population, the psychiatrists were asked types of problems could occur if an individual with co-occurring intellectual disability does not receive the correct diagnosis. They were asked specifically what are the most common misdiagnoses that occur with an individual with intellectual disability and what types of problems can result from failure to diagnose intellectual disability in an individual before the age of 18. Lastly we looked at a diagnosis of intellectual disability interfering with recognition and diagnosis of other forms of mental illness.

Procedures

The four psychiatrists were asked to sign the release and audio release. The psychiatrists were asked to fill out the demographics questionnaire and then were asked to complete the interview. The psychiatrists were given the written questions to go over before the interview. The interview took place at a mental health clinic in the office of the psychiatrists. They were emailed the interview guide and asked to call the researcher when they had a cancellation and had the opportunity to do the

interview. All the interviews took from 15 to 20 minutes to record. The interviews were recorded and were later transcribed.

Protection of Human Subjects

Individuals were looked at indirectly and their names will remain anonymous. No intensifying information was taken. Only information that was taken was that of the psychiatrists. Researcher took every measure to keep privacy of interviewees. All written documents were kept in a locked drawer and all recordings and transcriptions were kept in a secure file in a computer that was protected with passcodes.

Data Analysis

The data was collected through qualitative study. The questions were compared through four different psychiatrists in a Riverside county clinic. To start, an audiotaped raw data from face-to-face interviews and then it be transcribed verbatim and a coding scheme will be developed. As a part of this qualitative study, similarities and differences were identified and recorded. Categories and relationships between major themes of mental illness and intellectual disabilities were looked at and any patterns that emerge from the data set. Resources that are lacking will be looked at and explored. In addition, demographics were taken down to look at to look at limitations that can be considered.

Summary

Through a qualitative study, difficulty in diagnosing mental health clients with an intellectual disability were looked at through their psychiatrist to better assist future treatment and if their needs are being met. It is believed that intellectual disabilities are not being properly addressed among individuals with mental illnesses due to difficulty in diagnosis.

CHAPTER FOUR

RESULTS

Introduction

In this chapter the results of the interviews will be covered. What similarities were found and what the main differences were. Four psychiatrists from Riverside University Health Systems, Behavioral Health adult clinic were interviewed. Their demographics were taken and they were all given the same interview guide.

Presentation of the Findings

Four psychiatrists in Riverside University Health Systems, Behavioral Health were interviewed. Two of the psychiatrists are Hispanic, one is Indian (Asia), and the last was mixed African American and Hispanic. The ages ranged from 30 to 57 years old. All four of them were males and all four them hold a position in a Mental Health clinic as a full time staff psychiatrist. The years of experience ranged from 5 to 21 years working with this population.

All four of the psychiatrists were given an informed consent (See Appendix C), a demographics questionnaire (See Appendix A) and an interview guide (See Appendix B). All of the interview guides were recorded and transcribed. Similarities among he answers and differences were looked at while looking at the findings.

When participants were asked what population they serve, all of the psychiatrists answered similarly stating that they served the underserved mentally ill population of Riverside County. Participants asked how many clients they served have a mental illness and they unanimously stated that 100% of their clients have a mental illness because it is a requirement to have a mental illness in order to see them. The proportion of clients also having an intellectual disability ranged from 5 to 20%.

The psychiatrists are running into several problems when diagnosing individuals who have mental health issues and a dual diagnosis with an intellectual disability. Participant 1 stated, "The ability to communicate to the patient and patient understanding of mental health problem. Also, the patient's ability to interpret their challenge in treatment" (Participant 1, January 2016).

Participant 2 stated:

The main problem is that they can't be primarily diagnosed with a primary psychiatric illness because there is a lot of overlap and unclear history because a lot of people with intellectual disabilities tend to report certain symptoms like hearing voices or seeing things that is very common in that population. It seems to fit certain diagnosis but not be the case so becomes an unclear diagnosis (Participant 2, January 2016).

In regards to running into new problems Participant 3 stated:

First would probably say undiagnosed and not previously treated intellectual disability patients that are over 18 are the population that I see. But a lot of them have never been diagnosis their entire life but have an obvious intellectual delay. One more problem that we run into would be time constraints without enough time to be able to spend with each of the diagnosis to make sure that the patients and the family members understand the nature of the illness and the treatment plan (Participant 3, January 2016).

Participant 4 stated:

The main problem is that most of our patients don't have the childhood study and very few of them of the 15% were seen as kids and they come to us without a formal diagnosis. And now as an adult it's harder to make that diagnosis so they can get proper resources (Participant 4, January 2016).

The psychiatrists were asked what types of problems could occur if an individual with co-occurring intellectual disability does not receive the correct diagnosis. Participant 1 stated, "Over medication, polypharmacy, poor compliance, and non compliance. Side effects that are not addressed" (Participant 1, January 2016). Participant 2 stated, "Incorrect treatment. One for the other. Intellectual disability not caught on then we don't get to offer services, IHSS, vocational and if miss mental health then they suffer from

depression and psychosis with further decompensating” (Participant 2, January 2016). Participant 3 stated:

The patient’s needs would not be met. Mainly as far as resources that can be potentially be offered to the patient and also the family would not be as involved and be able to assure that the patient is understanding the treatment plan and assisting the patient in caring out the treatment plan and desired goals for the patient (Participant 3, January 2016).

Participant 4 stated, “A misdiagnosis in mental health and most importantly not being able to access resources” (Participant 4, January 2016).

When asked what the most common misdiagnoses that occur with an individual with intellectual disability, that is where I saw some similarities. Three of the psychiatrists stated that a possible misdiagnosis could be bipolar disorder. Two psychiatrists stated two other misdiagnosis could be schizophrenia or schizoaffective. The last two psychiatrists stated it could be intermittent explosive disorder.

The psychiatrists were asked what types of problems can result from failure to diagnose intellectual disability in an individual before the age of 18 and most of the psychiatrists stated that they main concern is lack of resources. Participant 1 stated:

If not properly diagnosed these patients will not get access to the health system that they need. Not be able to have a meaningful job or quality of life. Mislabeled from diagnosis point of view. Over diagnosis

or over medicated. May face frustration when unable to deal with stresses and can be diagnosed of bipolar and schizophrenia. May use substance to correct their emotional need (Participant 1, January 2016).

Participant 2 stated, "The inability to access services because usually because most children with diagnosis can be carried as an adult and if diagnosed as adult it is difficult to obtain Inland Regional Center if even able to obtain"

(Participant 2, January 2016). Participant 3 stated:

If you don't diagnose them in due time preferably well before teenage years then they are not going to get the resources they need and they are not going to be able to develop intellectually or socially as they would if they had the proper resources along with the understanding of nature of the illness by family (Participant 3, January 2016).

Participant 4 stated:

When they turn 18 they have to transfer to the adult services and they lose any chances they had of receiving services from IRC and the appropriate continuation of supportive services and then they come to the mental health side and fall through cracks (Participant 4, January 2016).

There were several different answers to why some of the individuals with co-occurring intellectual disability do not get correctly diagnosed.

Participant 1 stated:

Some of them are due to the system and the way it is designed in our society. Lack on integration in care and lack of coordinating care.

Family may have also their own limitation especially if they have own their own problems. Especially if they have co-occurring with intellectual in the family (Participant 1, January 2016).

Participant 2 stated:

They are themselves are poor historians. Interpret the world much more different then we do. The diagnosis criteria is made for people with average intelligence so when you get into the intellectual disability, their terminology and how they interpret the world is different so it becomes a huge hurdle (Participant 2, January 2016).

Participant 3 stated:

Limited time that providers given with the patient. Parents are not as involved as they could be or should be because of own illness or lives are too busy. Mental illness as seen as hereditary illness so its very possible parents or guardians or grandparents, family member who also have mental illness would not have the insight or patience or time to spend with the children to find out or be able to recognized the need for screening (Participant 3, January 2016).

Participant 4 stated:

Families may not understand that they have access to other services. Schools may not identify them early on. Sometimes families are

ashamed of having to access these services. Sometimes they are defined as something else such as defiant disorder and they are labeled as that kid that gets in trouble instead of getting the necessary services (Participant 4, January 2016).

There were a few similarities when the psychiatrists were asked what diagnosis has been used when intellectual disability has been missed. Three psychiatrists stated bipolar. Two stated it could be a personality disorder and two stated it could be Attention Deficit Hyper Disorder (ADHD). Two other psychiatrists stated that forms of psychosis have been diagnosis, such as schizophrenia, schizoaffective or schizoid personality.

They were lastly asked if a diagnosis of intellectual disability interfering with recognition and diagnosis of other forms of mental illness and three out of four psychiatrists it does not. The psychiatrist that stated it does stated:

In a way yes. I don't think we know enough at an early age to separate these. There are needs to be more attention and more services. A lot of times they are misdiagnosed and place in different treatment and set up in different type of treatment. Sometimes these kids get involved in drugs and clouds that clouds things even more. If they were going to have a diagnosis of behavioral or oppositional defiant disorder plus using substance that solidifies that it is a problem child (Participant 3, January 2016).

Summary

Through the interview guide we were able to find a few similarities and differences when looking into diagnosing individuals with mental illnesses and a co-occurring intellectual disability. All the psychiatrists work with clients who have a mental health issue and the chances of their patients having a co-occurring intellectual disability ranges from 5% to 20%. The problems that psychiatrists are running into are the fact that patients are not being correctly diagnosed before the age of 18 and are not able to get the resources that are needed, such as Inland Regional services.

CHAPTER FIVE

DISCUSSION

Introduction

In this chapter we will cover the interpretation of the results. Some similarities were consistent with some research that has been previously conducted and there were a few differences. Similarities that were found were misdiagnosing an intellectual disability with conduct disorder, mood disorders or a psychotic mental illness such as schizophrenia or schizoaffective disorder. There is a difficulty with communication and getting accurate accounts of history that it makes it difficult for psychiatrist to diagnose their patients. Research was consistent with findings and trainings and education in the social work field have to be increased.

Discussion

The quality of services is being looked at to see whether they can be improved. There is a lack of treatment targeting both illnesses. Riverside University Health Systems, Behavioral Health focuses on mental illness and the Inland Regional Center focuses on only the developmental delays. Both agencies are currently not working together. In order to get the proper treatment, an individual has been diagnosed with the proper diagnosis at an early age in order to get the proper treatment. When someone with a mental

illness and co-occurring intellectual disability, it is believed that misdiagnosis can occur according to previous research. One diagnosis can interfere with the second diagnosis or vice versa.

The study used an interview guide that asked four psychiatrists on how they are treating their clients with an intellectual disability in addition to their mental illness. The participants were asked about the difficulty in diagnosing individuals with a mental illness and a co-occurring intellectual disability. In addition to the difficulty in diagnosing, the psychiatrists were asked what types of problems psychiatrists are running into when diagnosing individuals who have mental health issues and a dual diagnosis with an intellectual disability. They were also asked what types of problems could occur if an individual with co-occurring intellectual disability does not receive the correct diagnosis and What are the most common misdiagnoses that occur with an individual with intellectual disability.

There were several similarities that were found when looking at difficulties that the psychiatrists were running into. All four of the psychiatrists stated that 100% of their patients have a mental illness. It appears that the range of co-occurring mental illness and intellectual disability ranges from 5%-20%. It does coincide with what Thomas and Bright (2001) estimated. They estimated that the comorbidity among adults is 10% to 39%. This is lower than what it is estimated according to Szymanknsi and King (1999) the co-occurring of mental illness and mental retardation (now known as intellectual disability)

would be from 30% to 70%. In order to be seen in a Riverside County Mental Health clinic, the main diagnosis must be a mental health issue and not an intellectual disability.

There were a few similarities when the psychiatrists were asked what diagnosis has been used when intellectual disability has been missed. The misdiagnosis can be bipolar, personality disorder or Attention Deficit Hyper Disorder (ADHD). Two other psychiatrists stated that forms of psychosis have been diagnosis, such as schizophrenia, schizoaffective or schizoid personality. The psychiatrists mostly do not believe that the diagnosis of intellectual disability interfering with recognition and diagnosis of other forms of mental illness.

According to Szymanski and Bryan (1999) “ The poorer the communication skills, the more one has to depend on information provided by caregivers familiar with the patient and on direct behavioral observations” (p. 6S). This is similar to what the psychiatrist observation was and the difficulties that they are coming across with.

Some participants also stated that some intellectual disabilities can be labeled as conduct disorder or mood disorders which is similar to previous studies. Masefsky et al. (2012) that 30% of kids that have been diagnosed with conduct disorder can also fall in the autism spectrum disorder. They also stated that most children with autism spectrum disorders have been diagnosed with a form of mood disorder or behavioral disorder.

Limitations

There were several limitations in this research. The sample that was taken was very small. Four psychiatrists were interviewed and all four psychiatrists were from the same clinic and they were adult psychiatrists and from the same background and demographics. They also gave me estimates of the clients they are seeing because they have several hundred patients that it would take them days to look at how many clients they actually have with a dual diagnosis. Information given to the researcher is far from accurate and limits the validity of findings. This small sample size will reduce the validity and generalizability of the findings.

The majority of the sample was Hispanic, which is not generalizable with the psychiatrists treating the co-occurring mental health clients with an intellectual disability. The clinic that the interviews were conducted is the only clinic with Spanish bilingual psychiatrists in Riverside University Health Systems, Behavioral Health.

Originally, at least ten psychiatrists from the adult clinics and ten psychiatrists from the children's clinic were supposed to be interviewed in order to compare and contrast the difficulties that they are having diagnosing an individual with a co-occurring mental illness and intellectual disability. Only four interviews could be conducted due to time constraints and availability of the psychiatrists. Psychiatrists at Riverside University Health Systems,

Behavioral Health only have half an hour to see and document each patient. For every new patient, they get ninety minutes to review chart, complete psychiatric assessment, and document and medicate. To find time to interview with these psychiatrists who already have time constraints due them serving the underserved was very difficult.

Recommendations for Social Work Practice, Policy and Research

Further research should look at several different clinics and a larger amount of psychiatrists. Child psychiatrists should be interviewed since they are the ones that usually diagnose the intellectual disability or are missing one of the diagnoses. The adult psychiatrists are stating that by the time they come to the adult clinic, it may be too late to diagnose an intellectual disability because certain diagnosis have to be diagnosis before the age of 18 in order to obtain resources through Inland Regional Center.

Inland Regional Center does not have a psychiatrists and Mental Health does not have the resources for the intellectually disabled. There should be a psychiatrist on staff with Inland Regional or there can be trainings for psychiatrists in the county for dealing with individuals with intellectual disabilities.

Social workers should get further training in co-occurring mental illness and intellectual disabilities and train mental health providers. At a macro level,

social workers should but for dual treatment where social workers trained in intellectual disabilities and mental health can assist psychiatrists in treatment. There should be a county program where there are psychiatrists that specialize in this treatment and social workers that are trained into linking to resources that were missed do to late diagnosis or a missed diagnosis.

Conclusions

There is a clear issue with missing diagnosis of an intellectual disability and it being confused with several different mood disorders and mental illnesses. If it found later in a person's life, they can lack resources that they could have received if they were diagnosed at an early age. Early intervention is necessary in order to better help this population. A more broad research should be done and training the mental health workers would be a great way to start.

APPENDIX A
DEMOGRAPHICS

Demographics

1. What is your age?
2. Gender?
3. Please specify ethnicity (race)
4. What is the highest degree or level of school you have completed?
5. What is your current position?
6. How long have you worked with the population you are currently working with?

Developed by Natalie Nevarez

APPENDIX B
INTERVIEW GUIDE

Interview Guide

1. What is your title and what population do you serve?
2. How many clients do you serve that have a mental illness?
3. Of those clients, how many have an intellectual disability?
4. What types of problems are psychiatrists running into when diagnosing individuals who have mental health issues and a dual diagnosis with an intellectual disability?
5. What types of problems could occur if an individual with co-occurring intellectual disability does not receive the correct diagnosis?
6. What is the most common misdiagnosis that occurs with an individual with an intellectual disability?
7. What types of problems can result from failure to diagnose intellectual disability in an individual before the age of 18?
8. What are some of the reasons why individuals with co-occurring intellectual disability do not get correctly diagnosed?
9. What are some other diagnoses that have been used when intellectual disability has been missed?
10. Is a diagnosis of intellectual disability interfering with recognition and diagnosis of other forms of mental illness?

Developed by Natalie Nevarez

APPENDIX C
INFORMED CONSENT



California State University, San Bernardino
Social Work Institutional Review Board Sub-Committee
APPROVED 1/21/2016 VOID AFTER 1/20/2017
IRB# SW21339 CHAIR Janet Chang

College of Social and Behavioral Sciences
School of Social Work

INFORMED CONSENT

The study in which you are asked to participate is designed to conduct research on the difficulties in diagnosing mental health clients with a dual diagnosis in Riverside County. The study is being conducted by MSW graduate student, Natalie Nevarez, under the supervision of Professor Janet Chang, School of Social Work, California State University. The study has been approved by the Institutional Review Board Social Work Sub-committee, California State University, San Bernardino.

PURPOSE: The purpose of the study is to conduct research on the difficulties in diagnosing mental health client with a dual diagnosis of an intellectual disability.

DESCRIPTION: Participants will be asked a few questions on their diagnostics criteria along side with some demographics about themselves. The interview will be audio recorded.

PARTICIPATION: Your participation in this study is totally voluntary. You can refuse to participate in the study or discontinue your participation at any time without any consequences.

ANONYMITY: Your responses will remain anonymous and data will be reported in group form only.

DURATION: It will take 40-60 minutes to complete the interview.

RISKS: There are no foreseeable risks to the participants.

BENEFITS: There will not be any direct benefits to the participants.

CONTACT: If you have any questions about this study, please feel free to contact Dr. Janet Chang at 909-537-5184.

RESULTS: Results of the study can be obtained from the CSUSB Scholar Works database at Cal State University, San Bernardino after July 2016.

This is to certify that I read the above and I am 18 years or older.

_____ Date
Place an X here

By signing this form, I am allowing the researcher to audio record me as part of this research.

_____ Date
Place an X here

909.537.5501 • fax: 909.537.7029 • <http://socialwork.csusb.edu/>
5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393

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Maritime Academy • Monterey Bay • Northridge • Pomona • Sacramento • San Bernardino • San Diego • San Francisco • San Jose • San Luis Obispo • San Marcos • Sonoma • Stanislaus

APPENDIX D
INSTITUTIONAL REVIEW BOARD APPROVAL

CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO
SCHOOL OF SOCIAL WORK
Institutional Review Board Sub-Committee

Researcher(s) Natalie Newman

Proposal Title Treatment of Mental Illness Co-occurring with Intellectual Disabilities

SW1539

Your proposal has been reviewed by the School of Social Work Sub-Committee of the Institutional Review Board. The decisions and advice of those faculty are given below.

Proposal is:

- approved
- to be resubmitted with revisions listed below
- to be forwarded to the campus IRB for review

Revisions that must be made before proposal can be approved:

- faculty signature missing
- missing informed consent debriefing statement
- revisions needed in informed consent debriefing
- data collection instruments missing
- agency approval letter missing
- CITI missing
- revisions in design needed (specified below)

[Signature]
Committee Chair Signature

1/21/2016
Date

Distribution: White-Coordinator; Yellow-Supervisor; Pink-Student

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