



## Health Guidelines for Adults with an Intellectual Disability

Permission to print kindly granted by Dr. Lennox of the Special Interest Research Group on Physical Health, the International Association for the Scientific Study of Intellectual Disabilities, and Prof. Bill Fraser, Editor of the Journal of Intellectual Disability Research

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Health targets were developed by individual members of the Special Interest Research Group on Physical Health, on behalf of the International Association for the Scientific Study of Intellectual Disabilities. The targets were presented and discussed at various international meetings and were further refined by experts in each target area and were restyled guidelines. The guidelines identify the health disorders that are most prevalent in people with intellectual disability and make recommendations for their prevention and management. The guidelines have been presented to WHO and it is hoped that international recognition of these frequent conditions will improve the health and healthcare of disabled people. This paper will discuss the development and implications of the guidelines.

### ***Dental health***

While the epidemiology of dental disease in people with an intellectual disability has not been extensively studied, several studies have indicated high rates of dental disease in this population. An Australian study (Scott et al 1998) noted that various types of dental disease, particularly periodontal disease, oral mucosal pathology, and moderate to severe mal-occlusion, were up to seven times as frequent compared to the general population. In a population study of adults with an intellectual disability, Beange et al (1995) found that dental disease was the most frequent health problem, occurring in 86% of subjects.

### ***Recommendations***

- Education and behavioural interventions, which ensure that appropriate dietary habits are established and oral hygiene practices are made a part of the daily life of persons with ID, should be directed toward individuals with ID, and their caregivers, to the maximum extent possible.
- Schedule dental visits for oral examinations and prophylaxis at three-month intervals for those with active disease and those at high risk for oral disease (most ID patients) and every six months for persons judged to be at low risk by the dental care team. This should be part of the overall health maintenance program for persons with ID.
- Preventive therapies such as fluoride or anti-microbial agents should be implemented where indicated.
- Multidisciplinary team approaches incorporating input from medical professionals and mental health providers, as well as dentists and dental hygienists, need to be adopted in many patients to ensure optimal oral health (Santos et al 1999).

### ***Sensory impairment***

Sensory impairments amongst people with an intellectual disability have health, educational and environmental implications. Individuals with such impairments may be relatively more handicapped because of the superposition of age-related losses upon childhood impairments, and the frequent combination with a motor handicap or a dual sensory handicap.

### ***Vision***

High frequencies of ocular disorders have been found in several surveys (Wilson & Haire 1992; Warburg & Rattleff 1992; Warburg 1994; Cathels 1993; McCulloch et al 1996). In a large community survey, Warburg (1994) found that non-correctable visual impairment was present in 10% of adults, at least 7 times higher than in the general population. Adults with Down syndrome aged 30 years and over are at risk for premature age-related cataract (Eissler & Longenecker 1962), increasing refractive errors, and degenerative corneal changes (Völker-Dieben et al 1993).

### ***Recommendations***

For adults with an intellectual disability, routine screening for age-related visual loss at 45 years and every 5 years thereafter has been recommended (Evenhuis & Nagtzaam 1998). If possible this should be done by an ophthalmologist. An extra vision check at age 30 years has been recommended for adults with Down syndrome.

### ***Hearing***

Deafness is common in this population, often unrecognised, and if recognised, poorly managed (Wilson & Haire 1992; Howells 1986). Hearing loss as a result of impacted earwax is a frequent problem in adults with an intellectual disability (Crandell & Roeser 1993). Adults with intellectual disability aged 30 years and over, especially those with Down syndrome, are at risk for early age-related hearing loss (Buchanan 1990; Evenhuis et al 1992).

### ***Recommendations***

Routine screening for age-related hearing loss of all adults at age 45 years and every 5 years thereafter has been recommended (Evenhuis & Nagtzaam 1998). If possible this should be done by an audiologist. Screening of the hearing function of adults with Down syndrome is recommended every 3 years throughout life.

### ***Nutrition***

Nutritional well-being is recognised as an important factor in maximising growth potential, maintaining health, and improving quality of life and longevity. Nutrition related health problems, particularly obesity and chronic constipation, are more common in people with intellectual disabilities than in the general population (Stewart et al 1994). People with severe disabilities and people with cerebral palsy have a high prevalence of dysphagia and gastro-oesophageal reflux disease (Böhmer et al 1996; Waterman et al 1992). This places them in a high-risk group for severe under-nutrition.

Nutrition risk screening has been recommended and implemented in programs for the elderly, for hospitalised patients and for early intervention in children (Campbell & Kelsey 1994; American Dietetic Association 1996). However, it has not been used widely with adults with intellectual disability (Bryan et al 1998).

### ***Recommendations***

Nutrition risk screening provides a systematic approach to improving recognition and management of nutrition problems that should also benefit adults with intellectual disabilities. Screening for nutrition related problems could be performed by anyone working with people with disabilities provided a simplified screening tool is developed. The tool should use indicators of weight and weight change, eating abilities, general appearance and a simple assessment of their food and fluid intake. Some basic knowledge of nutrition and knowledge of and access to a referral system is also required. The criteria for referral should be clear and as specific as possible. Simple and safe nutrition interventions should be applicable with the use of basic nutrition educational materials (Amundson et al 1994; Foltz et al 1993).

Individuals at high risk should be referred for a more systematic assessment of nutritional status by an experienced dietitian. People with persistent underweight or overweight, eating and drinking problems, chronic constipation or specific medical

conditions requiring more complex nutrition interventions (such as Coeliac disease) would be amongst those needing systematic assessment. A dietitian, preferably working with an interdisciplinary health care team, should review the screening form and conduct assessment of nutritional status. To be comprehensive, the process involves using medical, nutritional and medication histories; physical examination and anthropometric measurements; and biochemical data.

### ***Prevent and treat chronic constipation***

Constipation is significantly correlated with immobility, medication such as anticonvulsants, benzodiazepines, H<sub>2</sub>-receptor antagonists or proton pump inhibitors, food refusal, and IQ<35 (Bohmer, 2001). Jancar described death from complications of constipation, with symptoms not always recognised (Jancar, 1994).

***Recommendation:*** There is a need for dietary assessment, as described under nutrition, and pro-active medical treatments.

### ***Epilepsy***

People with an intellectual disability have a significantly increased lifetime risk of developing epilepsy (Corbett 1988). There is an association with higher prevalence of epilepsy and increasing disability. Community data suggest prevalence figures of approximately 22% (Welsh Office 1995). The aetiology of epilepsy is complex reflecting that of the disability itself, though in some cases it would appear that the epilepsy itself causes the intellectual disability (Binnie 1990).

There is good evidence that epilepsy adds both additional morbidity and mortality (Forgren 1996). The morbidity includes the physical trauma of the seizures leading to fracture and soft tissue injury, hospital admission, the impact on learning and development through seizure activity and the complex social impact of seizures (Baxter 1999). Less well defined is the negative impact of anticonvulsant medication on learning and attention. It is also apparent that epilepsy adds to carer strain and burden (Wilson 1998). There is reduced life expectancy for people with an intellectual disability who have epilepsy – though this may be correlated with the degree of disability and thus additional morbidity.

### **Health guidelines should aim to**

- Reduce seizure frequency
- Reduce epilepsy-related falls and fractures
- Reduce epilepsy-related admissions to hospital and emergency rooms
- Reduce atonic seizures
- Reduce side effects consequent to treatment (in particular, cognitive, emotional and behavioural)
- Reduce mortality due to seizures or accident in seizures
- Reduce epilepsy related morbidity in carers.

### ***Recommendations***

- Ensure all individuals with epilepsy:

- > have a plan for the acute management of seizures
  - > have a yearly assessment for medication side effects
  - > are assessed for accuracy of epilepsy diagnosis, appropriateness of current therapy and potential for improvement with further treatment
  - > are not restricted in terms of social, educational or employment access as a result of their epilepsy
- Provide education on epilepsy to all individuals and their carers.
- Ensure all individuals and their carers have appropriate education on hazard, especially safe bathing and water hazard.
- Ensure respite services are available which can support the management of seizures, in particular the administration of rectal diazepam.

### ***Thyroid disease***

Thyroid disease can be difficult to diagnose, particularly so in patients with developmental disability. Often the only 'symptom' is reported by the carer, usually mother, who observes that the patient's behaviour has changed in some non-specific way (Wilson & Haire 1992).

### ***Recommendations***

Thyroid disease should be considered at any new presentation. Thyroid function tests should be performed on any unusual presentation and annually in high risk subgroups (patients with Down syndrome and patients with a previous history of thyroid disease). Thyroid function tests should be performed every three to five years in other patients with development disability. The management is usually straightforward but may involve supervision of medication.

### ***Mental health***

Psychiatric disorders are more prevalent in people with an intellectual disability compared with the general population (Tonge & Einfeld 2000; Borthwick – Duffy & Eyman 1990; Corbett 1979; Gostason 1985; Reiss 1993; Rutter et al 1976). Specialist psychiatric services are available in countries such as the UK and the USA, however the provision of high quality psychiatric services remains a concern in many countries (Parmenter 1988; Lennox & Chaplin 1995; Lennox & Chaplin 1996; Molony 1993; White et al 1995; Beange et al 2000).

### ***Recommendation***

Health services should implement strategies to maximise the quality of identification and management of mental disorders.

### ***Gastro-esophageal reflux disease (GERD) and Helicobacter pylori***

GERD is a major clinical problem in people with an intellectual disability, overlooked and underestimated (Böhmer et al 1997a; ibid 1999; ibid 2000). The prevalence of GERD and reflux esophagitis (RE) in people living in institutions is very high, especially in those with specific and well-defined risk factors. In a Dutch institutionalised population, approximately one third of individuals with IQ<50 were diagnosed with RE (Böhmer et al 1999). Possible predisposing factors include scoliosis, cerebral palsy, use of anticonvulsant drugs or other benzodiazapines, & IQ<35. Symptoms indicative of reflux are vomiting, haematemesis, rumination and depressive symptoms. Helicobacter pylori infection is increased in populations of children and adults with an intellectual disability (Böhmer et al 1997b). This infection can cause peptic ulcer and gastric carcinoma (McColl et al 1998).

### ***Recommendations***

Identify and treat gastro-esophageal reflux disease and illness from Helicobacter pylori infection. Treatment should be undertaken with the same indications as for the general population.

### ***Osteoporosis***

Osteoporosis has been shown to occur with high prevalence among people with developmental disability, including an unselected population sample (Center et al 1998). Factors associated were small body size, hypogonadism, and Down syndrome. Sub groups of people with intellectual disability are at increased risk of fracture (Tannenbaum et al 1989), and an increased risk of falling has been documented (Spreat & Baker-Potts 1983). Falls and osteoporosis should be prevented where possible to decrease the frequency of fractures, which cause pain and further disability. Special attention should be given to persons on anticonvulsants, who are at increased risk of fractures (Tohill 1997).

### ***Recommendations***

Osteoporosis is common and would be best prevented. This requires a global approach, with the life long goal of optimising activity and nutrition, particularly calcium intake. People with an intellectual disability should be screened by osteodensitometry at least once in early adulthood; further decisions regarding progress screening should be based on that result. Individuals who have low sunlight exposure either due to management practices or to local climatic conditions, or are receiving anticonvulsant therapy, should have Vitamin D status assessed, and a Vitamin D supplement if identified as deficient (Compston 1995). All women should have bone mineral density assessed at the time of cessation of menstruation regardless of the reason for menopause, and all hypogonadal men require assessment (Eastell et al 1998). The local recommendations for treatment of osteoporosis in the general population should be followed and any decision to provide a different standard of care from that of the general population should be explicit.

### ***Medication review***

Polypharmacy (Reiss & Aman 1997) and inadequate medication review (Beange et al 1995) are acknowledged problems in this population. However, many individuals need daily medications because of the high prevalence of epilepsy, psychiatric disorders, and other serious disease. The nature of intellectual disability is such that affected individuals have limited ability to consent to medication or to monitor efficacy and side effects of

medication.

### ***Recommendations***

Medication should be regularly reviewed, ideally every three months and particularly when polypharmacy exists (Beange et al 1995; Aman 1987; Gowdey et al 1987; Reiss & Aman 1997). Prescribers need to acknowledge the inherent difficulties with monitoring (Tu 1979; Reiss & Aman 1997) and ensure that the patient and carers safely and reliably administer medication, are able to recognise adverse effects, monitor the efficacy of the medication and are aware of the review process. Systems for prepackaging doses for community based patients to maximise compliance and safety should be considered. Structured mechanisms for monitoring efficacy are valuable (Einfeld 1990). Consumer and carer education on the use of medication is important in ensuring compliance, recognising side effects and maximising efficacy. Continuing re-evaluation should ensure the least effective dose. Side effects should be monitored and ineffective drugs discontinued.

### ***Immunisation status***

In a group practice survey, Kerr et al (1996) found that individuals with an intellectual disability were less likely to have received regular immunisations when compared with age and sex matched non-disabled controls.

### ***Recommendations***

Immunisation schedules for adults with an intellectual disability should follow national guidelines. At a minimum we should ensure that immunisation rates for adults with an intellectual disability are the same as for the general community. Hepatitis A and B immunisations are indicated for people who live in institutions, and Hepatitis B is indicated for contacts of persons who are Hepatitis B carriers. Immunisation against influenza and the pneumococcus is recommended for the medically vulnerable (US Preventive Services Task Force 1996).

### ***Physical activity and exercise***

Physical activity and exercise levels amongst adults with an intellectual disability are generally considered to be low (Beange et al 1995; Pitetti & Campbell 1991; Rimmer et al 1993). A lack of opportunity for exercise in spite of increased cardiovascular risk factors has been documented (Beange et al 1995). Immobility is a predictor for mortality (Hayden 1998) and life expectancy is related to activity in those with severe intellectual disability (Fenhall 1993). Evidence exists that physical activity reduces mortality and morbidity in coronary heart disease, hypertension, obesity, osteoporosis and mental health disorders (US Preventive Services Task Force). All these conditions are increased in intellectual disability.

### ***Recommendations***

The American College of Sports Medicine and the Centres for Disease Control and Prevention recommend 30 minutes or more of moderate intensity physical activity on most, preferably all, days of the week for the general population (US Preventive Services Task Force). It should be possible to ensure this amount of moderate activity for most disabled people. Two cardiovascular training programs have been developed for people

with intellectual disability (Pitetti et al 1993). Some active or passive movement should be provided daily for those with limited mobility due to physical impairment. Some special services will be necessary for those who cannot access services for the general population.

### ***Comprehensive health assessments***

Many people with an intellectual disability need support to maintain a healthy lifestyle and access health services. There are numerous parallels between the elderly population and people with an intellectual disability. Both populations are heterogenous, and are known to experience unrecognised or poorly managed health conditions. Periodic comprehensive health assessment has been demonstrated to be effective in people 75 years and over (Byles 2000). Current research suggests this process will result in improved health in people with an intellectual disability also (Webb & Rogers 1999). For a vulnerable population, which has been found to suffer from multiple undetected and often obvious health problems (Beange et al 1995; Howells 1986; Wilson & Haire 1992), this simple measure is likely to be effective.

### ***Recommendation***

Organise regular comprehensive physical assessment and review by a medical practitioner.

### ***Genetics***

A genetic aetiology is common in this population. A definitive diagnosis is important to the patient since it allows a better estimate of prognosis and the anticipation of complications. It is important to the family since it enables full discussion and understanding of the cause of the condition and allows informed genetic counselling (Curry et al 1997). Estimates of genetic aetiology vary because of differences in ascertainment and methods of study. In round figures, it is generally agreed that 40-50% of cases are genetic, 15 -20% due to environmental factors and in 30-45% the cause is unknown. A significant proportion of the latter is also suspected to be genetic (Raynham et al 1996; Curry et al 1997; Hou et al 1998; Partington et al 2000).

### ***Recommendations***

Any patient without an aetiological diagnosis should be referred to a genetic clinic regardless of age. New genetic knowledge is constantly becoming available. Diagnostic reassessment at intervals is worthwhile even into adult life (van Gelderin 1992).

### ***Women's Health***

There is general agreement about the benefits of the main preventive screening services (Sox 1994; US Preventive Services Task Force 1996). Many countries have screening programmes available, and people with intellectual disability should take part in all these programmes. Clinical judgment is necessary to tailor the checkups to the needs of individual patients.

### ***Recommendations***

Papanicolaou smears are necessary if women have ever been sexually active. If the

examination is distressing or difficult, the risks of a Papanicolaou smear with/without sedation need to be balanced against the benefits (Palmer 1999). Mammograms are recommended according to country policy for the general population.

[References available on DDP website or from DDP staff upon request.]

## ABSTRACTS & TITLES

van Schroyen Lantman-De Valk, HMJ; Metsemakers, JFM; Haveman, MJ & Crebolder, HFJM. **Health problems in people with intellectual disability in general practice: a comparative study.** *Family Practice*, 2000, 17(5):405-407, by permission of Oxford University Press. <http://fampract.oupjournals.org>

In a GP database, 318 people with intellectual disability (ID) appeared to have 2.5 times more health problems than people without ID. This short report deals with the nature of the health problems. Consequences for health care policy are discussed.

**Introduction:** Nowadays, people with intellectual (ID) are seen as normal citizens who need individual support. Their health needs after deinstitutionalization are reported to be unmet. Mortality appeared to be markedly increased in this group. Information about mortality is scarce. There is need for an evidence-based health care provision for these people, who often advocate poorly for themselves.

The aim of the present study was to examine the differences in prevalence rates of health problems in people with and without ID who currently are being served by a GP.

**Amnesic syndrome presenting as malingering in a man with developmental disability** (1999). *Psychiatric Services*, 50(7):966-968. Sundheim, STPV & Ryan, RM. <http://psychservices.psychiatryonline.org/cgi/content/full/50/7/966>. [Reprinted with permission of the American Psychiatric Association.]

The authors report an unusual presentation of amnesic syndrome mislabeled as malingering in a man with mild developmental disability. The case highlights the challenges to medical personnel in treating persons who visit emergency rooms often, particularly individuals with mental retardation. Diagnostic overshadowing was a primary factor in the failure to diagnose amnesic syndrome. Overshadowing occurs when a patient's problematic behaviors are attributed to mental retardation, and no attempt is made to search for the root causes of the problem. The case also highlights the need for emergency room personnel to maintain links with agencies involved in the day-to-day care of persons with developmental disabilities.

Emergency room personnel can find it challenging to diagnose and treat people who visit emergency rooms frequently, particularly patients with mental retardation. A diagnosis of mental retardation can lead staff to overlook underlying causes of presenting problems.

**Staff and self-reports of health behaviours, somatic complaints, and medications among adults with mild intellectual disability** (2002) *Journal of Intellectual & Developmental Disability*, 27(2):125-135. Lunskey, Y.; Emery, CF & Benson, BA. Publisher: Taylor & Francis Health Sciences. <http://taylorandfrancis.metapress.com>

**Use of Potentially Inappropriate Drugs in Nursing Homes** (2002). *Pharmacotherapy*, 22(1):88-96. Dhall, J; Larrat, EP & Lapane, KL. [Reprinted with permission from the

American College of Clinical Pharmacy. ]  
[http://www.accp.com/pharmacotherapy/volume22\\_01.htm](http://www.accp.com/pharmacotherapy/volume22_01.htm)

**Study Objectives.** To examine patterns and determine predictors of inappropriate drug use in nursing homes.

**Design.** Retrospective study.

**Setting.** One thousand four hundred ninety-two nursing homes in five states.

**Patients.** A total of 44,562 residents admitted to nursing homes over 1 year.

**Methods.** Frequency of discontinuation and initiation of potentially inappropriate drugs over the first 90 days after admission to a nursing home was calculated. Data were collected using the minimum data set.

**Results.** On admission, 33% of residents were receiving at least one potentially inappropriate drug. After 90 days, the drug was discontinued in 16% of these residents. Of those not receiving a potentially inappropriate drug on admission, one was begun in 18%.

Demographic factors and number of drugs taken by patients were associated with the use of potentially inappropriate drugs.

**Conclusions.** Use of potentially inappropriate drugs was prevalent on admission and at 90 days after admission. Discontinuation was highest among patients with conditions for which potentially safer therapeutic alternatives existed.

**Fluvoxamine and aggression in mental retardation** (2001). *Psychiatric Services*, 52(8):1105. La Malfa, G; Bertelli, M & Conte, M. Letter to the Editor. [Reprinted with permission of the American Psychiatric Association.]

Among adults with mental retardation, aggressive behavior—directed against self and others—and challenging behavior are common obstacles to all types of treatment. Research on the usefulness of various medications to control aggressivity in this population has raised concerns about the efficacy and safety of all the agents studied.

Changes in serotonin levels in the central nervous system are a critical factor in the pathophysiology of aggressivity. Selective serotonin reuptake inhibitors (SSRIs) have been used successfully to control aggressive behavior (1,2). Fluvoxamine has particularly useful characteristics. It has a mild sedative effect, and it seems to be more selective for serotonergic pathways than most other SSRIs.

We sought to obtain preliminary data on the efficacy and safety of fluvoxamine in controlling aggressive behavior among adults with mental retardation.

Study participants were 60 aggressive inpatients with a *DSM-IV* diagnosis of mental retardation—40 with mild and 20 with moderate retardation. The mean  $\pm$ SD age of the participants with 30.6 $\pm$ 2.5 years. Twenty-nine were men (48 percent), and 31 were women (51 percent). Fifty-five patients (92 percent) lived in an institution, and five (8 percent) lived with their family. All the participants were Caucasian. Patients gave written consent to take part in the study.

The participants were treated for three weeks with fluvoxamine, which was initiated after a run-in period of three weeks—one week of no medication and two weeks of placebo. Over the three-week treatment period, the daily dose of fluvoxamine was gradually increased to a range of 200 to 300 mg, depending on individual response. The mean  $\pm$ SD dosage at the end of the treatment period was  $250\pm 41$  mg a day.

Aggressivity was assessed with the Handicaps, Behavior, and Skills Schedule (HBSS) (3) at three time points—at the end of the week without medication, at the end of the placebo period, and at the end of three weeks of fluvoxamine treatment. Side effects were assessed with the Dosage Record and Treatment Emergent Symptom Scale (DOTES) (4) at the end of the placebo period and after fluvoxamine.

The HBSS is a 12-item scale for measuring aggressive and aversive behavior among people with a mental handicap. The score on each item ranges from 0 to 2, with 0 indicating no abnormal behaviors and 1 and 2 indicating moderate and severe abnormal behaviors, respectively. The DOTES is a checklist that includes 33 possible side effects. The patient is assessed for the presence and severity of each side effect. The DOTES score ranges from 0 to 4, with higher scores indicating more severe side effects.

Two experienced psychiatrists administered the instruments to all patients. Before the study began, their interrater reliability, as measured by Cohen's kappa, was greater than .8 for both instruments. Student's t test was used to compare scores at the different time points. The significance level was set at .05.

The mean  $\pm$ SD HBSS score at the end of the week without medication was not significantly different from the score at the end of the placebo period ( $20.9\pm 1.8$  and  $20.2\pm 1.6$ , respectively). The DOTES score at the end of the placebo period was not significantly different from the score after fluvoxamine treatment ( $1.1\pm .2$  and  $1.1\pm .4$ ). However, the HBSS score after fluvoxamine was significantly lower than the score at the end of the placebo period ( $10.9\pm .8$  and  $20.2\pm 1.6$ ;  $t=34.82$ ,  $df=59$ ,  $p<.001$ ), indicating a reduction in the severity of aggressive behaviors.

Because of ethical and practical considerations, we could not conduct a more rigorous study. The findings must be considered preliminary because participants were not randomly assigned to treatment condition, the psychiatrists who administered the instruments were not blinded to the patients' treatment condition, and no control group was used. However, our results suggest that fluvoxamine is a well-tolerated treatment that is more effective than placebo in controlling aggression among adults with mental retardation.

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## WEBSITES & RESOURCES

<http://www.psychiatry.med.uwo.ca/ddp> An informative site from the University of Western Ontario with extensive links relating to the health and mental health of persons with developmental disabilities.

**For medical educators:** Check out the medical undergraduate education section compiled by the five medical schools in Ontario.

<http://www.psychiatry.med.uwo.ca/ddp/mededucation/titlepage.htm>

**Table Manners and Beyond** - The Gynecological Exam for Women with Developmental Disabilities and Other Functional Limitations, edited by KM Simpson, produced by K Lankasky. Available at: <http://www.bhawd.org/sitefiles/TblMrs/cover.html>

**People with Mental Retardation & Sexual Abuse** by LA Reynolds. Available at: <http://www.wsf.org/BEHAVIOR/guidelines/sexualabuse.htm>

**Note: Correction** - go to <http://www.wsf.org>. Click on "search," type in "sexual," and click on "Mental Retardation and Sexual Abuse" to access article.

**AAMR & IASSID Dementia Documents.** [http://161.58.153.187/dementia\\_docs.shtml](http://161.58.153.187/dementia_docs.shtml)

1. Test Battery for the Diagnosis of Dementia in Individuals with Intellectual Disability.
2. Practical Guidelines for the Clinical Assessment and Care Manager of Alzheimer and Other Dementias Among Adults with Mental Retardation.
3. Diagnosis of Dementia in Individuals with Intellectual Disability.

4. Evaluation Procedures for Establishing Diagnostic Criteria.
5. Epidemiology of Alzheimer Disease in Mental Retardation.

**Autism Fact Sheets** available from the US National Institute of Child Health and Human Development (NICHD). 1. Autism Facts; 2. Autism Questions and Answers for Healthcare Professionals; 3. Autism and Genes; 4. Autism and the MMR Vaccine; 5. Rett Syndrome; 6. The NICHD/NIDCD Network on the Neurobiology and Genetics of Autism: The Collaborative Programs of Excellence in Autism (CPEAs).

<http://www.nichd.nih.gov/autism>

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**What: NADD 19<sup>th</sup> Annual Conference & Exhibit Show – Mental Health Needs in Persons With Developmental Disabilities: Working Together in New Directions**

**Date:** October 23-26, 2002 **Location:** Adam's Mark Hotel, Denver, CO

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