Comprehensive Management of the Mentally Retarded/Mentally Ill Individual

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The management of the developmentally disabled population is difficult, and many professionals have devoted time and energy for methods to deal effectively with the individual problems presented by this population. In the person with both mental retardation and mental illness, the presenting clinical problems are more magnified and complicated. Therefore, this “dual diagnosis” population, which has been well addressed in other chapters in this section, tends to fall between the cracks since so few professionals want to deal with them, even in the medical field. These dually diagnosed individuals tend to get shuffled between the mental retardation and the mental health facilities, and few professionals claim acceptance for the full responsibility of their management. The purpose of this chapter is to offer the reader a descriptive analysis of both the diagnosis and management of this subpopulation from a developmental perspective. This approach perhaps differs from the other programs managed by psychiatrists and described throughout this book (e.g., Menolascino in Nebraska, Gualtieri in South Carolina, and Szymanski and Sovner in Boston), not to mention the management of programs by psychologists (such as Gardner and Matson), in that it does not take place in a large research-training-service facility. While such isles of excellence are essential, the less fortunate facilities may be tempted to despair with their own limitations. Hopefully, this brief chapter on how to establish an affordable and available team approach will be encouraging to the practitioner.

The more modern management approaches to the mentally retarded/mentally ill population is a comprehensive view that begins at the time an “at-risk” disorder is recognized. An initial comprehensive evaluation of a child suspected of being at high risk for a developmental disability should be initiated. At minimum, this encompasses a psychosocial assessment, a developmental pediatric examination, a psychological evaluation, and a speech and language (with audiological) evaluation when warranted. Upon gathering clinical evidence that an emotional/behavioral problem might exist, a psychiatric assessment is then required. Often, among our mentally retarded/mentally ill population, one has to distinguish whether the behavioral findings are purely psychiatric in nature or a manifestation of a neurological condition such as seizures or neuromuscular disorders.
As clinicians, we are then obligated to rule out all other possible causes of atypical behaviors other than an emotional one. In the event that the behavioral disorder is emotional in nature, the psychiatric clinician involved needs to work in full cooperation with the other medical specialists and team professionals in the management of the mentally retarded/mentally ill individual. The responsibilities of the clinicians do not cease upon diagnosis but, in fact, just begin. Mental retardation/mental illness is a lifetime condition that can improve or modify under treatment. Educational and vocational needs and community involvement, which are totally dependent on early intervention, have to be planned by an interdisciplinary team, as well as enhanced by the pediatric and psychiatric input and, perhaps, leadership.

Our approach involves assessment in our evaluation clinic where the team members discuss the case and usually arrive at a clinical impression/diagnosis with specific recommendations. Thereafter, the findings and recommendations are discussed with the parents—who are fully advised of their rights to agree or disagree and/or to seek a second opinion if they so desire. Most of the time, the parents agree to the findings and recommendations. The parents are a vital part of the child’s management. Thus, they should be made an integral component in the planning and treatment implementation process of the mentally retarded/mentally ill individual’s destiny.

Education

Preschool

Usually, a preschool program is recommended for early treatment/intervention. In this aspect, the school and the clinical team should be communicating as often as necessary in the management of the child. In our experience, the earlier the proper intervention is instituted, the more chances the mentally retarded/mentally ill individual has in ameliorating, controlling, or redirecting their behaviors. This type of intervention makes the individual's behavior more functional and acceptable to society.

Often, there are very few programs that are geared to deal with the mentally retarded/mentally ill population since insufficient numbers of clinicians and preschool teachers—nationwide—are trained to deal with this special population.

School Age

Children with mental retardation/mental illness benefit greatly from accepting educational systems. The child who has experienced acceptance in a preschool program has a smoother transition to the regular educational system than do other children at risk. Their problems seem to diminish, and the children adjust and perform better than the mentally retarded/mentally ill child who enrolls for the first time at a later age. The younger the mentally retarded/mentally ill child