Dual Diagnosis II

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STAFF TRAINING PROGRAM

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Minot State University
Center of Excellence
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Introduction

This module is intended to provide program managers/internal case managers and supervisors information to assist in development of quality services to people with a dual diagnosis of I/DD and a mental health disorder or mental illness (MI). It is not intended to prescribe specific methods. The information in this module has been gathered from national discussion and research regarding dual diagnosis and from state and federal regulations.

In order to understand and participate in the treatment of mental health disorders it is important to know the history, barriers, and recent advances of psychopathology (the manifestation of mental health disorders and their study) and psychiatry (branch of medicine that deals with the diagnosis, treatment, and prevention of mental and emotional disorders).

Looking back, we can see that some attitudes linger regarding treatment of people who exhibited “abnormal” behavior. Some of the stigmatization still exists. Mental illness has been associated with shame and disgrace which results in barriers to mental health* care. People are often reluctant to seek appropriate care which results in a delay in returning to well-being. Crisp, Gelder, Rix, Meltzer, Rowlands (2000) found from surveying over 1,700 people, the concept of mental illnesses produced different types of prejudice. The general public has a more sophisticated view of mental illness than simply categorizing people with mental illness as one homogeneous group.

The systems serving both the I/DD population and the mental health system serving the general public sometimes find themselves at odds in understanding and providing needed services. However, mental health professionals are becoming better educated regarding the impact I/DD has on assessment and treatment, and person-centered teams serving individuals with I/DD are accessing new and individualized community services for treatment.

Advances in technology, particularly brain imaging, has led to discoveries of how trauma and early adversity can lead to psychiatric vulnerability in adulthood. This technology has allowed scientists to discover normal and abnormal pathological processes in the brain. The imaging has permitted researchers to uncover information about the brain such as metabolic processes, changes in neurotransmitter receptors, and brain connectivity. We are beginning to see the relationship between environmental and social stressors. The potential unique impact of these factors will help service providers understand behavior better. As research continues, we can expect to see assessment, treatments, and service systems change.
For those who have been dually diagnosed with an Intellectual and Developmental Disability (I/DD) and a mental health disorder or mental illness (MI) these advances will result in changes in services as well. Professionals, families, and people experiencing mental health issues should be ready for improvements but also different challenges.

* “Behavioral health” is an emerging term and often used as replacement language for the term “mental health.” In general, the two are relatively equivalent, except that “behavioral health” is a little broader. It may be a little less ‘medical’ in foundational approach and may be preferred by some because of the stigma attached to the term “mental health.” Some publications and discussions use the term “behavioral health” to include both mental health and substance abuse.”
Chapter 1 – Models/Theories of Psychopathology

Objectives

Upon successful completion of this lesson, staff members will be able to:

- Compare models of psychopathology
- Describe how maladaptive behaviors could be a result of delayed development
- List three skills a QDDP/Program Coordinator/Case Manager might need in team participation supporting someone with dual diagnosis

Service systems are based on models or theories. Models give frameworks or structures from which to design services, interventions, assessments and evaluations. They help us make sense of what we observe. Without them, professionals and funded services would not be able develop meaningful programs or interventions to help people. Using what we know about a model and our personal beliefs, we can make decisions that are guided by these frameworks.

It is not unusual, personally and professionally, to change models over the years based on experiences, new research, economic conditions, or even litigation. It is also not unusual to use tenets of all the models or theories to build programs or interventions. In person-centered services, we use strengths and needs of the person to begin to understand and build individualized services and supports. However, it is also prudent to understand theories/frameworks used by other disciplines.

Growth in understanding and explaining psychopathology has occurred over the past 60 – 70 years. The medical model or what is usually referred to as the bio-medical model was brought about by discoveries in medicine. The discovery that paresis (weakness of voluntary movement) was caused by a bacterial organism and could be cured by penicillin reinforced the view that biological causes and cures might be discovered for mental disorders. The rapid adoption of electro-convulsion therapy and lobotomies in the 1930s and ’40s encouraged the expectation that mental disorders could be cured. The use of medications or pharmacology started in the 1950s. During this time, it was discovered that compounds could reduce the symptoms of psychosis, depression, mania, anxiety, and hyperactivity.

In 1980, the DSM III was published. This was regarded as a re-affirmation of American psychiatry’s commitment to scientific medicine. The purpose of the medical model was, and continues to be, to gain knowledge about how to prevent or lessen the negative consequences of the disability through health care. The bio-medical model seeks to find
out the cause of the impairment and study the risk factors and relationships to psychopathology.

The **social model** of psychiatry began in opposition to the medical model in the 1960s. This model not only looked at the cause of mental illness but also the nature of care, treatment, and cure. It can be traced to a growing criticism of the large psychiatric – custodial institutions. This model focused on the individual and suggested that motivation for change was internal and could be developed through psychoanalysis. It used major life events as precipitators to mental illness. The social model also focuses on disability as a consequence of barriers to social and societal participation. This model’s purpose is to identify the barriers that exist in a society that is constructed primarily for those without impairments. The central idea of the social model is that the main contributing factor to disability is not the physical impairment, but rather a society that fails to take individual differences into account. Psychopathology, in this model, is a result of marginalization or lack of support that would allow a person to lead a self-determined life.

Another model, the **developmental psychopathology theory/model**, is a general approach to understanding the relationship between development or maturation and maladaptive behavior (Achenbach, 1990). The developmental approach focuses on explaining the interaction between biological, psychological, and social aspects of normal and abnormal development across the lifespan. This approach attempts to understand how various experiences (trauma, disability, socio-economic conditions, or culture) in the course of development can cause a person to use adaptive or maladaptive behaviors. This approach seeks to understand how the experiences of people with I/DD have influenced their behavior. For instance, one developmental milestone is the ability to see another’s point of view. When this social skill does not develop at the typical age because of a developmental delay, social interactions with age-mates may breakdown. The child might withdraw, continue to use egocentric (self-centered) methods, or develop aggression to accommodate or adapt. This breakdown between the person and the context can place a person at risk of maladaptive behavior. The field of developmental psychopathology appeared around the 1970s mainly through research of longitudinal studies of children at risk for developing schizophrenia. These studies generated knowledge about basic developmental processes underlying adaptive and maladaptive behavior.

Certainly these models are not exclusive. This comparative description is intended to point out the different philosophical perspectives but also to emphasize that current service systems usually do not practice only one model. It is also to point out that pieces of each model might make sense for some people and not for others. Practical service delivery is usually not purely based on the social model, developmental psychopathology model, or the bio-medical model. Teams who support people with I/DD develop the best fit for the person based on what they know and what is available. This is not to condone
the status quo but to challenge teams to change. Gaining knowledge and advocating for systems change is always part of team activity to better support people.

In this module, the following statement by the World Health Organization in 2001 best describes the philosophy held by agencies providing community services for people with dual diagnosis.

*The occurrence of a mental health disorder is best viewed as the outcome of complex interactions between developmental, biological, psychological, and socially determined risk. Positive mental health, reflected in resilience, and social/coping skills, is necessary in order to participate fully in society and be productive in satisfying ways.*

World Health Organization, 2001

**What we know about causes of Dual Diagnosis**

People with I/DD have a high risk of developing the full range of mental disorders. Various studies cite between 20 to 25% prevalence rate, indicating that intellectual disability is a high risk factor for the development of both mental illness and behavior disorder.

The question families, support staff, and mental health professionals ask is – what might be causing this? What are the vulnerabilities we know about? People with I/DD are at an increased risk of developing a mental health disorders due to the complex interaction of biological, psychological, and social factors. Biological evidence suggests that people with specific syndromes may have particular patterns of development and specific vulnerabilities.

**Fragile X syndrome.** This syndrome is caused by an abnormality of part of the X chromosome. This abnormality disrupts the production of a protein which in turn results in the observed characteristics (physical and behavioral). Physical characteristics include:

- A long face shape with prominent ears
- Hyper-extensibility in joints
- Enlarged testes in post-pubertal boys
- Epilepsy which may resolve in adolescence

Behavioral characteristics include:

- Difficulty inhibiting repetition
- Difficulty switching attention from one activity to another
- Self-injurious behavior which includes biting the backs of hands and fingers
- Shyness and gaze avoidance
**Prader-Willi syndrome.** This has been shown to be caused by abnormalities of chromosome 15. Physical characteristics are:
- Hypotonia and feeding difficulties in infancy with excessive appetite and obesity developing in later development
- Short stature with small feet and hands in childhood
- Abnormalities in growth, temperature control, and sleep
Behavioral characteristics are:
- Severe temper tantrums
- Will eat non-food items and will do anything to get food
- Picks at skin
- Mood changes

**Williams syndrome.** This is caused by a deletion of part of chromosome 7. Physical characteristics are:
- Short stature
- Wavy hair
- Congenital heart disease
- Blue eyes with a stellate or lacy pattern of the iris
Behavioral characteristics are:
- Perceptual functions are impaired (direction, patterns, math)
- Very adept at linguistic tasks
- Hyper-sociability or indiscriminate sociability
- High levels of anxiety, sleep disturbance, over-sensitivity to certain frequency and volume ranges of sound

**Down syndrome.** The most common genetic cause of I/DD is caused by an extra chromosome on the 21st pair. Physical characteristics are:
- Low muscle tone
- Flat facial features with small nose
- Upward slant to eyes
- Hyper flexibility
- Enlarged tongue
- Hearing defects
- Hypothyroidism
Behavioral characteristics are:
- Impulsiveness
- Warm and friendly disposition
- Language impairment
- Delayed social and motor development
- Short attention span
Autism spectrum disorder (ASD) is identified by observed behavior. Although studies have linked the increased risk of ASD occurring in families with other mental health disorders present, this has not been proven in the research. ASD behaviors are sometimes present in other syndromes. Behavioral characteristics include:

- A preference for sameness
- Pre-occupation with limited interests
- Delayed language development or nonverbal

More characteristics are found in the DSM 5.

Others such as Phelan-McDermid syndrome, Velocardiofacial syndrome, Angelman syndrome, epilepsy, or Fetal Alcohol Spectrum Disorder all have behavioral characteristics that may put the person at risk of a mental health disorder. These vulnerabilities can be seen as challenges or barriers that disrupt the development of adaptive skills/behavior.

Psychological vulnerabilities may be:

- Rejection or abuse
- Life events – separations or losses
- Poor problem solving/coping skills
- Social – emotional vulnerabilities (sexual abuse)
- Poor self-acceptance/esteem
- Devaluation and disempowerment

Social factors may be:

- Negative attitudes or expectations
- Social exclusion
- Poor social support network
- Inappropriate environments or services

What does it feel like to know you are different and can’t do what many others your age have achieved? You are dependent on parents and caregivers. If you live in a facility, you have endless people coming and going in your life. You have limited expressive and receptive language and your ability to make sense of your life is limited. Your sense of self-esteem may be low and you desire to be like everyone else. What vulnerabilities might have been present for the person described below?

A 27-year-old woman with a moderate ID was referred for help in reducing her behavioral problems. She was hyperactive, angry and negativistic; she exhibited rage outbursts and self-injurious behavior. In addition, she had sleeping difficulties. She lived in a group home with seven other residents and several professional caretakers. She was the third child in a family of low social economic status. After an uncomplicated pregnancy and delivery, her psycho-motoric development appeared to be delayed. The
behavioral difficulties began when she was 3 years old. She was hyperactive and stubborn, and was always seeking attention. These behavioral problems were the reason for her placement in an institution for children with ID when she was 8 years old. Shortly afterwards, her behavior worsened. She displayed aggression, self-injurious behavior and restlessness (at that time she also suffered from insomnia). For her behavior she received sedative medication, without an appropriate result. From that time on, she changed institutes several times, and each time, her behavior worsened. At the present group home she had no social contact with the other residents and had no special bond with the caretakers. Every once in a while she would go to her parents’ home for the weekend and she was very excited when these visits would take place. She would become very upset if they were cancelled.

Dosen (2005)

How might this woman’s early experiences have influenced the resulting maladaptive behaviors? Could an understanding of the presence of hyperactivity and teaching of skills to accommodate the hyperactivity have helped avert her institutionalization? Did medical problems exist that were undiagnosed? What were the strengths and capacities of this person? What do current environments offer or detract for this person?

Understanding the models that explain psychopathology and that are used by mental health professionals will aid us in developing support plans that are person-centered. As a manager, QDDP, program coordinator, or internal case manager, you will be part of the team leadership (program planning teams, direct support professionals, agency leadership) that assists in determining the intervention or supports for a person who is dually diagnosed. What you believe about mental illness and dual diagnosis will influence the path of the program.

What other members of the team believe or know will also influence outcomes for the person supported. The members will have varied experiences and some may believe myths about mental illness. You will work with other professionals from different disciplines who may not have experience with people with I/DD. You may supervise staff who have little knowledge about I/DD let alone mental illness. How quickly the team jumps to determining the reason for the disorder can determine how successful the ensuing support will be.

You will be responsible for guiding the team in conducting a functional assessment. You will need to follow guidelines and regulations regarding behavioral support and use of psychotropic medications. Being part of a team that brings quality to the life of a person with dual diagnosis can be a challenge that brings great personal and professional rewards. You will also be working in a field that has undergone changes and continues with growth in research and knowledge.
Chapter 1 Study Questions

1. List 4 areas The World Health Organization identifies as risks that may contribute to a mental health disorder.

2. What information might a professional who adheres to the developmental psychopathology theory gather in their assessment of a person exhibiting maladaptive behavior?

3. List three general behavioral characteristics of Prader-Willi syndrome

4. List three general behavioral characteristics of Williams syndrome.

5. How can the Case Manager/Program Coordinator/QDDP provide guidance/support to team members who have little knowledge about mental health disorders?

6. Which model of psychopathology (Medical/Bio-Medical; Developmental Psychopathology; or Social) is described in each phrase below (Answers may be used more than once.)

__________ a. Focuses on understanding the interactions between biological, psychological, and social aspects of normal and abnormal development

__________ b. Seeks to find out the cause of a mental health disorder by studying developmental experiences of people.

__________ c. Focuses on how to prevent or lessen the negative consequences of the disability through health care.

__________ d. Focuses on disability as a consequence of barriers to social and societal participation. Belief that the major factor to disability is not the physical impairment, but
rather a society that fails to take the individual into account.

e. Attempts to understand how various experiences in the course of development can cause a person to use adaptive or maladaptive behavior.

f. Is in agreement with the World Health Organization's description of the cause of mental health disorders.

7. T F People with I/DD have a high risk of developing the full range of mental health disorders. Prevalence rates may be as high as 50%.

8. Some syndromes put a person at risk of a mental health disorder because of the challenges or barriers that disrupt the development of ____________ skills/behavior.

9. People with certain syndromes (i.e., Fragile X syndrome, Prader-Willi syndrome, Williams syndrome, Down syndrome, Autism) have specific vulnerabilities to developing dual diagnosis due to the _____ ____________ typical of the syndrome.
Chapter 2 – Team Approach

Objectives

Upon successful completion of this lesson, staff members will be able to:

- Compare approaches to mental health treatment
- List the assessment steps mental health professionals use during diagnosis of mental health disorders
- List components of a mental status exam
- Describe factors that contribute to difficulties in diagnosing mental health disorders for people with I/DD
- Describe the purpose of the DM-ID
- Describe how the QDDP/Program Coordinator/Case Manager can contribute to the assessment process
- Identify a plan for data collection throughout the treatment of a person with dual diagnosis

Working in interdisciplinary teams is basic to services in the field of I/DD. All people supported must receive an individual program plan developed by a team that represents a range of professions, disciplines, or service areas. Person-centered teams are part of the mandated process developing effective support plans. This includes conducting multidisciplinary assessments, determining and implementing programs, and monitoring outcomes. The development of a coordinated treatment plan is essential for addressing the effects of integrating pharmacological and behavioral treatments. Further, effective integration can occur only if the team communicates regularly and its members, from various disciplines, are able to coordinate and release their role to direct support professionals. Psychiatry that serves the general public does not use this approach. The comparison chart below depicts what psychiatry or a mental health professional’s approach to treating the general public looks like in comparison to the approach to treatment for a person who receives services in a provider agency.

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<th>I/DD population</th>
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<td>Establish relationship</td>
<td>Relationship with the team</td>
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<tr>
<td>Conversation with detailed questions and answers</td>
<td>Verbal ability is limited and use of 3rd party information</td>
</tr>
<tr>
<td>Evaluate the overall presentation</td>
<td>Atypical presentation, behavioral vulnerabilities</td>
</tr>
<tr>
<td>Discuss diagnosis and treatment plan</td>
<td>“Team” treatment and negotiation</td>
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Beasley, J., 2014

There may be a scarcity of professionals who can cross over between the mental health service system and the I/DD system. It may be necessary to work with professionals that have little experience dealing with the team approach. In a study (Singh, 2002), psychiatrists and behavioral psychologists were adept at their discipline-specific
assessments, case conceptualization, and development of treatments, but were minimally responsive to collaborating with each other to produce meaningful, integrated treatments. Barksdale (2012) found that clinicians who were exposed to I/DD through coursework were more willing to consider working with individuals with I/DD. This lack of experienced trained professionals is changing. Mental health professionals are becoming better acquainted with the challenges and developing better methods of serving people who are dually diagnosed. The cross-over may mean that the mental health professional will need to understand the value of least intrusive alternative, monitoring side effects of medications, or positive behavioral support. It also requires that members of the team view medications, therapy, or behavior support plans as integrated in the overall plan. As a program coordinator, internal case manager/QDDP it will be your work in this integration process that determines the success of the plan.

A value of the team approach is person-centered planning. This value should be embedded in all the team does as the person supported should have a voice in how and what might be the methods of an intervention plan. It is easy to neglect this as people who have severe levels of intellectual disabilities might be viewed as not comprehending the use of particular medications, or the use of restrictive procedures for crisis management. Plans should include education for the person supported and assume the person has the competence to understand or learn to understand about their mental health concerns.

What is important to people with I/DD when coping with challenging behavior and the complexity of support? An analysis found the following themes from several research studies. These themes were the most important to people with I/DD in residential programs who struggled with challenging behavior:

- The residential placement and imbalance of power (staff attitudes and atmosphere of the living placement)
- Use of restrictive methods (understanding the method, abuse of the method, the emotional discomfort it caused)
- Desire to see more proactive methods (beneficial relationship with staff, a need for better strategies, and strategies for calming)

(Griffith, 2013)

The internal case manager/program coordinator/QDDP will need to assist in the gathering of information. It will be necessary to help the mental health professional understand the values and processes of person-centered planning and for agency staff to do likewise with the mental health assessment. It is important to collaborate with all professionals involved keeping the needs of the individual, the mental health professional, and the agency in perspective. There will be a need for:

1. Providing and communicating accurate behavioral data.
2. Assisting in building trust between the mental health professional and the individual supported.
3. Planning for compliance to regulations and educating the mental health professional accordingly.
4. Understanding the experience the mental health professional may have with I/DD.
Assessment – general population

Mental health professionals, particularly psychiatrists operate by a diagnostic approach, called the prescriptive approach. This means they are looking at the person and seeking to label or categorize the condition. They do this in 8 steps of assessment:

- Obtaining a history
- Evaluating the person’s mental status
- Collecting auxiliary data
- Summarizing principal findings
- Rendering a diagnosis
- Making a prognosis
- Providing a bio-psychosocial formulation
- Determining a treatment plan

The history will be of the present symptoms, issues, and/or events that bring the person to the psychiatrist or mental health professional that can diagnose mental health disorders. The history of present illness should describe when it began, what exacerbated it, what escalated or diminished its severity, what problems concurrently exist or existed, how the person has tried to resolve it, and the person’s subjective view of it. It should also estimate the time of onset and if the person has had the same disorder repeatedly. Other inquiries should cover present or past use/abuse of alcohol, drugs, and prescription medications and suicide ideation. Functioning prior to the current episode might be part of this history and is sometimes called baseline functioning.

Social and developmental history will gather information about the present family or living situation, occupation, residential setting, and financial status. The mental health professional will gather this information from the individual by asking:

- Name three or four crucial turning points in your life.
- Describe the most significant or memorable event during each developmental period.

A comprehensive developmental history would look at each stage (prenatal, infancy to adolescence, early and middle adulthood, and late adulthood) when applicable and ask questions related to typical milestones and events in that stage. Along with this history gathering will be the question about any abuse – physical, sexual, or emotional.

Family history will gather information about family history of mental disorders. The family history documents how the family members have influenced and been influenced by the person’s illness. This history might specify with whom the family and the person supported sees the most, trusts the most, and depends on in a crisis.

The medical assessment will consist of medical history, a physical exam, and laboratory tests. This is done to 1) detect any medical cause for the psychiatric symptom, 2) to identify physical states that may alter how psychiatric medications are prescribed, 3) to
discover previously undiagnosed medical diseases, 4) to alert to substance abuse, and 5) to monitor blood levels of various medications.

David Pitonyak suggests that there are some common physical problems that may cause a person with I/DD to increase or suddenly develop challenging behavior. When a person is non-verbal or has difficulty explaining their symptoms these may be considered. He uses the acronym HURTS:

- H – head
- U - urinary tract
- R – reflux
- T – thyroid
- S - seizures

The mental status exam is completed as the psychiatrist or mental health professional interviews the person. It describes the person’s appearance, behavior, speech, emotions, and cognitive and perceptual process. This is an objective report of the person’s current mental state as observed by the professional. It is collected first hand and in the moment. This exam might include some standardized questions that assess memory, thought process, or attention span. The following list are factors the professional will be assessing while they interview the person.

- Appearance – alertness, clothes, handshake
- Behavior – gait, gestures, twitches, impulse control
- Speech – loud, rapid, pressure, slow, soft, hesitant
- Mood and affect – smiles, not congruent with stated mood, affect, ability to interact during interview
- Thought processes and content – word usage, stream of thought, continuity of thought, content of thought, incoherence
- Perception – delusions or hallucinations, voices
- Attention and concentration – distractible
- Orientation – can they state the current time, date, year, season, part of the day
- Memory – remote, recent and immediate
- Judgment – acts appropriately during interview, hypothetical problem solving
- Intelligence and information – performing simple calculations or read something and explain what it meant
- Insight – intellectual recognition of problems, current behavioral problems

Auxiliary data is information gathered outside of the patient interview which can include interviews and results from the medical assessment. It can include psychological and neuropsychological testing such as achievement and aptitude tests. Neuropsychological testing might be a more in-depth look at abstract reasoning, memory, perception, language and attention using standardized tests.

No person would undergo surgery or take medication for severe stomach pain without obtaining an evaluation. This should also be the standard for psychiatry. No formal treatment or intervention should begin without an evaluation. This method of assessment
and evaluation might work for people who have I/DD, but what method and information will be useful and where to gather that information will be a task for the team and QDDP/case manager/program coordinator.

Assessment – I/DD

Diagnosing mental illness in this population can be difficult for a number of reasons.

- Challenging or disruptive behaviors may be attributed to an individual's intellectual disability instead of a potential mental illness (diagnostic overshadowing).
- Mental health professionals are seldom trained in diagnosing psychiatric disorders in individuals with intellectual disabilities.
- Certain disorders may manifest differently across a range of intellectual ability.
- Many diagnostic tools rely on an individual's ability to express their symptoms verbally.
- Social and interpersonal networks are small. These help to support good mental health. Feelings of loss, rejection, and isolation are major contributing factors in depression. The development of interpersonal coping skills is lessened due to cognitive limitations.

It may be that the mental health professional views Mental Illness and I/DD as two separate conditions. We know that the associated deficits of a disability, the lack of development of particular adaptive skills, the ensuing difficulties with social skills and psychological processes all contribute to vulnerabilities in development of maladaptive behavior. These factors make for a wide “net” to be cast when conducting assessments. There is a large amount of detective work involved in this kind of assessment. We want to assist the mental health professional and our team to avoid the following “wrongs”:

- Wrong diagnosis/behavioral analysis
- Wrong hypotheses driving the intervention
- Wrong program implementation
- Wrong setting/environment
- Wrong medication regimen

Caution – there can be a temptation to “tell” the mental health professional all they need to know about the person supported and get on with the treatment. After all the caregivers know the person best – right? That is not the primary purpose for a referral to the mental health practice. You are hopefully seeking help for explanation of behavior or lack of behavior that has not responded to previous interventions or support plans. Be sure to give the mental health professional all the time and information they need to assist in your efforts to provide a quality life. They have expertise that is needed and rushing the process produces wasted effort.
Interviews

Much of the information a psychiatrist gathers is from actually meeting and interviewing the individual coming for help. As much as possible this type of information gathering can and should be used to ascertain the congruence of information among the team members. Family members, the person supported, direct support professionals (DSPs), and others who would be able to provide information should be interviewed. It may be a temptation to forego this when DSPs currently giving care know the person well. The interview is used to ascertain historical influences as well as the current state.

There are cautions that come with interviewing. The problem of acquiescence or saying yes to all questions can be a common problem. Dr. J. Gentile (2012) provides some guidelines:

- Intersperse questions where the correct answer should be “no,” e.g. “Does it snow in summer here?” “Can you fly an airplane?”
- Pair questions that are opposite in meaning; “Are you happy?” “Are you sad?”
- Use pairs of questions in which the same question is asked in different formats, i.e. yes/no and either/or.
- Use informant checks. Is what team members said congruent with the interview?

The limited verbal ability is common and can be highly stressful if the interview is the primary source of information. Again, Dr. Gentile offers some guidelines for mental health professionals:

- Ask permission to involve collateral data sources.
- Use “who,” “what,” and “where,” questions rather than “when,” “how,” and “why.”
- High yield accurate information will most likely be gained from the use of pictorial multiple-choice and factual yes/no questions, closely followed by subjective yes/no questions.
- Avoid hypothetical or abstract future-oriented questions.
- Avoid jargon or slang, as well as other technical language.
- Use concrete descriptions and avoid figurative language.
- Avoid conversational punctuations such as “really” and “you know” because they may be taken literally.
- Frequently check understanding of conversation with the individual with ID.
- Ask what particular words mean to the individual, and use their words when possible.
- Match questions and answers with the individual’s expressive language.
- Avoid double negatives.
- Use words that they use for body parts.
- Avoid abstract concepts.
- Use alternative language systems – picture and line drawings as adjunct when needed.
- Match the interviewee’s mean length of utterance.
- Use plain language or language less than 6th grade level.
• Use single clause sentences. Example: “I like pumpkin pie”
• Use active verbs rather than passive ones.
• Use present tense whenever possible.
• Use time anchors when discussing the past.
• Avoid idioms – i.e., do not say “you can’t teach an old dog new tricks.”
• Avoid direct comparisons – i.e., “How do you like your new home and job?” Instead, ask each as separate questions.
• Yes/no questions are higher yield when used regarding activities and events, but they are not as accurate with feelings and emotions.
• Avoid confrontational or potentially embarrassing yes/no questions.
• Avoid leading questions - “you knew what you were doing was wrong, didn’t you?”
• Use caution with “why” questions.
• Exercise caution with use of humor.
• Eliminate irrelevant stimuli in the office which may steal the attention or create distraction.
• Use assistive devices used by individuals as part of the interview whenever needed.
• Learn the basics of sign language for commonly used words – thank you, bathroom, please, sad, happy, good, and bad.

While interviewing is a primary way to get acquainted, it is important to note that a person supported can only respond according to what they have experienced. What alternatives and choices have been part of their present and past? This is particularly relevant when asking them to evaluate or indicate their level of satisfaction. They may not have the breadth of experience and have low expectations.

**Diagnostic Manual – Intellectual Disability (DM-ID)**

Dr. Ann Hurley (1996) explored depression in the population of people diagnosed with Down syndrome. She reviewed cases of depressive episodes where the person displayed symptoms close to psychotic criteria. Behaviors that were observed across 5 cases were: loss of adaptive skills, delusions, agitation, statements of death, paranoid thoughts, inappropriate laughing and crying, mutism, and wandering. Treatment with antipsychotic medications provided no improvement or worsening, but treatment using an antidepressant showed marked improvement within only two weeks. The mental health professionals in these cases were hesitant to render the diagnosis of depression as the symptoms were more indicative of psychosis but also had some strong features of depression. Dr. Hurley suggested a framework of using diagnostic equivalents where behavioral manifestations are similar to those required in the DSM. For instance, in major depression episodes, verbal reports on inner states may be absent such as loss of interest, feeling tired, or worthless. People with I/DD may not be able to report this accurately. Substituting crying or statements regarding death as verbalizations of depressed feelings is an example of using behavior observed to “explain” what might be described in the interview.
The DM-ID was developed in 2007 by the National Association for Dually Diagnosed as a companion to the DSM –IV. Currently the DM-ID is under revision (DM-ID 2). The goal of the DM-ID was to provide more accurate psychiatric diagnoses for individuals with I/DD and mental illness. The purpose of the DM-ID is premised on the fact that psychiatric disorders are observed differently in individuals with I/DD than the general public. The DSM diagnostic criteria are “generic” in that they are applied to all patient populations and do not consider the person’s age, ethnicity, culture, gender, or any presence of I/DD. There have been many critics of the DSM arguing that developmental issues, cultural context, and other factors can affect the manifestation of disorders. The DM-ID describes identified differences and provides information about how to make an accurate psychiatric diagnosis in an individual with I/DD relying less on the individual’s self-report. The DM-ID not only assists in adapting diagnostic criteria but is also gives consideration for recognizing common behaviors of individuals with I/DD and how to differentiate the behavior from the psychiatric disorder. All major diagnostic categories of mental disorders as defined in the DSM-IV-TR are covered in the DM-ID. The DM-ID relies heavily on observation.

The DM-ID manual should be standard in the library of those who serve people with I/DD. Staff and team members should be able to use it as a reference to determine behaviors for observation and as discussion.

**Screening – Rating Scales/Checklists**

A screening is a tool to gather information regarding potential for a more formal examination. Screenings can be in the form of checklists or rating forms. There are many short/quick screenings on the internet as well but these have not been tested for reliability or validity. Screenings are not formal tests that would render a diagnosis but they may be used in conjunction with the interview and gathering of auxiliary data. They are usually completed by or under the direction of a mental health professional.

The PAS-ADD Checklist is a screening instrument specifically designed to help staff recognize mental health problems in people with an intellectual disability. The instrument consists of a life-events checklist and 29 symptom items scored on a four-point scale. Scores are combined to provide three threshold scores. The crossing of any of these thresholds indicates the need for a fuller assessment. The items are worded in everyday language, making the checklist suitable for use by individuals who do not have a background in psychopathology.

The mini PAS-ADD interview provides a framework for an interviewer to collect relevant information on psychiatric symptoms from an informant. This interview consists of 66 items in questionnaire format with probes. The mini PAS-ADD interview is designed to detect possible indicators of seven specific psychiatric disorders. The interview has been tested for agreement with the presence of a psychiatric disorder with 57 – 91 % reliability (Hobden & LeRoy, 2008, Prosser et al. , 1998)

The Reiss Screen for Maladaptive Behavior (RSMB) was developed to screen for psychopathology in adults with intellectual disabilities. This is a 38 item scale that can be
completed by a caregiver or family member. It produces eight subscale scores on the following dimensions: aggressive behavior, autism, psychosis, paranoia, depression – behavioral signs, depression-physical signs, dependent personality disorder, and avoidant disorder. This scale has been used for over two decades.

The above scales are just a sample of assessments that have been developed to help teams and mental health professionals determine the type or even the evidence for a mental health disorder in people with I/DD. The screening scales and the use of the DM-ID should help the team and the mental health professional identify the observable behaviors they will be monitoring for use in the integrated person-centered support plan.

**Observation**

Observation is another way data are collected. Obtaining information via observation can be challenging but the resulting data should drive the progression of the intervention. It is challenging because it requires more resources than other methods. These resources are usually time and expertise such as:

- Exact definitions of the observable behaviors. This takes time to discuss among team members and staff. Coming to a consensus on the important behaviors is not easy as each person on the team has personal ideas of what is important.
- Professional expertise is needed to make sure the observations are targeting the correct behaviors. Good planning on baseline behavioral data and subsequent observations will be foundational to a good intervention plan.
- Generating the most economical way to collect the data. This requires simple ways to record the behaviors as they occur.
- Staff time and expertise. Staff will need to understand what to observe, how to record and collect, and understand the ultimate importance of their accuracy. Observation and data collection can span several weeks and observation must also include data on the context of the environment.
- Supervisory time to make sure the observations and ensuing data collection is occurring.

Interviews can collect data but this information from the past can suffer from recall error. Personal interpretations of the person supported will be inevitable.

Observation is a necessary tool throughout the support plan as data will be collected before, during, and after intervention has ended. For instance, the mental health professional should provide the team with clarification regarding medications that are prescribed for reducing a behavior such as aggression with a diagnosis of psychosis. First the team should ask for clarification on how the aggression relates to the psychosis. The relationship should be logical, not just that they are aggressive because they have psychosis but that the individual hears voices that tell her to attack others, providing the linkage between the aggression and the diagnosis. This information can then be used to determine what specific behaviors to observe and what data to collect. What would the team need to observe to verify the person was hearing voices? How will aggression be documented? Is the goal of the medication to reduce the intensity of aggression, the duration of aggression, or just the occurrence? What about positive behaviors – should the intervention increase these? An example of this might be more social interaction as a result of a medication for depression.
Observation also includes the context. Human behavior is contextual. This means that things (e.g. interactions, noise, clutter, space, odors) in the environment can influence how people behave. This means that the environment (living, working, staff, family, schedule, social contacts) all have an important influence on the person supported. Some of these can be observed directly and some may not. It is good practice to consider and collect data with the environment in mind.

**Behavioral Assessment**

There is a positive relationship between challenging behavior and mental health disorders in people with I/DD. This relationship is even stronger with those diagnosed in the severe level of I/DD. It can then be assumed that referrals to mental health services for people with I/DD are made because a behavior exists that is considered maladaptive or challenging. There may be a temptation to be more focused on outer-directed behaviors that cause management problems, such as aggression, property destruction, or sexually inappropriate behavior. These could be possible symptoms of a mental health disorder. It is equally important to view behaviors such as extreme withdrawal or social avoidance as symptoms as well.

A very important contribution the team can make to the mental health examination is the history and current status of the positive behavioral support plan. The mental health professional will be familiar with applied behavioral principles such as antecedents and consequences. They have probably used methods of functional assessment and are proficient at developing hypotheses (best guesses) regarding the behaviors. Programs that ascribe to person-centered planning and positive behavior support must be as well. Since many people with dual diagnosis have come to mental health professionals because of challenging or maladaptive behaviors it is imperative that the team has done their homework in this area. The team should not rely on the mental health system because past behavioral support plans have been less than standard. Before referring to the mental health system the team needs to do some self-evaluation of past or current behavioral support.

The California Statewide PENT (The Positive Environments, Network of Trainers Leadership Team) has developed a guide to evaluate Behavior Intervention Plan Quality, (Wright-Browning, Mayer, Saren, 2013). This guide is meant for teachers but the criteria used to evaluate behavior intervention plans is easily transferable to support plans for agencies that serve adults and adolescents in residential and vocational programs. According to the guide there are 6 key concepts in behavior intervention planning. Three of the basic premises with explanations are listed below:

1. Behavior serves a purpose. All behaviors, including problem behavior, allow the person to get a need met (i.e. behavior serves a function).

   *The behavior support plan must identify the function of the problem behavior in order to develop a plan that teaches a functional replacement behavior.*
2. Behavior is related to the context/environment in which it occurs. Something is either in the environment or not in the environment which increases the likelihood the behavior will occur. 

*The behavior support plan must identify what environmental features support the problem behavior in order to know what environmental changes will remove the need to use the problem behavior.*

3. There are two strands to a complete behavior plan. Changing behavior requires addressing both the environmental features (removing the need for use of problem behavior to get needs met) and requires teaching a functionally-equivalent behavior that the person can use to get the same need met in an acceptable way. 

*A complete behavior support plan must address both strands: make environmental changes that support acceptable behavior, and specify how to teach or elicit the functionally equivalent behavior.*

Other elements that contribute to the success of a plan are: 

4) new behaviors must be reinforced, 
5) implementers of the plan need to know reactive strategies that follow a hierarchy, and 
6) communication between all stakeholders needs to occur frequently.

Using this scale the PENT team encountered several common errors:

- lack of behavioral definitions of the problem behavior
- no analysis of the environment to identify necessary changes
- no correlation between the functional behavioral assessment data and the contents of the behavioral support plan
- reliance on punitive and negative methods

Using the above criteria, the evaluative guide mentioned above, principles taught in North Dakota’s Statewide Developmental Disabilities modules, *Positive Behavior Supports* and *Designing and Implementing Positive Behavior Support Programs*, a team/program coordinator/internal case manager can do some reflection on current and past plans. Once that has been done and the team is in agreement that a mental health professional’s expertise is needed a referral can be made with confidence.

**Planning – regulations**

Federal and state regulations require certain practices in support for people who have a dual diagnosis. These require planning on the part of the program manager/internal case manager/QDDP regarding data collection and team activity. Without this planning the behavioral support plan will be fragmented. Information might be collected after the intervention has started or not at all (e.g. baseline data). Functions of the behavior may not be defined as the data collection was haphazard or did not occur. Regulations require a formalized behavior support plan be used in conjunction with any medications that are used to control behavior (ICF/IDD §483.450). These regulations require:

- Data to justify the use of medication to manage behavior.
- Data to indicate the use of lesser restrictive methods.
Attempts to make environment alterations before more restrictive methods are used.
A functional behavioral assessment.
Active treatment plan integrating the behavioral support plan and medications to manage behavior.
Close monitoring of the medication to determine the efficacy related to the targeted behavior(s).
Close monitoring of medication side effects.
Gradual withdrawal of the medication on an annual basis with data to justify non-withdrawal activity.

Even though these regulations only apply to people who are supported in an ICF/IID program that does not mean that these principles should be ignored because the person is not served in such a program. Objective data must be monitored and used to make judgements about the effectiveness of the interventions.

Behavioral support plans may include medications as one part of the intervention but medications are not the complete or standalone method to managing behavior. In order to have a behavior support plan that produces results the team needs to conduct a functional assessment. The functional assessment is a prerequisite for effective behavioral supports. The QDDP along with the team will need to agree on the operationalized (observable and measurable) definition of all targeted behaviors. For instance:

Team A has determined that past behavioral interventions have been minimally successful. Rita (person supported) has become more agitated and is not sleeping regularly. No data has been taken on these two conditions but they have been on the increase for the past 5 months per staff’s report. The physician has prescribed a sleep aid, but this has not been effective.

Since a functional assessment’s purpose is to make a best guess or hypothesis regarding the function of the behaviors, the program manager/internal case manager/QDDP will first need to determine the behavioral definition of “agitation” and “not sleeping regularly”.

Embedded in the requirement of a functional assessment is the need to collect baseline data. In order to make sure the intervention, teaching, environmental modification and/or medication is assisting the person toward the desired direction/outcome, the team will need to know what Rita was like before. This requires the operationalized definition of the behaviors, observation, and data collection.

The functional assessment, if done correctly, will require time to conduct. Observations, collection of medical records, life events, interviews, and rating scales are all part of the process. It is not enough to have discussions and no observational data. Staff and team members should be involved in the collection of data. The internal case manager/program coordinator/ QDDP is responsible to aggregate the above sources of information to get an overall picture of the person’s present situation.
ICF/IDD regulations require that all medications prescribed for a mental health disorder have the side effects of that medication monitored. Since the psychiatrist has been the prescribing agent it is important to consult with him/her to know which side effects are important to monitor and how might those side effects manifest as observable and measurable behaviors.

The purposes for federal and state regulations and agency policy are to provide the best possible health, safety, and supervision services to people in the human services system. Without them it is easy for services to succumb to what is easy to do and what takes the least amount of resources. When support plans become complex, teams and agencies need guidelines. These regulations require data that has been carefully designed to help teams make the right decisions. This takes planning and coordination.
Chapter 2 Study Questions

1. How might the program coordinator/QDDP assist the mental health professional in gathering information?

2. Match the assessment step with its description:

   |   |   |
---|---|---|
| 1. Family History | A. Information about the present family or living situation, occupation, residential setting, and financial status. Looks at each stage (prenatal, infancy to adolescence, early and middle adulthood, and late adulthood) and ask questions related to typical milestones and events in that stage |
| 2. Medical Assessment | B. Information about family history of mental disorders. The family history documents how the family members have influenced and been influenced by the person’s illness. |
| 3. Social and Developmental History. | C. Medical history, a physical exam, and laboratory tests. Used to detect any medical cause for psychiatric symptoms. |
| 4. Evaluation of Mental Status | D. Information gathered outside of the patient interview. It can include psychological and neuropsychological testing such as achievement and aptitude tests. |
| 5. Collecting auxiliary data | E. Describes the person’s appearance, behavior, speech, emotions, and cognitive and perceptual process. It is collected first hand and in the moment. This exam might include some standardized questions that assess memory, thought process, or attention span. |

3. Compare differences in the treatment approach mental health professionals might have for a person with I/DD to a person without I/DD.

4. Medications, therapy, and behavioral support plans for persons with Dual Diagnosis should be _______________ in the overall plan. This requires collaboration across disciplines.

5. List two challenges that may arise for a mental health professional who has little experience with I/DD or the interdisciplinary teach approach.
6. Describe how an interdisciplinary team might assist the mental health professional in gathering assessment information.

7. Describe how you would explain the principle of the least intrusive alternative to a mental health professional who has little experience with the I/DD population.

8. Arrange each step of the mental health professional’s assessment process in the order it is completed.

___ make a prognosis
___ obtain a history
___ determine a treatment plan
___ summarize principal findings
___ evaluate the person’s mental status
___ collect auxiliary data
___ provide a bio-psychosocial formulation
___ render a diagnosis

9. List one adaptation that can be used when interviewing a person with I/DD who says yes to all questions asked.

10. List one adaptation that can be used when interviewing a person with I/DD that has difficulty with time concepts.

11. Which of the following strategies might be helpful for interviewing people with limited verbal ability?

___ a. Use “when”, “how”, and “why” questions
___ b. Use pictorial multiple-choice questions
___ c. Frequently check understanding of conversation with the person
___d. Use “yes/no” questions when gathering information related to emotions and feelings.
___e. Use “who”, “what”, and “where” questions
___f. Use abstract concepts instead of concrete.
___g. Use longer sentences than the person uses.
___h. Use plain language and avoid jargon.
___i. Use words that the person uses.
___j. Use passive verbs and past tense
___k. Avoid leading questions
___l. Be cautious about using humor.
___m. Use the language system the person uses, i.e. sign language, assistive devices as needed.
___n. Avoid double negatives

12. Why was the DM-ID developed?

13. Place an X next to those statements that are true of the DM-ID.
   
   __ The DM-ID can replace the DSM for help in rendering a diagnosis.
   __ The DM-ID is used where the individual cannot self-report.
   __ The DM-ID can be used by QDDPs, DSPs, Families, case managers to make a mental health disorder diagnosis.
   __ The DM-ID lists diagnostic equivalents of behavioral manifestations similar to those in the DSM.

14. Describe the purpose of a screening tool (checklists, rating scales).

15. What are some methods/tools that will help teams identify and come to agreement on the observable behaviors they will be monitoring?

16. Why would it be important to collect observational data on the environment as well as behavioral data?

17. Check items below that should be included in a positive behavioral support plan.
   
   ___ a general description of the person’s overall mood.
___a statement of the function of the behavior (hypothesis)
___anecdotal or narrative data collection
___description and methods for environmental supports
___description and methods for teaching a functionally-equivalent behavior
___a behavioral description of the targeted behavior
___data that describes the progress of the functionally equivalent behavior

18. When designing behavior support plans, decisions must be based on objective data. List the objective data that is necessary for teams to make decisions on medications and methods in positive behavior support plans.

19. Why is baseline data collected?

20. The __________ is a ‘best guess’ as to the function of the behavior.
Chapter 3 – Pharmacological and Behavioral Supports

Objectives

Upon successful completion of this lesson, staff members will be able to:

• Identify definitions of common terms used in pharmacology
• Define the purpose of medications in an overall treatment plan
• Describe how medications and a positive behavior support plan are used together to improve mental health/quality of life
• List best practices in the use of medications and behavioral support of people with dual diagnosis
• Identify components of the Guidelines for Use of Psychotropic Medications
• Recognize points in treatment where objective data is needed for decision making
• Identify person-centered values that guide crisis planning

Systems that serve people with I/DD in the public schools, community, healthcare, and in family homes have common values: respect, individualization, and inclusion. However, personnel from various sectors use different terminology. You might hear a healthcare professional refer to “treatment” but a DSP uses the word “support” – both mean ways to bring the person to a better quality of life. The systems might also differ based on the professional’s experience in serving people with I/DD. One system is not better than the other - each can learn from the other.

The National Institute of Mental Health (2012) reported an estimated 43.7 million adults ages 18 or older in the U.S. with any mental illness in the past year. This represented 18.6 percent of all U.S. adults. The most common disorders are:

- Obsessive compulsive disorder – 1%
- Schizophrenia – 1.1%
- Generalized anxiety disorder – 3.1%
- Post-traumatic stress disorder – 3.5%
- ADHD – 4.1%
- Personality disorder – 9.1%
- Mood disorder – 9.1%

The most common types of treatments (92%) for individuals with mental illness were outpatient and medication. Medication was used as the sole treatment type in 52% of patients receiving care. In this chapter, we will be focusing on medical or pharmacological and behavioral support.

Terms

Psychoactive drugs: Chemical substances that affect brain functioning, causing changes in behavior, mood and consciousness. These do not necessarily have to be drugs that have been prescribed.
**Psychotropic drugs**: Any drug capable of affecting the mind, emotions, and behavior. Many illicit drugs, such as cocaine, are also psychotropic.

**Pharmacology**: The branch of medicine and biology concerned with the study of drug action.

**Psychopharmacology**: The study of the effects of medication on mood, sensation, thinking and behavior, focusing primarily on chemical interactions with the brain and observing changed behaviors in a measurable behavioral form.

**Neuroleptics**: Medications primarily used to manage psychosis (including delusions, hallucinations, or disordered thought), in particular in schizophrenia and bipolar disorder, and are increasingly being used in the management of non-psychotic disorders. (also called antipsychotic medication).

**Second generation antipsychotics**: Also referred to as atypical antipsychotics. The term "atypical" refers to the fact that they generally do not cause the same degree of movement side effects that are common to the first generation, or so-called "typical" antipsychotics.

**Polypharmacy**: The administering of several drugs at the same time. Sometimes used to indicate excessive administration of drugs. The term is generally used when two or more medications of the same classification are used (e.g. two antidepressants) as there is no good research supporting such practices.

**Co-Pharmacy**: The administration of medications in combination from different classes (e.g., antipsychotic and antidepressant) in specific combinations to work together to reduce symptoms. While it can be overused, there is good research showing that it can be very effective when used sparingly.

**Use of Psychotropic Medications**

Medications for mental illness were first introduced in the early 1950s with the antipsychotic, chlorpromazine. Many other medications used for various mental health disorders have been introduced since then. Generally, medications improve the lives of people who have mental health concerns. In most cases, a prescription for a psychotropic drug from a psychiatrist is part of a complete treatment that has been preceded by an assessment as described in Chapter 2. A primary care physician may also prescribe psychiatric medication, but he/she may not have conducted as thorough of an evaluation as required of the mental health professional (Holden & Gitlesen, 2004).

Just as an aspirin reduces a fever without curing an infection, psychotropic medications only control symptoms. Reducing symptoms through medication is one arm of treatment. If someone is too depressed to talk, a medication may improve their symptoms enough so that he/she can benefit from psychotherapy or counseling. Medications may “turn off” the voices heard by someone with psychosis and help them see reality more clearly. Antidepressants can lift the dark, heavy moods. The degree of response depends
on a variety of factors related to the individual and the disorder. Medications do not produce the same effect in everyone. Some people may need larger doses than others and some respond to one medication better than another. The person’s age, sex, size, illness, diet and habits (e.g. smoking) can influence the person’s response to medication.

A behavioral support plan is required in conjunction with any form of behavior altering drug for people served in the human services system with or without diagnoses consistent with the medications being used. Behavior intervention plans are not designed to exclusively remediate mental health issues, although they can be an important contributing element. Rather, they specify how the person challenged by mental health factors will be supported in their current environments, strengthen coping skills the person can use to offset the mental health conditions, and help the support network better identify when and how to provide supports and coaching to be successful.

Psychotropic Medications in I/DD Population

Use of medication for mental health disorders in people with I/DD has been riddled with controversy. Historically, dual diagnosis was denied as possible for people with I/DD so no treatment was given. When medications for the general public became effective to treat behavioral symptoms, sedatives were used to treat seizures and barbiturates to treat insomnia. Antipsychotics such as chlorpromazine (Thorazine) were prescribed starting in the 1950s, but recent advances have produced medications that have fewer side effects.

The advent of de-institutionalization and more research advances in the understanding of cognitive disabilities gave rise to use of medications to deal with improving behavioral functioning for conditions such as hyperactivity and anxiety. Psychotropic medications became the treatment for agitation and other behavioral disturbances for individuals with I/DD living in the large institutions. In the late 1960s, Lipman (1967) reported that up to 50% of residents in institutions were receiving some type of psychotropic medication. Concerns arose over the misuse of medications and the resulting side effects including tardive dyskinesia (i.e. involuntary movements). Litigation and resulting regulation started to place the emphasis on habilitation rather than medication as the only treatment. Standards of care began to place limitations on the use of psychotropic medications and required:

1. A specific description of the behavior to be modified by the medication
2. Gathering of baseline data
3. Data collection/monitoring of identified target behaviors
4. Use of data to determine the effectiveness of the medication and to determine need or direction of changes

Federal and state regulations were developed and resulted in major changes for people with dual diagnosis in 1988. The Council on Quality and Leadership (CQL) and Center for Medicaid and Medicare Services (CMS) produced standards that are outlined later in this chapter. However, questions arose over the seemingly anti-medication bias. Again, litigation regarding personal choice and right to effective treatment resulted in the adoption of Personal Outcomes by CQL in the 1990s which placed more emphasis on personal outcomes and choice.
Currently best practices emphasize positive behavior support which suggests that treatment interventions include a functional behavioral assessment to:

1. Rule out medical variables
2. Assess environmental factors
3. Examine social, communication and learning variables
4. Evaluate psychiatric indicators

Even though there has been considerable progress made since the 1960s, people with I/DD present with a much higher average occurrence of mental health disorders than the general population and in use of psychotropic drugs. In some states, behavior altering drugs can be used without a mental health disorder diagnosis. A common complaint is the widespread use of antipsychotic drugs, and particularly the traditional neuroleptics (thioridazine, haloperidol, chlorpromazine). Claims have been made that they are over prescribed to people with intellectual disabilities without the use of behavioral approaches (assessment, data collection, teaching replacement skills).

* for a listing of classes of drugs see appendix

The National Core Indicators (2014 & 2012) reports:

Of the population of I/DD as reported by agencies serving adults who needed extensive support for behavioral challenges, 93% had a mental health disorder diagnosis. The most common psychiatric diagnoses are:

Other – 10%
Psychotic disorder – 15%
Anxiety – 21%
Mood Disorder – 33%

Extensive behavioral support was defined as a frequency to require regular assistance in managing self-injurious, disruptive and/or destructive behavior. Of those who had a mental health disorder diagnosis 88% took medications for one or more of the above diagnoses.

National Core Indicators Data Brief – Behavior support (2014)

Among the people taking medications for mood, anxiety or psychotic disorders, 41% did not have a psychiatric diagnosis.

National Core Indicators Data Brief, Psychotropic medications (2012).

**Psychiatric Symptoms and Challenging Behavior**

There is a statistical relationship between the presentation of challenging behavior and a diagnosed psychiatric disorder (Emerson et al., 2000; Felce, Kerr, & Hastings, 2009; Kearney & Healy, 2011; Marshall, 2004). The question of relationship is complex. Consider the following:
• Depression may be associated with an unwillingness to participate in activities, making the activities aversive. If the person learns that challenging behavior can terminate such events or avoid requests to join in events, then the immediate cause of the challenging behavior is not the depression but the activity or request to join the activity. The underlying cause may be the psychiatric disorder of depression. Psychiatric symptoms can be emotional, motivational states that increase the probability of challenging behavior (Holden & Gitlesen, 2008).

• The interpersonal style of staff can exacerbate environmental causes of the challenging behavior (or perceived psychiatric symptom). Willems, Embregts, Bosman, & Hendriks (2014) found that staff exhibited much less friendly, moderately more assertive control and less supportive, interpersonal behavior when working with people who present challenging behavior.

• A lifetime of experiencing disability and inability compared to peers may increase the likelihood of challenging behavior and certain risk factors for mental illness such as social isolation, separation from loved ones, sudden and unplanned life changes, or unsympathetic or ill treatment.

Imagine a world where you are constantly surrounded by individuals who are more skillful than you. You have memories of childhood where siblings, relatives and peers were all able to figure out things more quickly than you were. Imagine being able to remember the points in your life where younger siblings “passed you by” in terms of problem-solving skills. If this had been your past, year after year since as far back as you could remember, how would you feel when someone asked you to do something you weren’t quite sure what exactly they were asking? How or would you express frustration?

• Using circular explanation for the behavior can lull team members and families into using the effect of the behavior as the cause. The person is aggressive because they have a diagnosis of psychosis; the child is uncooperative because of his hostile attitude. The woman is aggressive because she has an impulse control disorder and the aggression is the evidence for a diagnosis of impulse control disorder. This is an oversimplified explanation and often leads to a prescription from the psychiatrist.

**Something to Think About:** Are challenging behavior and mental illness in people with I/DD manifestations of the same phenomenon?

In Chapter 1, different models that attempt to explain the cause or etiology of mental illness were reviewed. The World Health Organization’s explanation: “The occurrence of a mental health disorder is best viewed as the outcome of complex interactions between developmental, biological, psychological, and socially determined risk.” best fits the person-centered value of services to this population. It encompasses an integrated approach to not only looking at symptoms but restoring the person to mental health wellness.
In an integrated model, as described by Dosen (2007), emphasis is placed on assessment of developmental delays in not only cognition but also social, psychological, and biological areas. At each developmental level, the person has specific emotional needs, shows specific motivations, coping abilities and adaptive interactions with the environment. The developmental theory explains that maladaptive behavior may emerge as a result of internal or external stimuli in stages of development and progress or accumulate leading to onset of psychiatric disorders.

A 21 year old man with mild ID was referred for abrupt and sometimes dangerous aggressive behavior. Through examination and assessment it was determined that emotional development was low (<2 yr), and aggression was motivated by frustration. This aggression was present since childhood. The integrated treatment program first defined his basic emotional need of security and developing autonomy. Staff were instructed to provide acceptance and attention to main emotional needs and not his aggressive behavior. His environment was adapted to provide opportunities for positive activities. He was taught to recognize the first symptoms of his frustration and anger to self-manage with appropriate actions. He was also prescribed a psychotropic medication to diminish his enduring irritability.

Dosen (2007)

When a psychiatrist examines a person he/she typically does not view challenging behavior by itself, but in the context of how it co-varies with other symptoms to make a differential diagnosis. Aggression may be of less interest in and of itself than when it is associated with loss of sleep, family history, and life experiences which would assist in making an accurate diagnosis.

A treatment or support program that only relies on medication or only relies on behavioral support will most likely produce limited success. If the preliminary psychiatric evaluation does not look at the entire life of the person, interventions may only be primarily directed to the symptoms (challenging behavior) of the psychiatric diagnosis rather than whole person’s experience in life thus far. A combination of psychiatric treatment (medication and/or psychoanalysis) and behavioral support is best practice.

Best practices include:

- Rather than treating the behavior, identify the underlying cause(s) of the behavior disturbance and treat them.
- Use an interdisciplinary approach to identifying the underlying cause.
- Target medication trials to specific symptoms (e.g., irritable mood) or behaviors (e.g., self-injury), and monitor carefully for effectiveness, side effects, and risks vs. benefits of continuation.
- Monitor “target” symptoms and behaviors daily by the patient or caregiver(s).
- Change only one medication at a time and wait long enough for an effect.
- If anti-seizure medications are used as mood stabilizers, consider the anticonvulsant properties when adjusting the medications.
- Before starting another medication trial, withdraw the previous trial medication slowly.
Regulations in Use of Psychotropic Medication

Many people who exhibit challenging behavior have been given antipsychotic medications. There is evidence that there is an overreliance on these drugs to control behavior. It is not uncommon to see people with more than one or two medications for treatment of mental health disorders. Before we place blame, we need to remember:

- The evaluation and diagnosis process in persons with ID is very difficult and can result in misdiagnosis.
- Doctors feel under pressure to give medications when a family or team member presents the difficulty of living with the problem behavior.
- Psychiatric help (particularly professionals with experience working with dual diagnosis) is difficult to find.
- General practitioners are not trained in psychological/psychiatric methods of evaluation. Medications prescribed by a general practitioner are usually based on the behaviors rather than a thorough evaluation. In the United States, among the general population, almost four out of five prescriptions for psychotropic drugs are written by physicians who are not psychiatrists (Smith, B. 2012).

The American Journal on Mental Retardation (now the American Journal on Intellectual and Developmental Disabilities) devoted the entire May 2000 issue to guidelines in treating individual with dual diagnosis. Guideline 4 “Medication Treatment: General Principles” summarizes the best practices. These were developed from the Healthcare Financing Administration and Health Standards and Quality Bureau Center for Long Term Care (1996), and the *Guidelines for the Use of Psychotropic Medication* (Kalachnik et al, 1998). These were verified by experts in the field of medications for use with psychiatric disorders and are summarized below. Please note that MR (mental retardation) was the term used for “intellectual disabilities” at the time of publication.

| Psychotropic medication use should be based on psychiatric diagnosis or a specific behavioral-pharmacological hypothesis. This results from a diagnostic and functional assessment that addresses: | medical pathology  
psychosocial and environmental conditions  
health status  
current medications  
presence of a psychiatric condition  
history, previous intervention  
a functional analysis of behavior |
| --- | --- |
| Dosing Strategies | Start low, go slow, use lower initial doses and increase more slowly than in clients/patients without MR  
Use same or lower maintenance and maximum dose as in clients/patients without MR  
Periodically consider gradual dose reduction  
Reduce doses gradually at the same rate or even more slowly than in clients/patients without MR  
Avoid frequent drug and dose changes unless there is a valid reason for the change (e.g. development of side effects) |
| Evaluating treatment effects | Identify specific behaviors to track in order to better evaluate medication efficacy |
| Blood levels | Collect baseline data before beginning medication
| Track specific behaviors using recognized behavioral measurement methods (frequency, time sample) and summarize data by time period and/or drug and dose condition.
| Consider whether medication is compromising functional status (e.g. activities of daily living)

- Levels should be taken when serious side effects appear, nonresponse to usual doses, worsening of behavior, concern about compliance, determine level at which a positive response occurs.

| Regular review | Meet at least every three months.
| Prescriber sees the individual at each review.
| Review determines whether medication is still necessary. Lowest dose used.

| Evaluating for side effects | Do this regularly and systematically.
| Use a standardized assessment instrument constructed from standard pharmaceutical or medical references.
| Monitor for drug interactions.
| Assess for tardive dyskinesia if using antipsychotics using a standardized assessment instrument.
| Assess side effects at least every 6 months.

| Polypharmacy | Keep medication regimen as simple as possible.
| The use of two medications from the same therapeutic class (intra)class) at the same time is rarely justified.
| The use of two or more medications from different therapeutic classes (interclass) at the same time requires a rationale.
| A combination of medications is appropriate in certain situations (e.g. psychotic or bipolar depression, partial response to a single medication, presence of a co-morbid condition).

| Indications for hospitalization | Risk of suicide, self-injury, or harm to others.
| Acute psychotic symptoms

The Center for Medicaid and Medicare Services (CMS) requires facilities licensed to provide intermediate care for people with Intellectual Disabilities (ICF/ID) to follow specific practices when using medications to manage inappropriate behavior. Major points of CMS regulations (2013) for “medications prescribed and administered for purposes of modifying the maladaptive behavior of an individual in this type of service” are listed below: (Note: This is not an inclusive list. For a more detailed listing of regulations and specific expectations within each rule consult the CMS reference.)
• Medication to manage behavior may be considered a restriction. Follow agency policy related to inclusion of medication in a support plan for a person with dual diagnosis.

• Written informed consent is needed.

• Risk assessment must be done through the team process.

• Medications must be used within an active treatment program targeting elimination of the specific behaviors which are thought to be drug responsive.

• Implementation and monitoring of non-drug intervention (positive behavior support plan) in conjunction with the use of medication to manage the behavior(s) are required.

• Use of medication must be based on a comprehensive psychiatric evaluation.

• Regular reviews are required which include attempts to withdraw the medication and monitor side effects.

• Staff must be aware of what response the drug is expected to achieve.

The individual for whom the medication is prescribed should always be involved in the decision to use the medication. Even when the person has a legal representative appointed to help make decisions, the individual should be involved. Anything done for or on behalf of the person should be the least restrictive of their basic rights and freedoms and in their best interests.

Note: ND Protection and Advocacy (2015) defines a chemical restraint as: medication that is used to manage behavior, such as in an emergency situation or per their medication or behavioral intervention protocol such as in PRN – Pro re nata “as needed” or “as the situation arises” order.

Behavioral Support

Behavioral programming or applied behavioral methods are usually considered first in any attempts to reduce or eliminate challenging behavior. In the justification for resorting to medications, which may be considered a restraint, lesser intrusive methods are necessary to use first. Behavioral methods require operational definitions (specific, observable, measurable) of the target behaviors and a functional assessment. With the use of medications, functional assessment may be ongoing.

Using methods of applied behavioral analysis and positive behavior support in addition to medication intervention make the collection of data even more important but also more complicated. Consider the assumption that is common about medications for physical ailments. If the symptoms of the malady disappear after the completion of a medication regimen, then it is logical to assume the person had the specific sickness for which it was prescribed. In the arena of mental health disorders and particularly challenging behaviors, this is not true but a widely held assumption. For example, if the antipsychotic prescribed reduced the targeted behaviors of self-injury, screaming and physical aggression then supporters assume that the person must have a psychotic disorder. This explanation is similar to the circular thinking explained above. Response to the drug does NOT prove or disprove diagnosis. An explanation of psychotropic medications treatment complexity is provided in an interview with Dr. Andrew Levitas, MD and Dr. Anne Hurley, PhD (2008):
"We can only follow signs and symptoms to measure improvement or lack of. Psychiatrists often are unsure of diagnosis, so we may measure improvement by changes in those signs and symptoms. If a person cannot sleep and is prescribed an antidepressant and improves—did the person really have depression? There would need to be appetite, mood, and levels of energy changes along with sleep changes to make a case for depression. In addition, antidepressants treat anxiety disorders which can cause sleep disturbance. Some antidepressants are sedating and can cause sleep in anyone."

The danger to this premise, type of drug working = solid diagnosis, is that teams will be hesitant to begin withdrawal of something that is working and will negate the need to continue collection of data. They feel they have found relief for the person. This type of assumption paves the way for justification of abandoning the positive behavior support plan and only relying on medication to control symptoms. Absence of the challenging behavior is only one part of the plan. The team needs to focus on improving mental health – quality of life.

If medication effectiveness is only determined by the absence of challenging behaviors and the presence of positive behaviors is not taken into account, there is no true assessment of medication/behavioral support effectiveness. **Positive outcomes are achieved when more appropriate responses replace the challenging ones.** Positive behavior support has many components but the most essential feature is the functional behavioral assessment (identification of the events/circumstances that reliably predict and maintain problem behaviors). This is accomplished by understanding the underlying causes and by teaching replacement behaviors.

The goal of medications should be to make the problem behavior responsive to change. How do we measure this part of the Positive Behavior Support plan? Focusing data collection on measuring the intensity, duration, or frequency of the challenging behavior is not sufficient. The function of the behavior must also be assessed and monitored. By tracking various dimensions of the behavior, the team can determine when it is time to: 1) make changes in the medication portion of the positive behavior support plan and/or 2) modify the supports/methods in the plan.

Jeremy is a 24 year old male diagnosed with autism, profound intellectual disability and hydrocephaly. He lives in a group home and attends a workshop daily. Target behaviors were self-hitting, head banging, and destructiveness which were defined as tearing, breaking or throwing material. Compliance was also measured as correctly responding to a verbal or gestural prompt. The introduction of Risperidone decreased the destructive behavior when directives or compliance was expected but destructive behaviors remained unchanged when a tangible was not available or when Jeremy was not receiving social attention. The self-injurious behaviors decreased across all conditions (tangible, compliance, social attention).
What might be some considerations the team could make based on this analysis?

- Since destructive behaviors decreased when directives were presented this might be the opportunity to teach some appropriate communication to delay or refuse the request.
- Once Jeremy understands the use of the appropriate function of communicating his desires in the compliance condition, the same methods could be introduced for the tangible and attention conditions. Timing in introducing this intervention would be important.

This example does not take other variables into consideration, i.e., changes in staff, physical conditions, family events, roommates or co-workers. These are viable influences, but it is important to use objective data to determine if they have significant power to explain the function of behavior.

Merging frequent functional assessment data with the expertise and assessments from the psychiatrist can assist in getting the best picture of the individual. This regular monitoring is necessary to ensure that a person is not on medications for long periods of time. It also allows for a discussion of side effects and correct dosages and helps the team determine if the plan is headed in the correct direction.

Remember that the best practices summarized earlier stipulate that the individual is present for medication review. Medication reviews require preparation. This means that:

1. The individual should be coached before the appointment. Inform them where they will be going, what he/she will be doing, and who they will be talking to etc. Help them think about questions they may have.
2. Staff need to prepare. They need to bring data and know that specific language is needed instead of general statements. Talking in general terms (i.e., “doing better” or “more agitation lately”) should be avoided. These statements are not as helpful as specific language. The target behavior should be operationally defined. Present frequency data as well as other important information about when and where the behavior occurs.
3. Come with specific questions. The role of the program manager/QDDP/case manager should be active rather than passive. The psychiatrist is busy and needs to use the time wisely – you do too.

**Positive Behavior Support Plans**

Whether the challenging behavior has been treated in various ways prior to your role as a program manager/QDDP/case manager or the behavior recently emerged, the steps in supporting the individual should be based on positive behavioral supports.

*Chloe is a 62 year old female with intellectual disability who moved to your transitional living program 2 months ago. Her behavior program is only service oriented (service objectives) and tracks the occurrence of agitation (defined as refusals and screaming). At her first physical exam it was brought to the physician’s attention that there have been complaints from*
staff members of increased combativeness and agitation when staff try to help her complete her activities of daily living. Chloe had similar behaviors of increased agitation in the winter and was found at that time to have a urinary tract infection. She is otherwise relatively independent at home. Her medications are as follows:

- Risperidone 3 mg po BID
- Quetiapine 400 mg po BID
- Clonazepam 1 mg po TID
- Fluvoxamine 100 mg po BID
- Divalproex 500 mg po BID
- Phenytoin 300 mg po daily
- Gabapentin 800 mg po BID
- Hydrocodone/Acetaminophen 5/500 1-2 po Q6h prn pain
- Levothyroxine 125 mcg po daily
- Benztropine 1 mg po BID
- Calcium Carbonate antacids 2 po TID
- Aspirin 325 mg 1 po daily
- Calcium carbonate 600 mg + Vitamin D 125 IU 1 po BID
- Multivitamin 1 po daily
- Pink Bismuth 30 mL po daily
- Docusate sodium 100 mg po daily
- Metoclopramide 10 mg po BID prn constipation
- Ferrous sulfate 325 mg po BID
- Ranitidine 300 mg po BID
- Omeprazole 20 mg po BID

The doctor is concerned with the number of medications and wants to work with the team to support Chloe. He has question about the number of medication and any comorbid disorders common in individuals with developmental disabilities. The untangling of this support program should begin. But how? What are the first steps?

Chloe is relatively new in her residential placement but has lived there long enough for everyone to get to know her.

1. The first step is to define the challenging behavior. To “operationalize” or define the behavior means to describe the behavior in terms of what you see or hear. It is an explicit definition that two or more observers would be able to identify. This is an essential step as it will aid in writing the goal of your support plan and to conduct the functional behavioral assessment.

2. The second step is to collect data on the defined behaviors to obtain a baseline. This should begin immediately. This is important to assist in determining the effectiveness of the support plan the team develops. You need to know where you have been to determine if you have arrived. Usually the amount of baseline is determined by the trend. In other words, you should continue baseline until the trend is stable – no wide fluctuations or cycles.
3. Concurrently, conduct a thorough investigation of medications. You will want to know the type of medication (what each one is for), dosages (what levels are considered normal, high etc.), what behavior each psychiatric medication is addressing, and side effects. A long conversation with the former provider would be important. If that is not possible, talk to the physician that prescribed the medications.

4. What if you come up with dead ends? Another activity that is done concurrently or as soon as possible is to rule out any medical cause for the behavior. Another trip to the doctor for Chloe should occur as soon as possible. As this was a reason for the past incident it is important not to wait on this.

As a program manager/QDDP/case manager, you will be responsible for coordinating and making sure that the support plan is technically sound. The visit to the doctor will bring changes and these will interfere with your baseline data. Technically sound programs do not introduce changes in the midst of baseline but your first obligation is Chloe’s health and safety.

5. The team should meet as soon as possible. The behavior plan needs to be reviewed. Currently, it is only tracking the absence of a behavior. Is the status quo the consensus of the team? A review of the purpose of each medications is essential. The physician asked questions regarding the number of medications and related conditions. You also need to determine:
   a. Does the team see the current behavior state as needing a more or better intervention?
   b. Is the behavior occurring often enough for concern?
   c. Is it threatening safety of others and Chloe?
   d. Is it interfering with learning and relationship development?
   e. Is it occurring across environments?

6. If the baseline data is stable and no changes have been made to the medication regimen, begin to collect information on the possible functions of the targeted behavior. The four main functions that maintain behaviors are:
   - Escape/Avoidance: The individual behaves in order to get out of doing something he/she does not want to do.
   - Attention Seeking: The individual behaves to get focused attention from parents, teachers, siblings, peers, or other people that are around them.
   - Seeking Access to Materials: The individual behaves in order to get a preferred item or participate in an enjoyable activity.
   - Sensory Stimulation: The individual behaves in a specific way because it feels good to them.

By understanding the function of the behavior, we determine how to select the replacement behaviors. ABC analysis, scatter plots, observations, and interviews can be done to determine additional factors that maybe influencing the behavior. Those factors may be:
7. Once the team has met and determined the best possible guess as to the function of the behavior, the hypothesis should be written to guide support plan development. The hypothesis statement should state under what conditions the behavior occurs, description of the behavior, and what they achieve: “When ______ occurs, Chloe ______ in order to ________.”

More information is provided in the next steps for selecting replacement behaviors and other interventions to include when designing the support plan are discussed in Designing and Implementing Positive Behavior Support Plans module in the North Dakota Community Staff Training program curriculum.

Other considerations include the need to plan for medication reduction. What data will be collected while medications are changed/reduced? Also, you may need to schedule a complete psychiatric assessment (if one has not been done).

The steps delineated above may vary depending on the circumstance, but the basic steps must be addressed. These steps are ones that lead the team and individual to determine the function of the operationalized behavior, the influences the mental illness has on behavior, the data collection methods (initially and ongoing), and the impact of medications essential to a successful plan. It is also important to view the behavior support plan as a bridge of information (history) when teams experience turnover. Consistent approaches, documentation of changes, and data monitoring are vital to successful support.

Support for dually diagnosed people should not primarily focus on eliminating challenging behaviors and eliminating stress factors. The focus should be on teaching new sets of adaptive behaviors. It should include teaching the person to recognize and manage their symptoms (internal control). The support should also teach and create opportunities for social acceptance, social relationships, and positive affection. These are essential elements in working towards long-term mental health for people with intellectual disabilities. The prerequisites of mental health of people with intellectual disabilities include a balance of social skill development, a place of one’s own and a role in one’s surroundings, and opportunities to function according to one’s own ability.
Crisis Management

Individualized plans also need to include methods to provide adequate supports to the person experiencing a crisis. Proactive approaches emphasize prevention and develop capacities of staff to provide effective supports during crisis situations. In any crisis situation, the safety of the individual, other people, and the rights of the person must be safeguarded. Unfortunately, crisis plans can be influenced by capacity barriers of the agency, family, or community. However, these limits should not dictate the end result. Teams always should plan based on the individual’s needs – not what the program or community can offer. Supportive services may range from a mobile crisis intervention team to emergency room services. The plan should be individualized to the person supported. (See sample in Appendix.)

Brammer (1985) defined crisis as: "the experiencing of ... a situation as an intolerable difficulty ... that exceeds the person's current resources and coping mechanisms (1)." It "... usually refers to a person's feelings of fear, shock, and distress about the disruption, not the disruption itself.

People often think of the hospital environment as places where crises are taken under control but it is less than a “therapeutic” place. Hospital staff may not have experience with people with dual diagnosis as defined in this training. Hospital stays are usually short, transient, and disruptive to the usual secure routine; and resources cannot easily be adapted and individualized to accommodate the learning styles of individuals with I/DD. Crisis management should not be left to the medical community or the emergency room staff.

The team must plan for the possibility of a crisis and define the point at which crisis intervention will start. For the general public, these are considered crisis points:

- Suicide ideation: expressions about how to kill oneself, which can range from a detailed plan to a fleeting consideration and does not include the final act of killing oneself.
- Making choices that place that person at serious risk.
- Serious side effects from medications.
- Drug overdoses.
- Acute psychosis (e.g., hallucinations or delusions).
- Nonsuicidal self-injury: deliberately hurting oneself without suicidal intent (e.g., cutting, burning).
- Reaction to trauma.

The above points might be a starting place for teams to consider in their plan for people with dual diagnosis. However, the core elements of responding to a mental health crisis should be person-centered. The Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2009) suggests the following values guide the crisis plan:
- Harm. Consider risks and benefits. Control danger to allow for watchful waiting over immediate risk of significant harm. Minimize the duration and restrictiveness of interventions used.
- Avoid rote interventions. Instead use personal preferences/accommodations and consider how goals can be incorporated into the crisis response.
- Assist the person in regaining control. Consider the person an active partner rather than a passive recipient.
- Personal safety. Consider what is needed for that person to experience a sense of security and what intervention would increase feelings of vulnerability.
- Based on strengths. Include resources the person can use not only to recover from the crisis but to prevent another.
- Consider the whole person. Even though they are experiencing a mental health crisis, they have other issues in their life that are usual for any person. These could include job, relatives, pets, etc.
- The person is a credible source. The person needs to be allowed to describe (as much as possible) their experience. This is important for understanding the person’s strengths and needs.
- Evaluation. Consider those factors that contributed to the crisis and use that information to prevent the next crisis.

The perspective of crisis planning or management must be forward-looking or pro-active rather than just reactive. Success should be viewed as prevention of further crisis and returning the person to a stable life in the community. This takes an involved team; one that communicates consistently, uses the data to make decisions, and knows the person they support well. They advocate and make plans for that person based on what they need rather than what is available.

Summary

While dual diagnosis might seem complex, there are solutions and best practices that can help people live quality lives. It requires an interdisciplinary team that is willing to contribute and release their role, communicate across all members and know the person well. The plan the team produces should be comprehensive. Positive support plans should address quality of life and community inclusion, not just reduction of symptoms. Agencies should consider their services capable of supporting the person regardless of the level of psychiatric disorder or intellectual disability. The challenge is not with the individual but with building a successful support plan. Professionals from the mental health field and intellectual disabilities need to train and educate each other. Data are a universal language.
Chapter 3 Study Questions

1. What is the most common type of treatment for people who have a mental health disorder in the general population?

2. Define the following terms:
   - Psychotropic drug
   - Psychopharmacology
   - Neuroleptics
   - Atypical antipsychotics
   - Polypharmacy

3. What is the purpose of using medications in the treatment plan for a person with dual diagnosis? Give an example.

4. Explain the statement, “Psychiatric symptoms can be emotional, motivational states that increase the probability of challenging or maladaptive behavior.”

5. What is the purpose of the functional behavioral assessment?

6. What are some explanations for over-reliance on medication for treatment of mental illness in people with I/DD?

7. According to the Guidelines for Use of Psychotropic Medications, list three of the suggested guidelines for evaluating treatment effects.

8. According to the Guidelines for Use of Psychotropic Medications, list two of the suggested guidelines for polypharmacy.
9. According to the *Guidelines for use of Psychotropic Medications* monitoring for side effects should include:

10. Explain the statement, “The goal of medications should be to make the problem behavior responsive to change.”

11. Would data collection on the challenging or target behaviors cease once the medication for the treatment of the mental health disorder starts? Why or why not?

12. List factors that might be influencing the challenging or target behavior when completing a functional behavioral assessment.

13. Support for people with a dual diagnosis should is not exclusively focused on eliminating challenging behavior and eliminating stress factors. Where should the focus be?

14. What steps should the QDDP take to prepare for ongoing treatment reviews with the psychiatrist?

15. Define elements of a mental health crisis.

16. A value of crisis management is personal safety. What does this mean? Give an example.

17. A value of crisis management is evaluation. What does this mean? Give an example.

18. What is considered success in crisis management?
Chapter 4: Cognitive Behavioral Therapy Approaches

Objectives

Upon successful completion of this lesson, staff members will be able to:

- Define the goal of cognitive behavior therapy
- Identify factors that might hinder the use of cognitive behavior therapy with people with I/DD
- Describe how self-determination can be fostered by cognitive behavior therapy
- Describe methods of different types of cognitive behavior therapies
- Describe how DSPs can be supporters of cognitive behavior therapy

As a form of psychotherapy, cognitive behavioral therapy (CBT) is a treatment that focuses on examining the relationships between thoughts, feelings and behaviors (NAMI, n.d.). Also known as “talk therapy” (because a person speaks with a trained therapist in a safe and confidential setting), CBT is a short-term intervention which focuses on problem solving with an emphasis on exploring and understanding feelings, changing unhelpful thinking and behavior, and gaining coping skills. Cognitive Therapy (CT), or CBT was pioneered by Dr. Aaron Beck in the 1960s, while he was a psychiatrist at the University of Pennsylvania. Dr. Beck’s research found that CBT resulted in long lasting improvements when people in treatment for mental illness changed their underlying beliefs about themselves, their world, and other people. Dr. Beck called this approach “cognitive therapy."

The foundation of cognitive behavioral approaches can be summarized as follows:

- Thoughts, beliefs, and perceptions influence overt behavior as well as emotion or affect.
- People are active learners, not just passive recipients of environmental influence. Their learning histories can result in cognitive dysfunctions or wrong patterns of thinking.
- The person understands the intervention strategies and goals and participates in the planning.
- Treatment is focused on creating new adaptive learning to overcome cognitive dysfunctions and produces positive changes that will be generalized outside the clinical setting.

(Stenfert-Kroese, 1997)

Cognitive behavioral therapy has been used with people in the general population to become aware of inaccurate or negative thinking, to view challenging situations more clearly, and to respond to them in a more effective way. This form of therapy has been very helpful in treating mental disorders or illnesses, especially anxiety or depression. In addition, cognitive behavioral therapy is a useful tool to address emotional challenges in the following areas:

- Managing symptoms of mental illness (either by itself or in combination with other treatments)
• Preventing a relapse of mental illness symptoms
• Learning techniques for coping with stressful life situations
• Identifying ways to manage emotions (such as anger or sadness)
• Resolving relationship conflicts
• Learning better ways to communicate
• Coping with grief
• Overcoming emotional trauma (related to abuse or violence)
• Managing chronic physical symptoms (such as pain, insomnia, or fatigue)

(Mayo Clinic, n.d.)

While there is substantial data to support the use of CBT with individuals in the general population, evidence behind the use of CBT with people with I/DD is much more limited. Prior to the 1960s, professionals believed that people with cognitive disabilities could not be diagnosed with a mental illness because they were not capable of worry or expressing feelings. Maladaptive behavior was incorrectly viewed as a result of the intellectual disability and thus not treatable. This caused many people who needed mental health services to go without. Some practitioners still believe that people with I/DD do not have the potential to identify feelings, problem solve, or manage themselves to direct their own lives. Freud (1904) stated (as cited in Stenfert-Kroese, 1997, p.5) that psychoanalysis is not suitable for “those patients who do not possess a reasonable degree of education and a fairly reliable character.” People with intellectual disabilities have often been seen as unable to benefit from cognitive and other talking therapies because of communication barriers and limited understanding and experience in social contexts. Factors to consider related to the use of CBT as part of the treatment plan for people with I/DD include:

• CBT requires the ability to reflect upon the meaning and motivation of behavior and make inferences about beliefs. It requires ability to understand the relationship between beliefs and emotions.
• People with I/DD might have a lack of confidence in their cognitive abilities. They may not believe that they will be successful in CBT.
• People with I/DD generally have less control of their lives than those without disabilities. They may not see themselves as responsible for their own destinies.
• The focus person may not see the need for therapy. Their referral to a psychologist or psychiatrist is often facilitated by someone else such as a case manager or caretaker.

While studies involving the use of cognitive behavioral therapies with people who have I/DD are minimal, there is growing support internationally for appropriately modifying the intervention to simplify and adapt the procedures used in CBT for this population. Like members of the general population, cognitive behavioral therapy can be an effective tool to help individuals with disabilities to better manage stressful life situations.

Self-Determination

Cognitive Behavioral Therapies are a type of intervention that can help people with I/DD to have more control in their lives. Because of this, Cognitive Behavioral Therapies align nicely with the principle of self-determination. Self-determination theory (SDT) states
that human beings can be pro-active and engaged or alienated and passive. The degree of self-determination is largely based on social conditions in which the individual develops and functions. Self-determination theory cites that there are three basic human needs: competence, autonomy, and relatedness. When these needs are met, people become self-motivated, engaged, and growth oriented. When the three basic needs are thwarted, people tend to lack self-motivation and social integration. When people are merely externally controlled (what happens to them is determined by others) they are less interested, less motivated, and less confident.

People have a natural tendency to be curious, try new challenges, exercise their capabilities, explore, be playful and have the desire to learn. When people are in their healthiest state, they tend to do these things without any obvious reward – they are intrinsically motivated. Maintaining this state or level of mental health requires supportive conditions. Knowledge of conditions that foster or undermine human potential can assist teams in the design of environments/conditions that maximize development, performance and well-being. Personal satisfaction from activities and events (intrinsic motivation) and external consequences (extrinsic motivation) are important factors for the team to evaluate to understand what is important to the person.

What are some non-supportive conditions that would disrupt this state? In the general population, non-supportive conditions or externally motivated conditions are threats, tangibles, deadlines, directives, and pressure. The “locus of control” is outside of the person or extrinsic. Ryan & Deci (2000) found that acknowledgement of feelings and opportunities for choice and self-direction enhance intrinsic motivation because they allow people a greater feeling of autonomy.

Promotion of self-determination in people with I/DD is considered best practice for systems, teams, and daily interactions. Supporters generally promote choice making in some areas such as clothing choices and which TV show to watch. They may encourage the person to choose what to do with free time. However, there is much more to consider in using SDT to promote healthy lifestyles.

Behavioral interventions for challenging behavior or for symptoms of mental illness are preferred. We have moved from solely controlling behavior through contingencies and/or medications to using more positive methods (Positive Behavior Support). These methods still use behavioral principals but emphasize the importance of control, real choice, and the opportunity to express oneself. The real meaning of self determination has to be individualized. The social contexts and experiences the person has had – their human experience, will influence where they are in the self-determination continuum. Are they engaged and active as described above or are they experiencing mental health issues because they have experienced less than optimal developmental events? What might be those be?

Learning how to take a leadership role in your own life is what self-determination is all about. With the use of cognitive behavioral therapies/methods a person is given the tools, direction, and teaching to change the long held negative beliefs about their capacities.
Factors that Impact Individuals with Intellectual and Developmental Disabilities

There are many factors that impact a person’s ability to cope and learn. Previously in this module, possible risks for dual diagnoses were identified for specific syndromes. However, maladaptive behavior and psychopathology are not exclusive to people with I/DD. The general population also experiences poor health, poverty, social exclusion, low self-esteem, and disruptions in life (mental and physical). In people with I/DD, these experiences are compounded by the cognitive processing challenges that make it more difficult to cope and learn from adversity.

Executive function can be overwhelmed. This “cognitive load” can place stress on a person’s ability to utilize adaptive strategies or learn new ones. When cognitive resources are needed but impaired, maladaptive behavior is more likely to occur. A person with I/DD may find the following challenging:

- **Integration of processing information**: “Simultaneous processing” refers to integration of movement, visual stimuli, and auditory information at the same time. For example, during a social interaction, a person is required to not only read the facial expression or body language of their friends but also to process verbal communication and the activity of the environment to keep up with the conversation and feel accepted by the group. If this is taxing and rarely leads to a pleasant outcome for the individual, they may try to avoid such situations in the future. This may be difficult for individuals with sensory impairments but also for those who have hidden disabilities (i.e., learning disabilities, TBI, ID).

- **High amount and speed of information**: Cognitive load increases when an individual is required to integrate, recall, or assess large amounts of information. Consider how a person who is processing the loss of a check mark on their chart would understand this explanation. “You lost the check mark because you did not do all the steps on your morning check list even though you did do three out of five, and remember that you have to have at least three consecutive check marks to get to go bowling this week.” He/she may decide the effort to understand is too taxing.

- **Emotional response to information while processing information**: Emotional responses increase cognitive load. Now the person is not only trying to place the new information in memory and process the information, but also deal with emotions that are strong.

- **Poor attention**: A study by Merrill (1992) found that individuals with disabilities, when compared to those without a disability, were more concerned about completing a task not the accuracy. The fear of being labeled as disabled or stigmatized caused them to be disorganized, confused and have a lack of focus.

- **Problematic thinking patterns**: When individuals with I/DD experience stress, they may jump to conclusions without evidence or disregard important facts of a situation. Often problem solving skills are lacking. The person uses emotions to explain the situation and these become problematic thinking patterns.

Brown (2011)
Emotions, cognition, and behaviors create complex interactions that may produce maladaptive behaviors or vulnerabilities to mental health disorders. The person’s repertoire of internalized rules or explanations for why things occur can become patterns of thoughts that can become undesirable patterns of living. Cognitive behavior therapy is based on the premise that these thoughts or emotions can be changed, controlled, or eliminated.

*Initial analysis of persistent aggressive behavior in a 20 year old woman with I/DD shows a relationship between the aggressive outbursts and attention. The question of why this person was seeking attention was investigated and a number of important facts were included in the functional analysis:

- She had extremely low self-esteem.
- She believed she was responsible for the resignation of a favorite staff member in the previous year.
- She had been abandoned by significant others on a number of occasions in her past.
- Her mood rapidly alternated between mania and extreme depression.
- She was jealous of an older sister who had recently married.*

The functional analysis revealed a number of potential areas where help could be targeted and a multimodal treatment package involving both behavioral and cognitive methods were used.

(Stenfert-Kroese, 1997)

Consider how developmental factors can contribute to maladaptive behaviors.

*Limited communication, stressors due to cognitive challenges, neurological and physical limitations and limited independence may explain difficulties in expressing feelings. This may result in expression of frustration or internal problems in a more externalizing way, i.e., challenging behavior. Adolescents with I/DD experience more stress as they face personal limitations in adaptive behavior, particularly in social contexts. These may lead to more internalizing problems as they move into adulthood. They see themselves surpassed by friends and family in skills or life milestones (i.e., getting an apartment, going to college, getting a job). At this point, they may also move or experience an out-of-home placement with limited choice of housemates. They may have new rules, roommates, transportation limitations, staffing issues, and their role in their family may change. Relationships with support staff can be a source of strength in their life as well as a vulnerability. People with I/DD rarely have the opportunity to choose who will be supporting them. Staff turnover, personality clashes, power and control issues, and lack of attention are all factors that may add to internalizing maladaptive responses to changes in their life.*
It is theorized that many life events cause stress and even trauma. Like the general population, there are many factors that can lead to mental health issues such as depression and anxiety for individuals with I/DD. These include: a negative view of self, learned helplessness, and social factors such as stigmatization, health morbidity, unemployment, low income, and social isolation. Because of these factors, unresolved thought patterns may have developed and shaped the person’s emotional vulnerability resulting in behavioral expressions that seem maladaptive to us. Although behavior support plans and medications cannot directly affect behavior that stems from an internal function, improving the person’s quality of life can help reduce the negative impact of the person’s disability. Opportunities to develop and practice competencies, opportunities to make friends, ongoing staff training, individualized therapies (i.e., speech, occupational therapy), increasing opportunities for control, and mental health treatment are important features in the overall support plan. Furthermore, cognitive behavioral therapies have potential for people with I/DD. Therapies that help the person understand how negative thoughts and beliefs impact behavior and strategies to make changes should be considered. Traditional behavior therapy techniques can be used for people with cognitive impairment, if the techniques are broken down to a level consistent with that person's level of understanding.

Types of Cognitive Behavioral Therapies

I. Rational Emotive Behavior Therapy (REBT)

REBT was developed by Albert Ellis in the mid 1950s. It is a cognitive behavioral therapy that focuses on resolving emotional and behavioral problems and disturbances. The fundamental premise of REBT is that people do not get upset by the adverse event, but by their views of that event.

At the core of REBT is the ABC theory. The A represents an activating event. This is usually some adverse life event. For a person with I/DD it might be rejection from a supposed “friend.” The B represents the belief that takes over. The person realizes they are different and maybe not as capable as others. This belief takes over and causes the emotional consequence represented by the C. If the belief is rational, “sometimes people will mistreat me,” the consequence is only temporary. If the belief is irrational, “there is something wrong with me that is why people mistreat me,” the consequence might be maladaptive resulting is depression, anger, or acting out behavior. The key to REBT is that the belief, not the event, causes the consequence. If the person has a number of irrational beliefs, then he or she is likely to experience mental anguish and be vulnerable to mental health problems.

External behavioral analysis techniques are effective in controlling the problem behaviors. However, if these are the only strategies, the responsibility for improvement will be on staff primarily. The individual has little to no responsibility for his or her own emotional well-being. Treatment is more generalizable if the underlying emotions and beliefs associated with the behavior are addressed. Recognition of emotional states by the person is an important aspect for learning coping skills. Even though individuals with cognitive impairment may have difficulty accurately labeling different emotional states, they do not show any difference from people without cognitive impairment when it
comes to discriminating between pleasant and unpleasant emotions. Joyce, Globe, and Moody (2006) found that receptive language levels and the ability to connect events and emotions were linked. These abilities reinforce the importance of generating creative ways to adapt and include people in REBT treatment opportunities.

II. Life Story Therapy or Narrative Therapy

Life Story Therapy or Narrative Therapy is a cognitive behavioral approach in which problems and the stories that dominate the person’s life are identified. Problem stories are deconstructed and the person is supported in reconstructing stories that lead to better outcomes.

Narrative therapists do not focus on exploring a person’s feelings or fixing the problem but instead explore how people construct meaning about themselves and their relationships with others. The process involves; 1) listening and understanding the person’s story, 2) deconstructing the problem stories, 3) re-storying, and 4) maintaining the change (Matthews, 2005).

Listening and understanding involves being alert to the person’s story as they tell it by:

a) Listening to what they select to tell you
b) Knowing how their story fits within the family and friendship circles they have or had.

This process gives the listener an idea of how the person sees themselves and their preferred way of being.

In deconstructing, the person is assisted in deconstructing their problem stories. They are invited to look at the problems from a different perspective. The purpose is to help them notice how the story was constructed. The emphasis is to bring their attention to how that “story” places limits on them. The therapist uses the labels the person describes such as “the angries” or “the troubles” throughout the deconstruction.

In reconstruction, the person is encouraged to talk about the way they would prefer to be and what they would like to see happening in their lives. This is done through careful and respectful questioning of the person.

In sustaining, the person may be asked, “Is that a good thing or a bad thing?” or “Is that something you want more of in your life?” Helping the person identify positive capacities about themselves such as a good memory, or being an enthusiastic person is essential to identifying the preferred story. Using visuals such as a chart identifying things that bring happiness is encouraged in re-storying. The sustaining stage focuses on “thickening” the preferred story. This is done by bringing in people who will support them in this process. This is done by remembering and validating the changes seen in the person. For example, “If your dad was here, what would he say about all the happiness coming into your life?” The focus is on the preferred story and asking questions of witnesses which facilitates a richer description.
For a more detailed description of the Narrative therapy method and individual examples use the following resource.
http://www.ijder.ca/VOL04_01_CAN/articles/matthews.shtml

III. Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy is a comprehensive cognitive behavioral approach developed by Marsha M. Linehan in 1993. The focus was to treat individuals with borderline personality disorder (BPD). However, a person does not have to have a diagnosis of BPD to benefit from this method. The behavioral patterns of emotional, cognitive, and behavioral dysregulation are experienced by many who have a mental health disorder. The comprehensive DBT treatment model is designed to help people change highly reinforced, long-term patterns of behavior associated with impaired emotion regulation. It is helpful in improving self-management skills. This therapy has been used successfully with people who have eating disorders, sexual offenders, suicidal patients and substance abusers. DBT is an evidence-based treatment for overt problem behaviors.

Brown, Brown, and Dibiasio (2013) developed adaptations for using DBT with individuals with I/DD who had severe challenging behavior and resided in community programs. These behaviors included sexual offenses, aggression, self-injury, suicide attempts and which resulted in hospital stays. Their adaptations included the following:

- Involvement and training of support staff in the methods of DBT. Staff were required to narratively summarize target adaptive and problematic behaviors that occurred during each time period they were with the individual.
- Adapted diary cards (documenting the urges, moods, feelings and how the person did or did not use the DBT skills) included simplifying the documentation by using symbols or pictures.
- Task analyses were used to teach skills such as problem solving related to identifying emotions and feelings and the use of adaptive skills.
- Shaping was used to help the person use the adaptive skills or change their emotional reactions.
- Contingency plans or behavioral support methods were in place to reward the person for using adaptive behaviors and to address problem behaviors.
- A framework of “red flags” to classify problem behaviors (which included identification of low, medium, and high intensity problems) was developed for each individual. These were used to identify the escalating chains of problem behavior. This framework was used to improve self-awareness and facilitate early intervention with more adaptive self-regulation alternatives.
- Support staff were trained in being coaches of these methods.

The adaptations in the above study (with was conducted with 40 individuals ranging in age from 19 – 63 years) resulted in a 76% reduction of challenging behavior across a four year period. For a more comprehensive description of adaptations and tools used see the Skills System Instructors Guide (2011) developed by Julie F. Brown.
IV. Motivational Interviewing

As another type of cognitive behavioral therapy, Motivational Interviewing (MI) is a collaborative, ongoing conversation used to strengthen a person’s own motivation and commitment to change. It is person-centered. The focus is to address the common problem of ambivalence about change by paying attention to the language of change. It is intended to strengthen the individual’s motivation and movement towards change. This is done by eliciting and exploring the person’s own reason for change. The collaborative atmosphere is highly accepting and full of compassion – non-judgmental at all times. Essentially, MI is a way of communicating with people. It has evolved from experience in the treatments of addiction and was first described by William Miller in 1983;

The model focused on responding differentially to client speech, within a generally empathic person-centered style. Special attention was focused on evoking and strengthening the client’s own verbalized motivations for change. There is a clear difference from other therapies which is more of a confrontational style of addiction counseling. Pushing or arguing against resistance seemed particularly counterproductive in that it evoked further defense of the status quo.

(Miller & Rose, 2009)

Motivational interviewing is not direct persuasion of the person to change, nor is it a method to help the person identify underlying feelings. It is:

- Seeking to understand the person's frame of reference, particularly via reflective listening.
- Expressing acceptance and affirmation.
- Eliciting and selectively reinforcing the person's own self motivational statements, expressions of problem recognition, concern, desire and intention to change, and ability to change.
- Monitoring the person's degree of readiness to change and ensuring that resistance is not generated by jumping ahead of the person.
- Affirming the person's freedom of choice and self-direction.

Motivational interviewing is consistent with self-determination theory. The MI model proposes that over-controlling environments diminish self-determination, while efforts to promote a sense of competence and autonomy have the opposite effect. MI has an inherent focus on the person’s perspective.

Motivational interviewing has had success with the general population but there is little published research or reports on its use with people with I/DD. Although no evidence has been shown for efficacy in treating people with brain injury, Medley & Powell, (2010) have proposed MI as a method for engaging brain injury victims by enhancing readiness for rehabilitative interventions.

Rüsch and Corrigan (2002) proposed changes to MI for people with schizophrenia who usually display poor abstract thinking, memory and attention deficits. They recommend
the following strategies: repetition of information, longer behavioral sequences (developing personal goals or readiness to change) broken down into single steps, and the use of memory aids (visual checklists, electronic aids – phones or tablets).

Rose and Walker (2000) worked with an individual with Prader-Willi and found that more self-determined methods such as appropriate assistance rather than external restriction significantly reduced challenging behavior. The spirit of MI was used in this single case study along with behavioral principles. The results were a significant and permanent reduction in challenging behavior along with effective control over diabetes. Modifications to MI used in this study included:

- Staff were educated in depth on the Prader-Willi syndrome and the person’s history of behavior related to obtaining food.
- Staff were educated on the avoidance of arguments with the individual. When discussion turned into arguments, staff were instructed to wait for a more appropriate time to “plant the seeds” of MI and then wait.
- Staff were always mindful to view and express the competence of the individual and to remind the person to “show” others his competence in making the change.
- The individual was involved in a “food team” which planned for good nutrition and dietary needs for all housemates.
- Staff were consistent in giving clear feedback in the person’s progress toward his goal of weight loss and reduction of challenging behavior. This was to note all efforts this person used to move towards his goal and calling attention to it.

Frielink and Embregts (2013) conducted focus group interviews of individuals, families, and staff in community programs serving individuals with I/DD regarding the use of MI in this population. The use of understandable language and support staff characteristics emerged as two broad themes.

**Implementing Cognitive Behavioral Techniques**

Regardless of the specific approach that is being implemented, cognitive behavioral therapy typically includes the following steps:

1) Helping the individual to identify troubling situations or conditions in his or her life (e.g., symptoms of a mental illness such as depression or anxiety, grief, anger, a medical condition, etc.)
2) Supporting the individual to prioritize the situations or conditions on which he or she would like to focus during therapy sessions. This step also includes setting goals for the therapy session.
3) Assisting the individual to become aware of his or her thoughts, beliefs, and emotions associated with these situations or conditions.
4) Helping the individual to identify negative or inaccurate thinking about his or her difficult situations or conditions.
5) Challenging the individual’s negative or inaccurate thinking.
6) Assisting the individual to develop an action plan (e.g., relaxation, exercise, self-reinforcement, self-talk, positive imagery) or homework in which he or she can implement solutions to problems or to make changes in their thinking and action.
7) Supporting the individual to carry out the action plan in multiple settings so that he or she can shift to helpful thinking and behavior patterns.

(Mayo Clinic, n.d.)

Traditional cognitive behavioral therapy typically takes place in a clinical setting. This is usually a weekly visit with a therapist who is specifically trained in the counseling technique. This can be problematic for people with I/DD for a number of reasons:

- Treatment is done in an institutional - unfamiliar setting to the individual. This creates barriers to generalization for people with I/DD.
- The relationship between the therapist and individual is key in supporting people with I/DD. With sparse time to develop a relationship, the treatment may not produce any noticeable effect until the relationship is established and this may take too long.
- Caretakers incorrectly assume that the therapist will solve the problem without any commitment from support personnel to carry over the therapy methods.

Clearly, the relationship between the therapist who is counseling and teaching skills and those who live and work with the person receiving the treatment is vital to the success of the therapy. When there is a readiness and willingness to carry out the methods across environments, it is more likely the person will experience desired outcomes. It is important to assess this readiness and willingness on the part of the support staff.

- Do they understand the concepts of beliefs about an event and how beliefs can play a central role in determining emotions and behavior?
- Are they pessimistic about the ability of people with I/DD to benefit from CBT.
- Are they willing to change their present approach to the person?
- Are they knowledgeable about the person? Do they know facts about the disability or syndrome the focus person experiences and do they know the history of that person (social and behavioral)?
- Does the treatment plan include training the staff in the specific methods of the therapy the professional is using?
- Do they believe the current problems are stable features of the individual’s life or do they believe that, “The person has challenging behaviors because they have Prader-Willi syndrome?”

Members of an individual’s support team (family members, caregivers, and direct support professionals) play a pivotal role in the success of cognitive behavioral treatments that deal with internal causes to challenging behavior and/or mental health disorders. The involvement of a support team is essential in assisting an individual with I/DD to move successfully through his or her cognitive behavioral therapy sessions (Anderson & Kazantis, 2008). It may be beneficial for a support worker to attend therapy sessions with the individual to provide greater continuity and to assist participants in practicing and generalizing skills outside of the sessions.

Furthermore, the support of the team is also crucial following completion of the individual’s therapy sessions. It is counterproductive to send someone to therapy sessions and then return them to a “toxic” environment. It is important to plan proactively so that
an individual’s support team will be part of the treatment strategy and that they will be carrying out or carrying over the therapy on a day-to-day basis. Jahoda, Dagnan, Kroese, Pert, and Trower (2009) conducted out a survey study of direct support professionals who support people receiving cognitive behavioral therapy. They found that before the implementation of CBT, staff had more limited knowledge of the process and aims of CBT. Prior to implementation of CBT, the staff described their goal for the individual as largely centered on other people’s well-being as opposed to the individual’s well-being. For example, they were heard to say, “I hope the therapist can talk some sense into ___ and get him to stop lying and stealing” After nine therapy sessions, the staff attitudes were more individual focused with more empathy. Staff understood that the therapist had helped the person understand and modify the thought patterns that were leading to their negative behaviors.

Perspectives on Behavioral Support

Like Cognitive Behavioral Therapy, the outcome of most behavioral support approaches is to help a person live a higher quality of life. This might include learning how to manage themselves without the control of others and to generalize those skills across all environments. How the person reaches those outcomes is always individualized and not solely based on a single model or framework of methods. Interventions we have reviewed have similar features.

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Why problems?</th>
<th>What do we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral</td>
<td>Consequences promote problem behavior</td>
<td>Re-arrange consequences and teach appropriate behavior</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Mental Illness</td>
<td>Therapy Healthy interactions Medication</td>
</tr>
<tr>
<td>Person - Centered</td>
<td>Life doesn’t match preferences</td>
<td>Determine preferences and supports needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Beasley (n.d.)</td>
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</tbody>
</table>

In all our efforts we must be students of the people we support. We must seek to understand them and always be good listeners.

“Time after time, I have found that when people are taken seriously, when they are respected, when their behavior is interpreted, understood and responded to accurately, when they are engaged in mutual dialogue rather than subjected to unilateral schemes of ‘behavior management,’ somehow as if miraculously, they become more ordinary. I know a number of people who have had severe reputations who have shed them when those supporting them listened more carefully.”

Herb Lovett, Ph.D.
Chapter 4 Study Questions

MATCHING

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1. Dialectical Behavior Therapy</td>
<td>A. Designed to help people change highly reinforced, long-term patterns of behavior associated with impaired emotion regulation. It is helpful in improving self-management skills.</td>
</tr>
<tr>
<td>2. Narrative Therapy</td>
<td>B. A collaborative, ongoing conversation used to strengthen a person’s own motivation and commitment to change. It is person-centered. It is intended to strengthen the individual’s motivation and movement towards change</td>
</tr>
<tr>
<td>3. Motivational Interviewing</td>
<td>C. Problems that dominate the person’s life are identified and deconstructed. The person is supported in reconstructing stories that lead to better outcomes</td>
</tr>
<tr>
<td>4. Rational Emotive Behavior Therapy</td>
<td>D. The fundamental premise is that people do not get upset by the adverse event, but by their views of that event.</td>
</tr>
</tbody>
</table>

5. List the four foundations of cognitive behavioral approaches:

6. Why have people with intellectual disabilities been seen as unable to benefit from cognitive and other talking therapies?

7. How does cognitive behavior therapy promote person-centered planning and positive behavior support? Give an example.

8. List three examples of intrinsic motivation.

9. List three examples of extrinsic motivation.

10. Describe an example of how a person might develop a maladaptive coping method in response to executive functioning or cognitive load difficulties.
11. List three cognitive abilities that are needed to benefit from cognitive behavior therapy.

12. Explain the statement, “Treatment (cognitive behavior therapy) is more generalizable if underlying emotions and beliefs associated with the behavior are addressed.”

13. What does ABC stand for in Rational Emotive Behavior Therapy?

14. How are personal stories used in Narrative Therapy?

15. How might the traditional method of cognitive behavioral therapy implementation be a hindrance to treatment for a person with I/DD?

16. How would you prepare DSPs to carry over cognitive behavior therapy goals and methods in the home and vocational program?
Chapter 1 Study Question Answers

1. List 4 areas The World Health Organization identifies as risks that may contribute to a mental health disorder.

   Developmental, social, biological, and psychological

2. What information might a professional who adheres to the developmental psychopathology theory gather in their assessment of a person exhibiting maladaptive behavior?

   Events that may have had impact on the development of the individual such as trauma, disability, socio-economic conditions, or culture

3. List three general behavioral characteristics of Prader-Willi syndrome
   - Severe temper tantrums
   - Eat non-food items
   - Pick at skin
   - Mood changes

4. List three general behavioral characteristics of Williams syndrome.
   - Very adept at linguistic tasks
   - Hyper-sociability, may even be indiscriminate sociability
   - High levels of anxiety, sleep disturbance, or over-sensitivity to certain frequency and volume ranges of sound.

5. How can the Case Manager/Program Coordinator/QDDP provide guidance/support to team members who have little knowledge about mental health disorders?
   - Examine your own knowledge level of mental illness and how developmental disabilities places a person at risk.
   - Help team members to increase their knowledge as well. This can be done by recommending workshops, articles and informative pieces geared toward a particular mental health disorder.
   - Educate team members in the best practices and regulations regarding behavioral and psychotropic interventions.

6. Which model of psychopathology (Medical/Bio-Medical; Developmental Psychopathology; or Social) is described in each phrase below
   Answers may be used more than once.
   a. Developmental Psychopathology
   b. Developmental Psychopathology
   c. Medical/Bio-Medical
   d. Social
   e. Developmental Psychopathology
   f. Developmental Psychopathology

7. False
Chapter 2 Study Question Answers

1. How might the program coordinator/QDDP assist the mental health professional in gathering information?
   - Provide and communicate accurate behavioral data.
   - Assist in building trust between the mental health professional and the individual supported.
   - Plan for compliance to regulations and educate the mental health professional accordingly.
   - Understand the experience the mental health professional may have with I/DD.

2. Matching
   - B_1. Family History
   - C_2. Medical Assessment
   - A_3. Social and Developmental History
   - E_4. Evaluation of Mental Status
   - D_5. Collecting auxiliary data

3. Compare differences in the treatment approach mental health professionals might have for a person with I/DD to a person without I/DD.
   Your answer should include the principles taken from the chart in chapter 2.

<table>
<thead>
<tr>
<th>General population</th>
<th>I/DD population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish relationship</td>
<td>Establish relationship with the team</td>
</tr>
<tr>
<td>Conversation with detailed questions and answers</td>
<td>Verbal ability is limited and use of 3rd party information</td>
</tr>
<tr>
<td>Evaluate the overall presentation</td>
<td>Atypical presentation, behavioral vulnerabilities</td>
</tr>
<tr>
<td>Discuss diagnosis and treatment plan</td>
<td>“Team” treatment and negotiation</td>
</tr>
</tbody>
</table>

4. Medications, therapy, and behavioral support plans for persons with Dual Diagnosis should be __integrated________________ in the overall plan. This requires collaboration across disciplines.

5. List two challenges that may arise for a mental health professional who has little experience with I/DD as a result of the interdisciplinary team approach.

   A. Understanding the values of person-centered planning such as:
      - least intrusive
      - positive behavior support
      - inclusion
      - integration of the person-centered plan in the overall treatment plan.
   
   B. Understanding regulations that govern the decisions and activities of the team.
6. Describe how an interdisciplinary team might assist the mental health professional in gathering assessment information.

- Providing and communicating accurate, objective data.
- Assisting in building trust between the mental health professional and the person supported.
- Planning for compliance to regulations and educating the mental health professional accordingly.
- Understanding the experience the mental health professional may have with people who have a diagnosis of I/DD.

7. Describe how you would explain the principle of the least intrusive alternative to a mental health professional who has little experience with the I/DD population. Your answer should include the principle of choosing a treatment method that will minimize stigma.

8. Arrange each step of the mental health professional’s assessment process in the order it is completed.

6. make a prognosis
1. obtain a history
8. determine a treatment plan
4. summarize principal findings
2. evaluate the person’s mental status
3. collect auxiliary data
7. provide a bio-psychosocial formulation
5. render a diagnosis

9. List one adaptation method that can be used when interviewing a person with I/DD who says yes to all questions asked. Answers can include any of the suggestions in chapter 2 under the subheading of interviews. Some are listed below.

- Pair questions that are opposite in meaning; “Are you happy?” “Are you sad?”
- Use pairs of questions in which the same question is asked in different formats, i.e. yes/no and either/or

10. List one adaptation method that can be used when interviewing a person with I/DD that has difficulty with time concepts. Answers can include any of the suggestions in chapter 2 under the subheading of interviews. Some are listed below.

- Avoid future-oriented questions.
- Use present tense whenever possible.
- Avoid the use of metaphors or idioms that are time oriented such as “in a little while”, or “did that come later?”
- Use visuals (pictures, charts, graphs, line drawings).
11. Which of the following strategies might be helpful for interviewing people with limited verbal ability?

- a. Use “when”, “how”, and “why” questions.
- b. Use pictorial multiple-choice questions.
- c. Frequently check understanding of conversation with the person.
- d. Use “yes/no” questions when gathering information related to emotions and feelings.
- e. Use “who”, “what”, and “where” questions.
- f. Use abstract concepts instead of concrete.
- g. Use longer sentences than the person uses.
- h. Use plain language and avoid jargon.
- i. Use words that the person uses.
- j. Use passive verbs and past tense.
- k. Avoid leading questions.
- l. Be cautious about using humor.
- m. Use the language system the person uses, i.e. sign language, assistive devices as needed.
- n. Avoid double negatives.

12. Why was the DM-ID developed?

- People with I/DD may not be able to self-report accurately.
- Mental health disorders are observed differently in individuals with I/DD than the general population.
- The DM-ID gives consideration for recognizing common behaviors of individual with IDD and how to differentiate the behavior from the psychiatric disorder.

13. Place an X next to those statements that are true of the DM-ID.

- The DM-ID can replace the DSM for help in rendering a diagnosis.
- The DM-ID is used where the individual cannot self-report.
- The DM-ID can be used by QDDPs, DSPs, Families, case managers to make a mental health disorder diagnosis.
- The DM-ID lists diagnostic equivalents of behavioral manifestations similar to those in the DSM.

14. Describe the purpose of a screening tool (checklists, rating scales).

Screening tools are used to gather information regarding the potential for a more formal examination. They may be used as auxiliary data by the mental health professional in their assessment.

15. What are some methods/tools that will help teams identify and come to agreement on the observable behaviors they will be monitoring?

Consulting the DM-ID, observation, interviews of staff/family, understanding the mental health professional diagnosis and resulting treatment plan (what medications will be targeting), data collected from observation such as an ABC chart or scatter plot.
16. Why would it be important to collect observational data on the environment as well as behavioral data?

*Human behavior is contextual. Things (interactions, noise, clutter, space, odors) in the environment can influence how people behave.*

17. Check items below that should be included in a positive behavioral support plan;

- ___ a general description of the person’s overall mood.
- X___ a statement of the function of the behavior (hypothesis)
- ___ anecdotal or narrative data collection
- X___ description and methods for environmental supports
- X___ description and methods for teaching a functionally-equivalent behavior
- X___ a behavioral description of the targeted behavior
- X___ data that describes the progress of the functionally equivalent behavior

18. When designing behavior support plans, decisions must be based on objective data. List the objective data that is necessary for teams to make decisions on medications and methods in positive behavior support plans.

*Baseline data, data to indicate the justification of less or more restrictive methods, target behavior, replacement behavior, medication changes (dosage and/or additional medications), side effects of psychotropic medications*

19. Why is baseline data collected?

*In order to make sure the intervention, teaching, environmental modification and/or medication is assisting person toward the desired direction/outcome, the team will need to know what Rita was like before. This requires the operationalized definition of the behaviors, observation, and data collection*

20. The **hypothesis** is a ‘best guess” as to the function of the behavior.

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**Chapter 3 Study Question Answers**

1. What is the most common type of treatment for people who have a mental health disorder in the general population?

*Outpatient therapy and medications*

2. Define these terms:
   a. Psychotropic drug - *Any drug capable of affecting the mind, emotions, and behavior.*
   b. Psychopharmacology - *The branch of medicine and biology concerned with the study of drug action.*
   c. Neuroleptics - *Medications used mainly to manage psychosis particularly in schizophrenia and bipolar disorder.*
   d. Atypical antipsychotics - *Second generation antipsychotics which do not cause the same degree of movement side effects*
   e. Polypharmacy - *The administering of several drugs and usually a term used to indicate excessive administration of drugs.*
3. What is the purpose of using medications in the treatment plan for a person with dual diagnosis? Give an example.

The response should include a specific example consistent with this explanation. (The explanation is not sufficient, however.) To control the symptoms of the mental health disorder so that the person can learn to manage the symptoms with more appropriate methods and to eventually lead a quality life. A person with obsessive compulsive behaviors and rigid thinking may have difficulty getting things done, when redirected they may become irritable. Learning how to manage the rigidity and compulsiveness is necessary to leading a quality life. Medications may take the edge off the irritability and help the person learn to devise ways of staying on task.

4. Explain the statement, “Psychiatric symptoms can be emotional, motivational states that increase the probability of challenging or maladaptive behavior.”

Maladaptive behavior can be the tool a person is using to relieve the symptoms or the consequences of the symptoms. A person who is irritable when reminded to change or transition to another task might find change difficult because of their compulsive/obsessive tendencies. The psychiatric symptom of compulsiveness or difficulty changing to another task is challenged when the person is reminded, to get out of the change they lash out or become irritable. When being irritable results in relief, the maladaptive behavior has been reinforced and provided relief.

5. What is the purpose of the functional behavioral assessment?

The purpose is to make the best guess on what factor(s) may be influencing the behavior.

6. What are some explanations for over-reliance on medication for treatment of mental illness in people with I/DD?

- The evaluation and diagnosis process in persons with ID is very difficult and can result in misdiagnosis
- Doctors feel pressure to give medications to relieve the caregiver dealing with the behavior.
- General practitioners are not trained in psychological/psychiatric methods of evaluation. Medications prescribed by a general practitioner are usually based on the behaviors rather than a thorough evaluation. In the United States, among the general population, almost four out of five prescriptions for psychotropic drugs are written by physicians who aren't psychiatrists.

7. According to the Guidelines for use of Psychotropic Medications, list three of the suggested guidelines for evaluating treatment effects.

Any of the following:

- Identify specific behaviors to track in order to better evaluate medication efficacy
• Collect baseline data before beginning a medication
• Track specific behaviors using recognized behavioral measurement methods
• Consider whether medication is compromising functional status

8. According to the Guidelines for use of Psychotropic Medications, list two of the suggested guidelines for polypharmacy.

   Any of the following:
   • Keep medication regimen as simple as possible
   • The use of two medications from the same therapeutic class at the same time is rarely justified
   • The use of two or more medications from different therapeutic classes at the same time requires a rationale
   • A combination of medications is appropriate in certain situations

9. According to the Guidelines for Use of Psychotropic Medications monitoring for side effects should include:

   - Evaluate for side effects at least every six months
   - Use a standardized assessment instrument constructed from standard pharmaceutical or medical references
   - Monitor for drug interactions
   - Assess for tardive dyskinesia if using antipsychotics using a standardized assessment instrument.

10. Explain the statement, “The goal of medications should be to make the problem behavior responsive to change.”

    Positive outcomes are achieved when more appropriate responses replace the challenging ones. When medications can relieve the symptoms so the person can begin to learn more adaptive behaviors, the combination of medications and the positive behavior program have created responsiveness to change.

11. Would data collection on the challenging or target behaviors cease once the medication for the treatment of the mental health disorder starts?  No

    Why or why not? The answer should include principles of behavior analysis that requires ongoing tracking of the symptoms the medication was prescribed for to determine if the medication is being effective. This is part of the Guidelines for the Use of Psychotropic Medication chart under the heading of “evaluating treatment effects.”

12. List factors that might be influencing the challenging or target behavior when completing a functional behavioral assessment.

    - Environmental/contextual
    - Physical conditions
    - Medications
    - Abilities/interests/capacities/personal preferences – how often do these occur?
    - Characteristics of the mental health disorder
13. Support for people with a dual diagnosis should not be exclusively focused on eliminating challenging behavior and eliminating stress factors. Where should the focus be?
   Teaching new sets of adaptive behaviors; Teaching the person to recognize and manage their symptoms. Teaching and creating opportunities for social acceptance, social relationships, and positive affection.

14. What steps should the QDDP take to prepare for ongoing treatment reviews with the psychiatrist?
   Coach the individual so they can think about questions they may have.
   Bring objective data and use specific language to describe the person’s current behavior/status.
   Prepare specific questions that you and the team have for the psychiatrist.

15. Define elements of a mental health crisis.
   - Suicide ideation- expressions about how to kill oneself
   - Choices that place the person at serious risk
   - Serious side effects of the medications
   - Drug overdose
   - Acute psychosis (hallucinations or delusions)
   - Non-suicidal self–injury
   - Reaction to trauma

16. A value of crisis management is personal safety. What does this mean? Give an example.
   The person experiencing the crisis needs to feel secure. What interventions in the crisis plan would make this happen? The team also needs to consider what would make the person feel more vulnerable. Use of the ER may not be the best option for severe behaviors that cause injury to self and others. It might even make it worse as this is a strange place with strange people.

17. A value of crisis management is evaluation. What does this mean? Give an example.
   The whole purpose of crisis management is to prevent a future crisis or to be proactive – not reactive. During evaluation the team would consider what caused the crisis and use that to prevent recurrence.

18. What is considered success in crisis management?
   Prevention of further crises.

Chapter 4 Study Questions

1. A
2. C
3. B
4. D
5. List the four foundations of cognitive behavioral approaches:
a. Thoughts, beliefs, and perceptions influence overt behavior as well as emotion or affect.

b. People are active learners, not just passive recipients of environmental influence. Their learning histories can result in cognitive dysfunctions or wrong patterns of thinking.

c. The person understands the intervention strategies and goals and participates in the planning.

d. Treatment is focused on creating new adaptive learning to overcome cognitive dysfunctions and produces positive changes that will be generalized outside the clinical setting.

6. Why have people with intellectual disabilities been seen as unable to benefit from cognitive and other talking therapies?
Communication barriers and limited understanding and experience in social contexts. However, there is growing support internationally for appropriately modifying the intervention to simplify and adapt the procedures used in CBT for this population.

7. How does cognitive behavior therapy promote person-centered planning and positive behavior support? Give an example. The answer should include the following.

- Person-centered planning is based on dreams, goals, capacities, personal preferences. Using that information assists the person to achieve goals that are important to and important for the person. Cognitive behavior therapy involves the person in their treatment by helping them understand thoughts and beliefs. They are active participants contributing to their treatment and participating in the planning.

- Positive behavior support considers the dreams, goals, capacities, personal preferences of the person in teaching the person to learn new more adaptive skills. Cognitive behavior therapy assists the person to understand or become aware of their behavior (thoughts and thinking) and teaches them to respond in a more effective way.

A person who has anxiety and avoids going to work by refusing and being verbally aggressive after prompts by DSPs may need to understand why he/she is anxious. Cognitive behavior therapy would use specific techniques that would help the person explore their feeling and thoughts about work (or leaving their home). Based on what works well with that person (their personal preferences), the support plan will teach the person an appropriate replacement behavior or skill to cope or overcome the anxiety.

8. List three examples of intrinsic motivation.

- being able to develop talents (competence)
- being independent and in control (autonomy)
- having meaningful relationships (relatedness)
9. List three examples of extrinsic motivation.
   - Deadlines
   - Prizes
   - Directives
   - Paycheck

10. Describe an example of how a person might develop a maladaptive coping method in response to executive functioning or cognitive load difficulties.

   The example may include any real life scenario in which the person has limitations in memory, poor attention, or integration of information processing. For example, a person may find it very difficult to sift out all the information that is coming to them in the environment (people talking, noises, movement and body language of people) so they can only get immediate relief from the bombardment by making noises themselves. These noises get louder as the environmental noises get louder.

11. List three cognitive abilities that are needed to benefit from cognitive behavior therapy.
   - Ability to reflect upon meaning and motivation of their behavior
   - Have confidence in their abilities to discuss, reflect, think, solve problems
   - See the need for treatment and/or therapy
   - Understand their behavior affects others
   - Understand they can make changes.

12. Explain the statement, “Treatment (cognitive behavior therapy) is more generalizable if underlying emotions and beliefs associated with the behavior are addressed.”

   The purpose of cognitive behavior therapy is to assist the person in changing underlying feelings and thoughts which usually are pervasive (across all environments, times, activities). When those underlying elements are changed and the person can substitute more adaptive thoughts and behaviors, these will be useful in all environments, times, or activities – generalized across all areas of the person life.

13. What does ABC stand for in Rational Emotive Behavior Therapy?
   - $A =$ activating event
   - $B =$ belief
   - $C =$ emotional consequence

14. How are personal stories used in Narrative Therapy?

   The stories are used as a way for a person to tell or construct meaning for the person. The therapist takes note on what the person selects to tell the therapist, understanding how the story fits in with their family and friend circle. This helps the therapist understand how the person sees themselves and their preferred way of being.
15. How might the traditional method of cognitive behavioral therapy implementation be a hindrance to treatment for a person with I/DD?
   • Treatment is done in an institutional (office or hospital) or unfamiliar setting.
   • Difficult developing a relationship when therapist and individual connect only monthly or quarterly
   • Caretakers may incorrectly assume that the therapist will “fix” the problem.

16. How would you prepare DSPs to carry over cognitive behavior therapy goals and methods in the home and vocational program?
   Assess willingness and readiness to carry out the methods across environments.
   • Do staff understand the concepts and beliefs can be a central role in determining emotions and behavior
   • Are they pessimistic about the ability of the person to benefit from cognitive behavior therapy
   • Are they willing to change their present approach to the person
   • Are they knowledgeable about the person
   • Does the treatment plan include training staff
   • Do they believe the current problems are stable features of the individual’s life?
References


Crisp AH, Gelder MG, Rix S, Meltzer HI, Rowlands OJ. (2000) Stigmatisation of


Lipman R,(1967). Results of a survey on psychotropic usage in institutions for the mentally retarded. Paper presented at the May meeting of the American Association on Mental Deficiency, Denver, CO.


APPENDICES

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<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Did the symptom occur? (Circle Y/N)</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delusions</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
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<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Grossly disorganized or Catatonic behavior</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Catatonic features</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Affective flattening</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Alogia</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Avolition</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Depressed mood</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Loss of interest or pleasure</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Irritable mood</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Significant weight loss when not dieting or weight gain</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Insomnia or hypersomnia nearly every day</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Psychomotor agitation</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Fatigue or loss of energy nearly every day</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional)</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Diminished ability to think or concentrate</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Thoughts of death, suicidal ideation or a suicide attempt or a specific plan to commit suicide</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
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<tr>
<td>Persistently elevated, expansive, or irritable mood</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Inflated self esteem, grandiosity</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Decreased need for sleep (feels restored after only 3 hours of sleep)</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>More talkative than usual or pressure to keep talking</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
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<tr>
<td>Flight of ideas or subjective experience that thoughts are racing</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
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<td>Distractibility</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Increase in goal-directed activity or psychomotor agitation</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>Excessive involvement in pleasurable activities</td>
<td>Morning Y / N</td>
<td>Afternoon/Evening Y / N</td>
</tr>
<tr>
<td>that have a high potential for painful consequences</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sources**


Diagnostic and Statistical Manual of Mental Disorders – Text Revision (DSM-IV-TR)  Copyright 2000 – American Psychiatric Association
### Positive (an excess or distortion of normal functions) Symptoms of Schizophrenia

**Delusions** – a fixed belief in something that is a distortion in thought – erroneous beliefs that usually involve a misinterpretation of perceptions or experiences. The delusion is reality to the person.

**Hallucinations** – Auditory hallucinations involve hearing voices, sounds, static, or other noises within their head. The person may be observed giggling, verbally responding to the voice, or appear as if listening to someone speak. Visual hallucinations are seeing things that others cannot see. The person may look off to the corners of the room, or suddenly attend to something not present in the room.

**Grossly disorganized or Catatonic behavior** – a noticeable decrease in their reaction to their environment, sometimes reaching an extreme degree of complete unawareness, maintaining a rigid posture and resisting efforts to be moved, active resistance to instructions or attempts to be moved, or excessive motor activity with no purpose.

**Catatonic features** – stands like a statue for long periods of time, stays in the same position for long periods of time, seems very still and unresponsive for long periods of time, has very odd postures or paces.

### Negative (a loss of normal functions) Symptoms of Schizophrenia

**Alogia** – poverty of speech; brief, terse, empty replies

**Affective flattening** – face appears immobile and unresponsive, with poor eye contact and reduced body language; range of emotional expressiveness is clearly diminished

**Avolition** – inability to initiate and maintain goal-directed activities
### SST Symptom Tracker

**Depressive Symptoms**

**Depressed mood** – sad facial expression, flat affect or absence of emotional expression, rarely smiles or laughs, cries or appears tearful.

**Loss of interest or pleasure** – refuses preferred activities, appears withdrawn, spends excessive time alone, participates but shows no signs of enjoyment, becomes aggressive in response to request to participate in activities he or she used to like, has lost response to reinforcers, finds previously motivating events or object no longer motivating, avoids social activities, aggresses or becomes agitated when prompted to attend social activities once enjoyed.

**Recurrent thoughts of death, suicidal ideation without a specific plan, or a suicide attempt or a specific plan to commit suicide** – often talks about death or people who have died or has other morbid preoccupations, has frequent unrealistic or unfounded physical complaints and fears of illness or death, makes threats to kill or harm self or has actually attempted suicide (unconventional means such as running in front of cars or jumping from windows may be impulsive acts, but may be suicidal in nature).

**Insomnia or hypersomnia nearly every day** – difficulty falling asleep, awakens in the early morning, sleeps excessively, has shown a recent increase in problem behavior late at night, very early in the morning, takes frequent naps, falls asleep during the day, is up and down all night, sleeps very little at night and seems tired.

**Psychomotor agitation** – rarely sits down, is up and down from seat a lot, paces, walks rapidly, fidgets, has slowed movements, has decreased or stopped talking, vocalizes much more or less than usual, is much less physically active than before.

**Fatigue or loss of energy nearly every day** – appears tired or reports feeling tired, refuses or becomes agitated about activities that require physical effort, spends excessive amounts of time just sitting, or excessive amounts of time lying down, has dark circles under eyes.

**Irritable mood** – appearing grouchy or having angry facial expression, onset or increase in agitated behavior.

**Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional)** – makes negative self-statements, identifies self as a “bad” person, often expects punishment without a history of harsh treatment, blames self for problems inappropriately, unrealistically fears caretakers will be angry or rejecting, even after minor transgressions, excessively seeks reassurances that he or she is accepted as a good person, or makes other negative self-statements at a high frequency.

**Diminished ability to think or concentrate** – shows a reduced productivity at work or day program, has diminished self-care skills, appears easily distracted or can’t complete tasks he or she used to be able to finish, has shown the onset of or increase in agitated behaviors when asked to do activities that require concentration, has apparent memory problems that “come and go”, has unexplained skill loss, shows an uncharacteristic inability to learn new skills as expected, or has had to stop working or attending programs due to poor performance.

**Significant weight loss when not dieting or weight gain** – eating to excess, is obsessing about food, stealing food, refusing meals, agitated behavior emerges during meal times or in relation to food (throws food on floor, screams when meal arrives).
### SST Symptom Tracker

<table>
<thead>
<tr>
<th>Manic Symptoms</th>
<th>More talkative than usual or pressure to keep talking</th>
<th>Distractibility (attention is too easily drawn to unimportant or irrelevant external stimuli)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistently elevated, expansive, or irritable mood – has loud inappropriate laughing or singing, is excessively giddy or silly, is intrusive, getting into other’s space, and smiles excessively and in ways that are not appropriate to the social context</td>
<td>Increase over baseline in vocalizing, screaming, noise making, or talking; nonstop or very rapid vocalizing, etc., asks repeated questions, doesn’t wait for answers, decreased ability to listen, frequently interrupts, increase in perseverations, engages in frequent monologues, singing loudly</td>
<td>Shows a reduced productivity at work or day program, has diminished self care skills, appears easily distracted or can’t complete tasks he or she used to be able to finish, has shown the onset of or increase in agitated behaviors when asked to do activities that require concentration, has apparent memory problems that “come and go”, has unexplained skill loss, shows an uncharacteristic inability to learn new skills as expected, has had to stop working or attending programs due to poor performance. These problems focusing attention are new and represent a change from baseline (are not life-long). The problems in concentrating or completing tasks seem mostly due to not being able to finish what is started or stay with a project and because attention is easily drawn to noise or activity going on around the person.</td>
</tr>
<tr>
<td>Inflated self esteem, grandiosity – exaggerated claims of skills or stature (based on developmental profile at baseline, i.e., individual claims he has a car but does not, claims skills he doesn’t have such as ability to drive, states he is the director of the hospital), exaggerates social events (“I’m getting married” when not seeing anyone or engaged), claims a relationship with a famous person, claims a relationship with a brief acquaintance, believes he is a super hero (not fantasies consistent with developmental profile)</td>
<td>Increases in noise making or vocalizing or screaming that is non-verbal; all symptoms are a departure from usual baseline either because the symptoms are new or much more intense and frequent (baseline exaggeration)</td>
<td></td>
</tr>
<tr>
<td>Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments) – engages in much more sexual behavior or talk, reports more activity than usual, masturbates frequently and much more than before, exposes self in public and this is unusual, and is touching others in a sexual manner</td>
<td>Decreased need for sleep (feels restored after only 3 hours of sleep) – sleeps 0 – 3 hours per night, goes to sleep much later than usual, wakes much earlier than usual, gets ready for the day very early. More problem behaviors may occur at night than previously. The individual may be doing usual day time activities in the middle of the night. When sleeping less, there may be minimal signs of fatigue the next day. The individual may appear tired but cannot sleep except briefly, keeps active – seems “driven”. The sleep problem resists treatment and is a departure from baseline (the individual does not have a roommate making noise all night, is not sleeping during the day, and does not have a life long history of poor sleep)</td>
<td>Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation – engages in activities in a “sped up manner”, rarely sits down, is up and down from seat a lot, paces, walks rapidly, seems “driven”, races around the room, has become very intrusive, is much more physically active than before, and can’t even sit long enough to eat</td>
</tr>
</tbody>
</table>

**Flight of ideas or subjective experience that thoughts are racing**
- Jumps rapidly from topic to topic, or states things like “My thoughts are moving fast.”
# Quick Reference to Psychiatric Medications

**Antidepressants**

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>Usual Daily Dosage Range</th>
<th>Sedation</th>
<th>ACH¹</th>
<th>NE</th>
<th>5-HT</th>
<th>DA</th>
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<tr>
<td>imipramine</td>
<td>Tofranil</td>
<td>150-300 mg</td>
<td>mid</td>
<td>mid</td>
<td>+++</td>
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<td>Norpramin</td>
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<td>++++</td>
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<td>amitriptyline</td>
<td>Elavil</td>
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<td>Aventyl, Pamelor</td>
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<td>trazodone</td>
<td>Olestra</td>
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<td>0</td>
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<td>nefazodone</td>
<td>Geriact, Only</td>
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<td>venlafaxine</td>
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<td>Prialt</td>
<td>50-400 mg</td>
<td>low</td>
<td>none</td>
<td>+++</td>
<td>++</td>
<td>0</td>
</tr>
<tr>
<td>fluvoxamine</td>
<td>Lura</td>
<td>50-300 mg</td>
<td>low</td>
<td>low</td>
<td>0</td>
<td>+++</td>
<td>0</td>
</tr>
<tr>
<td>mirtazapine</td>
<td>Remeron</td>
<td>15-45 mg</td>
<td>mid</td>
<td>mid</td>
<td>+++</td>
<td>++</td>
<td>0</td>
</tr>
<tr>
<td>citalopram</td>
<td>Celexa</td>
<td>10-40 mg</td>
<td>low</td>
<td>none</td>
<td>0</td>
<td>+++</td>
<td>0</td>
</tr>
<tr>
<td>escitalopram</td>
<td>Lexpro</td>
<td>5-20 mg</td>
<td>low</td>
<td>none</td>
<td>0</td>
<td>+++</td>
<td>0</td>
</tr>
<tr>
<td>duloxetine</td>
<td>Cymbalta</td>
<td>20-80 mg</td>
<td>low</td>
<td>none</td>
<td>+++</td>
<td>++</td>
<td>0</td>
</tr>
<tr>
<td>vilazodone</td>
<td>Viibryd</td>
<td>10-40 mg</td>
<td>low</td>
<td>low</td>
<td>0</td>
<td>+++</td>
<td>0</td>
</tr>
<tr>
<td>atomoxetine</td>
<td>Strattera</td>
<td>60-120 mg</td>
<td>low</td>
<td>low</td>
<td>+++</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

¹ ACH: Anticholinergic Side Effects  
² NE: Norepinephrine, 5-HT: Serotonin, DA: Dopamine (0 = no effect, + = minimal effect, ++ = moderate effect, +++ = high effect)  
*1: Available in standard formulation and time release (SR, XL, or CR). Prozac available in ZOLOFT, XR formulation.

**Bipolar Disorder Medications**

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>Daily Dosage Range</th>
<th>Serum¹</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>lithium carbonate</td>
<td>Eskalith, Lithonate</td>
<td>600-2400</td>
<td>0.6-1.5</td>
<td></td>
</tr>
<tr>
<td>olanzapine</td>
<td>Symbyax</td>
<td>6/25-12.5/50 mg</td>
<td>(2)</td>
<td></td>
</tr>
<tr>
<td>carbamazepine</td>
<td>Tegretol, Equetro</td>
<td>600-1600</td>
<td>4-10+</td>
<td></td>
</tr>
</tbody>
</table>

¹ Lithium levels are expressed in mEq/L, carbamazepine and olanzapine levels are expressed in mg/mL.

**Anti-Obsessional Medications**

| Generic | Brand | Dose Range¹ | |
|---------|-------|-------------||
| clomipramine | Anafranil | 150-300 mg | |
| fluoxetine | Prozac | 20-80 mg | |
| sertraline | Zoloft | 50-200 mg | |
| paroxetine | Paxil | 20-60 mg | |
| fluvoxamine | Lura | 50-300 mg | |
| citalopram | Celexa | 10-40 mg | |
| escitalopram | Lexpro | 5-30 mg | |
| vilazodone | Viibryd | 10-40 mg | |

¹ Often higher doses are required to control obsessive-compulsive symptoms than the doses generally used to treat depression.

**Psycho-Stimulants**

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>Daily Dose²</th>
</tr>
</thead>
<tbody>
<tr>
<td>methamphetamine</td>
<td>Ritalin</td>
<td>5-50 mg</td>
</tr>
<tr>
<td>methylphenidate</td>
<td>Concerta</td>
<td>18-54 mg</td>
</tr>
<tr>
<td>methylphenidate</td>
<td>Metadate</td>
<td>5-40 mg</td>
</tr>
<tr>
<td>methylphenidate</td>
<td>Methylin</td>
<td>10-60 mg</td>
</tr>
<tr>
<td>methylphenidate</td>
<td>Daytrana (patch)</td>
<td>15-30 mg</td>
</tr>
<tr>
<td>methylphenidate</td>
<td>Quill Your</td>
<td>10-60 mg</td>
</tr>
<tr>
<td>dextroamphetamine</td>
<td>Focalin</td>
<td>5-40 mg</td>
</tr>
<tr>
<td>dextroamphetamine</td>
<td>Deseril</td>
<td>5-40 mg</td>
</tr>
<tr>
<td>lidocamphenamine</td>
<td>Vyvanse</td>
<td>30-70 mg</td>
</tr>
<tr>
<td>alprazolamine</td>
<td>Adderall</td>
<td>5-40 mg</td>
</tr>
<tr>
<td>modafinil</td>
<td>Provig, Norvil</td>
<td>200-400 mg</td>
</tr>
<tr>
<td>amphetamin</td>
<td>Noril</td>
<td>150-250 mg</td>
</tr>
</tbody>
</table>

¹ Note: Adult Dose. ² Sustained release.
# Antipsychotics

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>Dosage Range</th>
<th>Sedation</th>
<th>Ortho</th>
<th>EPS</th>
<th>ACH Effects</th>
<th>Equivalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorpromazine</td>
<td>Thorazine</td>
<td>50-800 mg</td>
<td>high</td>
<td>high</td>
<td>+</td>
<td>++++</td>
<td>100 mg</td>
</tr>
<tr>
<td>Thoridazine</td>
<td>Mellaril</td>
<td>150-800 mg</td>
<td>high</td>
<td>high</td>
<td>+</td>
<td>++++</td>
<td>100 mg</td>
</tr>
<tr>
<td>Clozapine</td>
<td>Clozaril</td>
<td>300-900 mg</td>
<td>high</td>
<td>high</td>
<td>0</td>
<td>++++</td>
<td>50 mg</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>Serquel</td>
<td>150-600 mg</td>
<td>mid</td>
<td>mid</td>
<td>+/0</td>
<td>+</td>
<td>50 mg</td>
</tr>
</tbody>
</table>

# Antipsychotics (High Potency)

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>Dosage Range</th>
<th>Sedation</th>
<th>Ortho</th>
<th>EPS</th>
<th>ACH Effects</th>
<th>Equivalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perphenazine</td>
<td>Trilafon</td>
<td>8-60 mg</td>
<td>mid</td>
<td>mid</td>
<td>++++</td>
<td>+</td>
<td>10 mg</td>
</tr>
<tr>
<td>Loxapine</td>
<td>Loxatone</td>
<td>50-250 mg</td>
<td>low</td>
<td>mid</td>
<td>++++</td>
<td>+</td>
<td>10 mg</td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>Stelazine</td>
<td>2-40 mg</td>
<td>low</td>
<td>mid</td>
<td>++++</td>
<td>+</td>
<td>5 mg</td>
</tr>
<tr>
<td>Fluphenazine</td>
<td>Prolixin</td>
<td>3-45 mg</td>
<td>low</td>
<td>mid</td>
<td>++++</td>
<td>+</td>
<td>2 mg</td>
</tr>
<tr>
<td>Thioridazine</td>
<td>Navane</td>
<td>10-60 mg</td>
<td>mid</td>
<td>mid</td>
<td>++++</td>
<td>+</td>
<td>3 mg</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>Haldol</td>
<td>2-40 mg</td>
<td>low</td>
<td>mid</td>
<td>++++</td>
<td>+</td>
<td>2 mg</td>
</tr>
<tr>
<td>Mesoazide</td>
<td>Orazo</td>
<td>1-10 mg</td>
<td>low</td>
<td>mid</td>
<td>++++</td>
<td>+</td>
<td>2 mg</td>
</tr>
<tr>
<td>Risperidone</td>
<td>Risperdal</td>
<td>4-16 mg</td>
<td>low</td>
<td>mid</td>
<td>+</td>
<td>+</td>
<td>1-2 mg</td>
</tr>
<tr>
<td>Paliperidone</td>
<td>Invega</td>
<td>2-12 mg</td>
<td>low</td>
<td>mid</td>
<td>+</td>
<td>+</td>
<td>1-2 mg</td>
</tr>
<tr>
<td>Clozapine</td>
<td>Zyproxa</td>
<td>5-20 mg</td>
<td>low</td>
<td>mid</td>
<td>+/0</td>
<td>+</td>
<td>2 mg</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>Geodon</td>
<td>60-160 mg</td>
<td>low</td>
<td>mid</td>
<td>+/0</td>
<td>+</td>
<td>10 mg</td>
</tr>
<tr>
<td>Iloperidone</td>
<td>Fanapt</td>
<td>12-24 mg</td>
<td>mid</td>
<td>mid</td>
<td>+</td>
<td>+</td>
<td>1-2 mg</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>Abilify</td>
<td>15-30 mg</td>
<td>low</td>
<td>low</td>
<td>+</td>
<td>+</td>
<td>2 mg</td>
</tr>
</tbody>
</table>

# Anti-Depressants

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>Dosage Range</th>
<th>Sedation</th>
<th>Ortho</th>
<th>EPS</th>
<th>ACH Effects</th>
<th>Equivalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepines</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diazepam</td>
<td>Valium</td>
<td>2-10 mg</td>
<td>5 mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chloridiazepam</td>
<td>Librium</td>
<td>10-50 mg</td>
<td>25 mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lorazepam</td>
<td>Alivan</td>
<td>0.5-2 mg</td>
<td>1 mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxazepam</td>
<td>Xanax</td>
<td>0.25-2 mg</td>
<td>0.5 mg</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

# Benzodiazepines

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>Single Dose</th>
<th>Equivalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diazepam</td>
<td>BuSpar</td>
<td>5-20 mg</td>
<td></td>
</tr>
<tr>
<td>Gabapentin</td>
<td>Neurontin</td>
<td>200-600 mg</td>
<td></td>
</tr>
<tr>
<td>Hydroxyzine</td>
<td>Atarax, Vistaril</td>
<td>10-50 mg</td>
<td></td>
</tr>
<tr>
<td>Propranolol</td>
<td>Inderal</td>
<td>10-80 mg</td>
<td></td>
</tr>
<tr>
<td>Atenolol</td>
<td>Tenormin</td>
<td>25-100 mg</td>
<td></td>
</tr>
<tr>
<td>Quinapril</td>
<td>Tenex, Intuniv</td>
<td>0.5-3 mg</td>
<td></td>
</tr>
<tr>
<td>Clobazam</td>
<td>Clobetasol</td>
<td>0.1-0.3 mg</td>
<td></td>
</tr>
<tr>
<td>Pregabalin</td>
<td>Lyrica</td>
<td>25-450 mg</td>
<td></td>
</tr>
</tbody>
</table>

# Hypnotics

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>Dosage Range</th>
<th>Single Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diazepam</td>
<td>BuSpar</td>
<td>5-20 mg</td>
<td></td>
</tr>
<tr>
<td>Gabapentin</td>
<td>Neurontin</td>
<td>200-600 mg</td>
<td></td>
</tr>
<tr>
<td>Hydroxyzine</td>
<td>Atarax, Vistaril</td>
<td>10-50 mg</td>
<td></td>
</tr>
<tr>
<td>Propranolol</td>
<td>Inderal</td>
<td>10-80 mg</td>
<td></td>
</tr>
<tr>
<td>Atenolol</td>
<td>Tenormin</td>
<td>25-100 mg</td>
<td></td>
</tr>
<tr>
<td>Quinapril</td>
<td>Tenex, Intuniv</td>
<td>0.5-3 mg</td>
<td></td>
</tr>
<tr>
<td>Clobazam</td>
<td>Clobetasol</td>
<td>0.1-0.3 mg</td>
<td></td>
</tr>
<tr>
<td>Pregabalin</td>
<td>Lyrica</td>
<td>25-450 mg</td>
<td></td>
</tr>
</tbody>
</table>

# References and Recommended Books

- Quick Reference & Bipolar Medications
- Free Downloads
- Website: www.PsyD-Fx.com

# Over The Counter

- St. John's Wort
- SAM-e
- Omega 3-EPA
- Folic Acid
- L-methylfolate
- N-acetylcycteine
- Chamomile
- 5-HTP

# Over The Counter

<table>
<thead>
<tr>
<th>Name</th>
<th>Daily Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. John’s Wort</td>
<td>600-1800 mg</td>
</tr>
<tr>
<td>SAM-e</td>
<td>400-1600 mg</td>
</tr>
<tr>
<td>Omega 3-EPA</td>
<td>12g</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>400-800 mcg</td>
</tr>
<tr>
<td>L-methylfolate</td>
<td>7.5-15 mg</td>
</tr>
<tr>
<td>N-acetylcycteine</td>
<td>1200-2400 mg</td>
</tr>
<tr>
<td>Chamomile</td>
<td>200-1500 mg</td>
</tr>
<tr>
<td>5-HTP</td>
<td>300-600 mg</td>
</tr>
</tbody>
</table>

# Over The Counter

- Treats depression and anxiety
- May cause significant drug-drug interactions
- Treats depression
- Treats anxiety
- Treats depression
- Treats anxiety
- Also available as Depakote (levotriptan/methylfolate) 7.5-15 mg

# Handbook of Clinical Psychopharmacology for Therapists
- Preston, O’Neal and Talaga (2013)

# Clinical Psychopharmacology Made Ridiculously Simple 8th Edition
- Preston and Johnson (2015)

# Bipolar Medications: A Concise Guide

# Child and Adolescent Psychopharmacology Made Simple
- Preston, O’Neal, Talaga (2015)
Crisis Plan with Instructions

The purpose of this document is for you to create a plan you and/or your providers can access when you are having a hard time. The best time to work on this document is when you are doing well. While those may not be the times you want to think about crisis, it can be beneficial for you should you ever need to access crisis services in the future. You can fill this out alone or in conversation with someone else. This is simply a guide, it is YOUR crisis plan, use it however you would like. This “Crisis Plan with Instructions” may help you answer many of the questions.

Name:
Address:
Phone #:
Birthdate:
Gender: Female Male Transgendered

Emergency Contact: Who would you like to have notified if you are having a hard time? Are there limits you would like set around this? For example, “I would like you to call my emergency contact if I can’t speak for myself; however, if you are able to converse with me, please ask my permission to contact this person. –or– only contact this person if my life is at risk.”

Health Needs: Are there things in regards to your health that you need to be mindful about? For instance if you have dietary arrangements, or allergies? Perhaps you have a c-pap breathing machine. These are things you should consider when you think about your needs when you are in crisis.

Directions to Home: This is helpful if you give your plan to a crisis team, peer organization, or others who may come to your home to support you.

Service Providers: Who are the “professionals” in your life? Are there some you want contacted when you are in crisis? Are there some you may need support around contacting?

Pets: If you have pets, what are the arrangements if you have to be away from home?

Children: If you have children living with you, what are the arrangements if you’re having a hard time or have to be away from home?

Cultural Heritage/Spirituality: Is there something about your culture you’d like to share? Is there something that would be important for someone who’s giving you support to know?
Describe what crisis looks and feels like to you?
What is different in times of crisis than in other times of your life?

<table>
<thead>
<tr>
<th>Crisis:</th>
<th>Other times in my life:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This question is an opportunity to look at what is different between a time of crisis and other times. You can also think of this in terms of a “good day” vs. a “bad day.” For example – Most days I have to struggle a bit to get out of bed, but I’m able to do it – when I’m in crisis it feels like getting up isn’t even an option. If I’m having a really hard time, it can be helpful to have encouragement to get up, sometimes a gentle reminder of how good it feels to get up and move around, feel the sun on my face and have some breakfast can really get me going. Thinking about what is helpful on a regular day, may enlighten you about what could be helpful during a time of crisis.

When you’ve been in a crisis situation what kinds of support did you seek?
What (people, places, services) things were the most helpful? Why?

<table>
<thead>
<tr>
<th>Support</th>
<th>What was helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Make a list of ways you’ve sought help before. Then think about that support and what was the most helpful. Consider all of your experiences, for instance, there may have been places that you hated going to, but there was something about it that really worked for you. Example: “I didn’t like feeling confined in the hospital, but it was helpful to have people to talk to.” When you’ve made your list of what was helpful, it should help you think about what you want to put into place when you are having a difficult time.
<table>
<thead>
<tr>
<th>What are the most difficult feelings for you to experience? Please check the Most difficult feelings or add any you don’t see listed here:</th>
<th>Think about what happens when these feelings get overwhelming. Consider the following: What does it feel like inside your body? What do you need when this happens? What can you do for yourself? What has been helpful before?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happy</td>
<td>Boredom</td>
</tr>
<tr>
<td>Joy</td>
<td>Loneliness</td>
</tr>
<tr>
<td>Sad</td>
<td>Emptiness</td>
</tr>
<tr>
<td>Grief</td>
<td></td>
</tr>
<tr>
<td>Afraid</td>
<td></td>
</tr>
<tr>
<td>Angry</td>
<td></td>
</tr>
<tr>
<td>Rage</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
</tr>
<tr>
<td>Overwhelmed</td>
<td></td>
</tr>
</tbody>
</table>

This exercise is an opportunity to think about “feelings.” Often when we have strong feelings it can be a signal that we need to do something to “make the feelings go away.” However, what if you could turn that around, and think about a strong feeling as a signal to do something different? For instance, consider feeling overwhelmed. “When I’m overwhelmed I feel like giving up, so I need to call someone so I don’t hurt myself.” Is it possible to challenge yourself to “sit” with the overwhelming feelings and think what the feeling is “telling you?” Are there other feelings involved? How long could you tolerate that before you would need someone else to support you? How do you know when it is time to reach out for support? Write about that in the following box.

When do you decide to reach out for support? How do you identify when you need to do something different? Write about that.
Think about the people around you when you experience crisis. Are there behaviors or actions you take that might frighten other people? Please Describe.

| How do you feel about these behaviors? What would you like the people around you to understand about this? How would you like them to react? What do you need to hear? Also identify what can make it worse, what you don’t want people to do. What do you need to do personally? Write about that. |

Sometimes when we’re not doing very well we may say or do things that result in other people feeling uncomfortable or even scared. Be honest. Are there things you say, or behaviors you have that have this result? If so, think about what it is you really need when this happens. For instance,” When I feel really pressured, I feel short-tempered, and I’ll snap at people. I may stomp around, grumble to myself and appear pretty unfocused. I know that I’m feeling out of control, and I need to focus on one task and let others focus on everything else. Sometimes it’s helpful for a person to point out that I’ve snapped at them and ask what is going on for me. It is not helpful for someone to snap back at me, or to tell me to stop pacing. I don’t need “directions at that point, I need assistance to identify what is happening for me.”

| Can you identify things that you’re not likely to talk about when you’re in crisis, or “code words” you may use? |
For example, “When I’m having a hard time I use the word ‘fine’ a lot. When I say “I’m fine” I’m usually feeling really lousy and hopeless. I really need for people to push me a little and explain what that means.

Are there people in your life who are important to you? (Children, Partner, Friends, Relatives, Clergy, Staff) Think about who they are, and who you may want to be in touch with if you’re experiencing crisis, or end up getting support other than in your home. List their information here.

<table>
<thead>
<tr>
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There are probably many people in your life who are important to you. In this list you may want to list only those you want to be in touch with when you’re having a hard time. This can be useful if you stay somewhere other than your home. You can use this list for people you are willing to have visit you.

Are there people from this list who you would want consulted if there was any question of “next steps” when you are in crisis. Name those people. Make sure their contact information is included in the list above.

If there is any question about if we are “ok” to stay at home, or go to a friend’s house rather than admission to a program, it can be helpful to have people who know us really well whose insight can be valuable. If that is true for you, list them here. Make sure their contact information is accurate, it may difficult to remember accurate information if you’re having a hard time. If you have this document with you when you’re meeting with a crisis team or hospital staff you can point out that you’d like them to consult with people on your list.

Is there anything else you would like people to know or consider when you’re “in crisis”? Is there anything else you need to remind yourself about when you’re “in crisis”? 

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This final question is an opportunity to say anything that wasn’t covered in the other questions. Remember this is YOUR crisis plan. You can write anything you want. Also remember – if you want people in your life to honor your requests when you’re having a hard time, you may want to share this with them. However, it is your personal decision whether you share this or not.