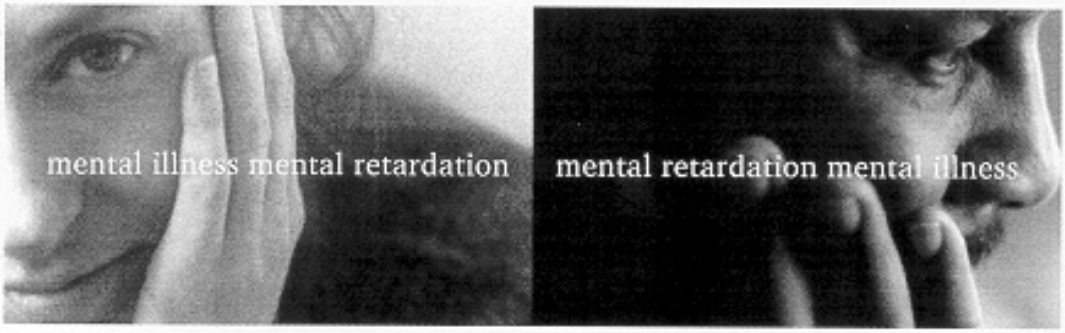

Report and Recommendations

Clinical Best Practices
for Serving People with
Developmental Disabilities
and Mental Illness

Ohio Department of Mental Health - Ohio Department of Mental Retardation and Developmental Disabilities Advisory Committee

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Acknowledgments

Many thanks to the members of the sub-committee, and to their colleagues around the state and nation who contributed many hours of work toward this project. Most of the work was done between meetings, and members and their network of colleagues drafted and reviewed sections of the document. Principle authors of the sections are:

Values and Mission
Michael Schroeder and Andrew Eddy, M.D., M.S.

Assessment and Diagnosis
Lani Eberlein, Psy.D.

Biopsychosocial Interventions
Betsey Benson, Ph.D. and Andrew Eddy, M.D.

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Schedule of Meetings

April 11, 2000

May 9, 2000

June 5, 2000

July 17, 2000

August 9, 2000

September 19, 2000

Each meeting lasted from 10 a.m. until approximately 3 p.m. As noted, much work was done between meetings.

Introduction

In February, 2000, Directors Michael Hogan and Kenneth Ritchey convened a broadly based committee to make recommendations for the improvement of services to Ohioans who are served by both systems. They charged the committee with three primary tasks:

- Identify Best Practices in serving and supporting people who are often poorly served
- Plan a conference or training events which involve
  1) Content - Generalize the training on Best Practices so that they are implemented around the state, and
  2) Process - Grow the spirit of collaboration, being sure to involve consumers and families
- Recommend ways in which the two systems can work better together

In order to accomplish these tasks, the committee divided into three sub-committees: Best Practices, Training, and Intersystems. In addition to members of the ODMH-ODMR/DD Advisory Committee, representatives of professionals, consumers, and family members from around the state have participated in sub-committee work.

The Best Practices Sub-Committee presented its report to the Advisory Committee in August, 2000. The Advisory Committee accepted the report, but asked for some minor modifications, which were made in September, 2000. The draft document was presented to Directors Ritchey and Hogan in November, 2000, and they asked that it be published and distributed to Boards and agencies in both systems.

This is truly the result of a cooperative effort begun by both Directors and involving many people from both systems. It should be noted that Best Practices are never static, and that the work needs to continue. This document does, however, establish goals toward which to work and a framework for accomplishing those goals.

Please use it as a guide to delivering and obtaining services. Discuss it with friends and colleagues. Contribute to success for the people we serve jointly.

Mission Statement

The MH-MR/DD Advisory Committee is committed to improving services and supports to people who experience co-occurring developmental disabilities and mental illness through recommendations to the Directors of both Departments. It is committed to the identification and reduction of systems barriers, to the development of integrated services, to encouragement of collaborative efforts to identify and spread best practices, and to train staff, consumers and family members in understanding how both systems operate, and how to obtain and/or provide state of the art services within each system.

Values Statement

People with developmental disabilities and co-occurring mental illness are among the most vulnerable of Ohio's citizens. All people have value, and all people should have access to needed services and supports regardless of disability. The Ohio Department of Mental Health, the Ohio Department of Mental Retardation/Developmental Disabilities, and Boards and agencies in each system have a necessary, equal, and shared responsibility to:

- Ensure that needs are determined on the basis of comprehensive and thorough diagnostic assessment of mental health and developmental needs of each individual
- Ensure that needs are not based solely on either mental health assessment or diagnosis, or developmental assessment or diagnosis
- Ensure that individual's needs are met in a way that preserves dignity, offers choices, and improves his or her health and safety
- Ensure that access to services is equitable
- Ensure that access to services is based on need
- Work collaboratively with other systems serving this population
- Serve people with co-occurring developmental disabilities and mental illness effectively
- Ensure that the services provided to the individual are consistent with what the person wants out of life and what supports he or she needs to accomplish this

In keeping with the spirit of these values, phrases such as "primary diagnosis" no longer have relevance nor should they be used in determining service delivery to persons with mental illness and developmental disabilities.

Incidence

While there are no studies specific to the incidence of mental illness among people with mental retardation in Ohio, there are a number of studies conducted elsewhere which place the incidence at 30 to 40 percent, a much higher rate than exists in the general population. If we consider that the incidence of mental retardation in the population is in the range of 3 percent, then, with a population of approximately 11 million, Ohio would have between 99,000 and 132,000 people with mental retardation who would, at some point in their lives, experience mental illness.

Guidelines for the Evaluation of Persons Dually Diagnosed with Mental Retardation and Mental Illness

Lead: Lani Eberlein, Psy. D.

Professionals

*The use of the word "Professionals" in this document refers to all persons (e.g., psychiatrists, psychologists, physicians, social workers, nurses, etc.) who assess, diagnose and treat persons with mental retardation and mental illness.

Introduction

Perhaps the most challenging clinical aspect of providing mental health care to people with developmental disabilities is the diagnostic assessment of psychiatric disorders. Although it has been reported that persons with mental retardation experience the full range of psychiatric disorders (Syzmanski & King, 1999), at rates higher than the general population (Borthwick-Duffy & Eyman, 1990; Eaton & Menolascino, 1982; Einfeld & Tonge, 1996; Reiss, 1990), many mental disorders, for various reasons, are misdiagnosed, under-diagnosed, or undiagnosed in this population. The degree of accuracy of diagnostic assessment with this population is critical to best practice as it provides the foundation for the treatment and service planning.

Best practices in the assessment and diagnosis of mental health disorders in people with developmental disabilities require ongoing, comprehensive, and thorough assessments conducted in multiple settings. This comprehensive assessment process must include the review of clinical records, in vivo behavioral observation, and interviews with multiple informants who know the individual and his or her level of functioning.

The purpose of diagnostic assessment is not to label, but to identify areas of need and to recommend treatment and services. Assessments must take into account the biopsychosocial aspects of the individual. Diagnostic assessment with this population requires more time than is typically allotted because the clinical interview with the individual alone is not diagnostic. It is necessary to collect and to integrate historical data about the individual's functioning and treatment with present data and observation.

Guidelines for the Evaluation of Mental Retardation and Mental Illness

I. General Guideline: Familiarity with Nomenclature and Diagnostic Criteria

A. Licensed professionals* performing clinical assessments of mental retardation and mental illness should be familiar with the prevailing diagnostic nomenclature and specific diagnostic criteria.

1. Practical Considerations

   Influence of Level of Mental Retardation

   Effects of Mental Retardation on the Diagnostic Process

   Diagnostic Overshadowing

   Strengths and Needs vs. Symptomatology and Disability

2. Adaptive Functioning (skill areas)

   Ability to cope with the natural and social demands of the environment

II. General Guidelines: Ethical Considerations

A. Professionals attempt to obtain informed consent.

B. Professionals gain specialized competence and only practice in areas in which they have unique training, experience and qualifications.

C. Professionals seek and provide appropriate consultation.

1. Information from many sources and from other professionals is

obtained prior to the evaluation

2. Family and other important collateral individuals will be involved in the assessment process

D. Professionals are aware of personal and societal biases and engage in non-discriminatory practice.

E. Professionals look for presentation of mental illness in the developmentally disabled population across age, sex, health differences.

III. Procedural Guidelines: Conducting Evaluations of Mental Retardation and Mental Illness

A. Professionals conduct a clinical interview as part of the clinical assessment, and are aware of the importance of therapeutic alliance.

B. Psychologists are aware that standardized psychological tests are important tools in the assessment of mental retardation and mental illness. They are also aware that there are few measures which are standardized for use in a dually diagnosed population, and are careful about instrument selection, administration and interpretation (and note rationale in report). Standardized instruments, while often providing important information, cannot alone diagnose the presence of dual diagnosis.

C. When measuring cognitive changes in individuals, psychologists attempt to estimate premorbid abilities based on old records, and on collateral information.

D. Psychologists are sensitive to the limitations and sources of variability and error in psychometric performances, and chose instruments that will best evaluate each individual.

E. Professionals recognize that providing constructive feedback, support and education, as well as maintaining a therapeutic alliance, can be important parts of the evaluation process.

F. Specialized formats

1. Recommended psychological and adaptive evaluation materials
2. Recommended psychological assessment report format
3. Recommended protocol for integrative team report/clinical assessment

Tenets of Best Practice

- Examining historical records and interviewing family members and care providers are necessary parts of the evaluation. All medical, developmental (especially prenatal and birth) and social history is important. It is important to try to verify the accuracy of records or verbal reports. Accurate diagnosis and effective care and treatment require knowledge of the context in which a person has experienced the world, and also how they relate in their current environment.
- The reasons for doing assessment and diagnosis is not to label, but to identify areas of need and services required. The assessment is to be holistic and include the individual's emotional, psychological, physical, social and other (e.g., educational, vocational, etc.) state at present, and is not

Tenet

There is no form of treatment that is equally effective for all types of mental illness. Treatments may or may not include medications, psychotherapy or other therapies, day treatment, residential, social or vocational skill training, behavior management programs, nutrition, etc., alone, or in combination. Other considerations as to the feasibility of treatments may include availability of service or practitioner, financial resources, time needed, environmental supports, least restrictive alternatives, quality of life, etc.

Tenet

Any treatment initiated needs to be evaluated based on accurate and complete records, as well as reports from the individual and significant others. Upon evaluation, or re-evaluation, the effectiveness, accuracy of diagnosis, further or other needs or treatments need to be considered. The person's level of intellectual functioning should influence the selection of interventions for treating the psychiatric disorder.

Services provided should be based on and support the individual's goals and aspirations in life.

just to catalog problem areas. The assessment and diagnosis is the foundation for the treatment plan for change in needed areas, and to identify areas of strength for each individual.

- This diagnosed population needs "informant tag-a-longs" who are very knowledgeable about the individual and his/her life. Records can be incomplete, absent, incorrect; but effective care and treatment require knowledge of the context in which a person has experienced the world, and also how they relate in the current environment.
- Assessment is an ongoing process, and must continue after an initial evaluation is completed. The assessment must be concurrent with treatment, as people change over time. People are not static and do change due to age, societal experience and circumstances. Mental illnesses also change over time and with treatment. Continued monitoring and re-evaluation of symptoms and behavior are needed to note progress and to identify changing needs.
- Assessment should be comprehensive, thorough and interdisciplinary. The greater the number of informed individuals contributing their observations, the more complete the picture of the client.
- In vivo observations must occur at home, work, school, hospital, etc.
- A thorough physical examination is a critical part of the assessment and additional psycho-neurological assessments may be necessary. Symptoms associated with mental illness also could be caused by a medical problem or medications. Eliminate the possibility that the symptoms have a medical cause prior to looking for mental illness.
- There may exist immediate circumstances that need to be addressed simultaneous to the assessment. Examples are behaviors that threaten safety or placements.
- Assessment interviews often last more than one hour, and cannot be completed based on an interview with the client alone, or by noting that "records indicate that this person has MR."
- Assessment is a complex effort that requires biopsychosocial evaluation, clinical data collection, psychological / intellectual evaluation, adaptive functioning assessment, and contact with collaterally involved others such as family, teachers, or other knowledgeable informants. It also requires review of old records and integration of all old and present information. Assessment can take several hours at least, and may need to occur over a period of weeks, or more.
- Agencies or counties with limited resources should not "make do" with what they have, but should contact a Center of Excellence (once the Centers are established) for suggestions, technical assistance and direction to needed resources. It is essential that the important task of assessment be completed competently for each individual.
- Several psychological screening/assessment instruments may also be determined to be helpful as part of the diagnostic assessment process (see Appendix A). As with other components of the comprehensive assessment process, these instruments are most useful when combined with other assessment techniques described above.
- Risk assessment may also be necessary, in addition to diagnostic assessment, for individuals who pose danger to themselves or

others. Risk assessment and crisis planning should occur simultaneously with diagnostic assessment and treatment. All members of the individual's team should conduct risk assessment and take part in crisis planning as a collaborative effort.

- Clinicians doing diagnostic assessment and treatment planning with people who have developmental disabilities need specialized education, supervision and training in the mental health aspects of developmental disabilities.
- Clinicians doing assessment and treatment planning need to be available to provide technical assistance on an ongoing basis to those persons providing services to the individual.
- Clinicians conducting assessments must recognize that various mental illnesses can manifest differently across the levels of mental retardation. In addition, mental retardation is not one condition; there are a number of syndromes, causes and levels of retardation, which may have behavioral implications. Clinical sensitivity to cultural, age and health related differences is necessary given their impact on an individual's presentation in an assessment setting. For example, infrequently seen conditions such as Asperger's, MIMR/blind, MIMR/deaf , MIMR/epilepsy, Autism, etc., may be difficult to diagnose across the span of variability mentioned above.

Diagnostic Assessment Process

I. Interview

- Individual
- Family/care providers/teachers
- Other professionals/service providers

II. Observe

- Individual in natural settings (home, schools, work, etc.)
- Individual's environment
- The behavior of those around the individual

III. Study

- All available historical records

IV. Psychological Testing/Evaluation (as appropriate)

- Administer psychological assessment instruments, if appropriate
- Collect information on adaptive functioning

V. Integrate/Organize

- Historical and current information and data

VI. Formulate

- Diagnosis

VII. Develop

- Service/treatment recommendations based on results of above

Information to Gather in a Developmental History

I. Birth history

A. APGAR score

B. Drugs or medicines used before and during conception

C. Alcohol, cigarette smoking or other drugs (OTC and illegal) used before and during pregnancy

D. Actual birth history

E. Known problems in other family members

II. Early Infancy

A. Developmental milestones

B. Odd or difficult behavior

C. Use of speech, how much, etc.

D. If was in pre-school, history of behaviors and interactions with others

D. Any ongoing medical problems

III. School Age

A. Usual tests with in-depth analysis of any "flag" items (including exceptionally bright)

B. Development of self-concept and self-esteem

C. Development of reciprocal interpersonal relationships with adults and peers

D. Note signs of special stress and how s/he coped with it

E. Any ongoing medical problems including substance use

IV. Adolescent and Adult

A. Usual histories with great concentration of social interaction and social responsibility

B. Personal responsibility – trustworthiness, idiosyncratic behavior.

C. Ongoing medical problems including substance use

D. Remember that for clinical purposes, intelligence relates to:

1. Sensory-motor development
2. Cognitive development
   a. Reception
   b. Perception
   c. Apperception
3. Rate of learning (what the I.Q. tests)
4. Social Awareness

Treatment Process

Treatment is founded upon accurate and complete diagnosis. The process of treatment planning needs to be individualized to the unique needs of each individual which were identified in the assessment. All aspects of treatment will be affected by the individual's level of functioning, cognitive level, as well as the type/s of mental illness. The special circumstances of this complex area of practice may require adjustment of the recommended treatment protocols for individuals without dual diagnosis. Of course, ongoing and continuous evaluation of treatment effectiveness needs to be conducted, and necessary changes implemented as often as necessary.

Considerations for providing treatment to dually diagnosed individuals:

1. Are there underlying medical causes for the symptoms or behaviors?

2. If the individual is on medication, are the symptoms or behaviors noted caused or made worse by the medication?
3. Would medication be effective with this disorder?
4. Has a comprehensive functional assessment been conducted?
5. Has relaxation training, desensitization or social skills or anger management training been taught?
6. Has the individual taken part in psychotherapy or counseling? Is s/he emotionally connected to the therapist?
7. Has a symptom-targeted behavior/support plan been implemented?
8. Has safety of the individual and of others been assured?
9. Will the environment be able to provide support and necessary structure for the treatment being considered?
10. Are there qualified persons readily available to implement the treatment plan?
11. Are treatment costs feasible for the individual, agency or system?
12. Has the individual agreed to the proposed treatment, and contracted to do so?
13. Have the individual's concerns been taken into consideration?
14. Have previous treatments and outcomes been reviewed as to what worked, and what did not, and have efforts been made to determine why in both cases?
15. Have the clinicians who provided the diagnostic assessment been involved in formulating the treatment plan? Are they available to assist by consulting (or providing technical assistance) to the persons implementing the plan?

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Journals of interest:

American Journal on Mental Retardation.

Mental Health Aspects of Developmental Disabilities.

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Betsey A. Benson, Ph.D., Henry Leland, Ph.D., Elizabeth Moussas, Ph.D., and Sandi Steiger

Biopsychosocial Treatment

Leads: Betsey Benson, Ph.D., and Andrew Eddy, M.D., M.S.

Introduction

People with dual diagnosis (MI/MR) are a heterogeneous group of individuals with a wide range of abilities, behaviors, and psychiatric disorders. The biopsychosocial treatment model integrates the psychological and sociological influences on mental health and behavior, as well as the biological causes of behavior and the biological response to medication treatment. These three areas of an individual's life are interdependent and interrelated. Therefore, an integrated treatment plan, based on a thorough assessment, that addresses the individual's needs, is necessary. The development and implementation of an integrated plan requires a team approach that includes participation of professionals, support persons, including family and staff, and the consumer. A team approach is consistent with a biopsychosocial model of treatment in which biological, psychological, and social attributes and influences are addressed in the assessment and intervention. The integrated plan should address consistency across settings. The integrated plan should be monitored and reviewed on a regular basis to determine if desired outcomes are achieved and if changes are needed in the plan. A comprehensive treatment plan may include both medication and psychosocial interventions.

Biological Treatment

The diagnosis and treatment of mental illness in the general population has been well described. Research has demonstrated the effectiveness of treatment strategies, particularly the use and effectiveness of psychopharmacology. There are accepted definitions and diagnostic criteria for mental illnesses that are elucidated in the current version of the American Psychiatric Association's "Diagnostic and Statistical Manual" (DSM). The American Psychiatric Association has produced practice guidelines for the psychiatric evaluation of adults, and practice guidelines for the treatment of several more common psychiatric disorders (www.psych.org). The American Academy of Child and Adolescent Psychiatry has published twenty practice parameters for the assessment and treatment of those mental illnesses that typically affect children. (See reference on page 18.) These "practice guidelines" and "practice parameters" are not standards by which therapy must be provided. Rather they are meant to provide professionals with assistance in formulating an individualized diagnostic and treatment plan.

In contrast, the treatment of mental illness in persons with MR/DD, until recently, was not well described and was not the focus of research. In the past few years great advancements have been made in the understanding of the psychiatric assessment, diagnosis, and treatment of mental illness in this population. We now recognize that mental illness for persons with mental retardation is in essence the same as for persons without mental retardation. Mental illness can occur in any individual, regardless of level of functioning or presence or absence of a disability. We also know that what works for a particular mental illness for a person without mental retardation will generally work for a person with mental retardation. The mechanisms of action of psychotropic medication are the same in both populations. Therefore, the general treatment principles, practice guidelines, and practice parameters that have been developed and accepted for use for the assessment, di-

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agnosis, and treatment of mental illness are in general also applicable to the population of persons with MR/DD and mental illness, with the following nuance.

The manifestation of mental illness in many individuals with MR/DD may differ from that in the general population. Mental illness in individuals with mental retardation may present as unusual or repetitive behaviors, withdrawal, aggression, self-injurious behavior, destructive behavior, agitation, anxiety, and sleep disturbance. Additionally, an individual with mental retardation and mental illness may be unable to adequately express symptoms of their mental illness. This may include difficulty in or inability to provide symptom description or to self-report symptoms, including thoughts, feelings, and physical concerns. The verbal expression of treatment efficacy, and verbal communication of medication side effects, may be impaired. These medical, neurological, and sensory impairments necessitate more behavioral observations rather than reliance on self-reporting and patient interview for assessment of the individual and assessment of treatment effectiveness.

A diagnosis from the current version of the DSM is preferable in order to guide appropriate treatment with psychotropic medication. However, some individuals will not present with symptoms of a specific DSM diagnosis. These individuals may have significant behavioral issues that do not respond or only partially respond to psychosocial interventions. In such cases, only a non-specific DSM diagnosis can be made. These situations may require treatment of an index behavior with psychotropic medication (Rush & France, 2000, Guideline 1B).

Guidelines for the psychiatric evaluation and psychopharmacolgic treatment for individuals with mental retardation and mental illness have been developed which expand on guidelines for general psychiatric care by considering the unique characteristics of mental illness in individuals with MR/DD. The most recent guidelines, *Treatment of Psychiatric and Behavioral Problems in Mental Retardation*, were published in the AJMR in May 2000. These guidelines present the most up-to-date consensus by medical experts in this field. In 1996, an international consensus conference was convened. The product of this endeavor was the resource book *Psychotropic Medication and Developmental Disabilities: The International Consensus Handbook*. Also in 1996, The Health Care Financing Administration released the ICF/MR training manual *Psychopharmacological Medications: Safety Precautions for Persons with Developmental Disabilities—A Resource for Training and Education*. These guidelines serve as a basis for the assessment and treatment of persons with mental retardation and mental illness.

Psychopharmacologic Treatment

Clinical psychiatry and treatment with psychotropic medication are important components of effective treatment for individuals with mental illness regardless of intelligence level. The goals of psychiatric care and psychopharmacologic treatment are the alleviation and reduction in symptomatology and an improvement in an individual's quality of life. The use of psychotropic medication based on these premises is appropriate for persons with mental retardation and mental illness. The following recommendations recognize this relationship between the use of psychotropic medication and the achievement of desired goals.

Recommendations for Psychopharmacologic Treatment

Psychopharmacologic treatment of individuals with dual diagnosis should follow the biopsychosocial model in which the use of psychotropic medication is part of an integrated treatment plan which includes psychosocial interventions and is based on a thorough and on-going assessment.

Psychopharmacologic treatment of individuals with dual diagnosis is the same as for persons without mental retardation.

- A thorough psychiatric assessment, including assessment of substance abuse as indicated, leads to a reasonable and rational diagnostic postulate.
  - The diagnosis should be as specific as possible
  - Some persistent and significant behaviors may lead to no diagnosis or to a nonspecific DSM-IV diagnosis (e.g. aggression, self-injury)
- Treatment with psychotropic medication is instituted with a medication appropriate:
  - for the diagnosis (psychotropic medications should be used for specific mental disorders),
  - for the persistent and significant behavior when either a nonspecific diagnosis from the current version of the DSM or no diagnosis is made (the index behavior or symptom complex is monitored closely for effectiveness of psychotropic medication).
- The decision to use psychotropic medication takes into consideration the anticipated benefits of the medication in light of the potential risks and side effects of the medication.
- Medication dosage is reasonable and within acceptable dosing parameters.
- Duration of treatment is long enough to assess effectiveness of medication.
- Effectiveness of treatment is measured by assessing for alleviation or exacerbation of symptoms and improvement or decline in quality of life (e.g., changes in index symptoms and behaviors, social integration and functioning, physical health, vocational skills and functioning, and living situation).
- If treatment is deemed effective, there should be consideration for continuation of medication at current levels, weighing the improvement in the mental health of the individual versus the potential side effects of the medication.
- If treatment is deemed ineffective, then accuracy of assessment and diagnosis should be examined, as well as issues such as medication compliance, and appropriate and consistent implementation of psychosocial treatment modalities.
- These treatment principles apply to both short-term treatment of extreme behavior that significantly impacts an individual's life, and to long-term treatment of a mental illness.

In performing an assessment, one should consider multiple causes for a behavioral disturbance. Behavioral disturbances may be the result of:

- a psychiatric disorder or mental illness (untreated or partially treated),
- an environmental stressor,

Interventions

Psychosocial interventions are a major component of effective treatment for psychiatric disorders of persons with MR/DD. Individuals with dual diagnosis can benefit from and often require psychosocial treatments, including psychotherapy and behavioral interventions.

Interventions should be provided in a consistent manner by trained individuals.

- an underlying medical condition (which may cause behavior or have associated psychiatric features, or may unmask or exacerbate behavior secondary to a psychiatric illness), due to:
  - CNS effect of medical condition,
  - pain and discomfort,
  - sleep disturbance,
  - fatigue and malaise due to chronic illness,
  - medication side effects, including akathesia from neuroleptics and disinhibition from sedative-hypnotics.

An individual's cognitive skills, communicative skills, adaptive skills, and current life situation should be considered in performing the psychiatric assessment and utilizing a diagnostic approach. Guidelines, such as those developed by the American Psychiatric Association (*Practice Guideline for Psychiatric Evaluation of Adults*) may need to be modified based on an individual's needs.

Records must be accurate and informative. Data, which are important to document over time, include:

- Assessments and diagnostic impressions, including rationale for medication use:
  - Medication dosages with corresponding blood levels (if appropriate),
  - Time length of medication trial,
  - Results of medication trial,
  - Narrative,
  - Index behavior data,
  - Medication side effects or adverse effects,
  - Reasons for discontinuation of a trial, (e.g. comorbid illness, drug-drug interaction, psychiatric side effects of medication for medical illness, changes in environment.)
- Documentation of minimal effective dose.
- Documentation of reason(s) for ongoing medication treatment and dosage.

Psychosocial Interventions

Psychosocial interventions are a major component of effective treatment for psychiatric disorders of persons with MR/DD. Individuals with dual diagnosis can benefit from and often require psychosocial treatments, including psychotherapy and behavioral interventions. The goals of psychosocial interventions include not only a reduction of symptoms, but improvement in quality of life. An important goal of interventions for people with dual diagnosis is to help them live and work in their communities. The treatment of persons with dual diagnosis should include appropriate individual, group, and/or family therapies that are consistent with the person's skills and needs. Interventions should be provided in a consistent manner by trained individuals.

Psychosocial interventions for persons with dual diagnosis frequently focus on the development of adaptive skills such as social skills, communication, self-management, and stress reduction.

Recommendations for Psychosocial Treatment

- Treatment of individuals with dual diagnosis should follow the biopsychosocial model in which services are part of an integrated treatment plan based on a thorough assessment; the plan may include both psychosocial interventions and medication.

- Key persons (caregivers, support persons, and the person with the disability) should agree that the intervention and its effects are worthwhile (social validity).
- Treatment should involve the family or other people who are important in the individual's life. Education of the family and staff about psychiatric and behavioral problems and appropriate responses is needed to support the intervention efforts.
- The individual with dual diagnosis should participate in the development and implementation of the person-centered recovery plan to the fullest extent possible.
- The various systems and agencies that interact with the individual should cooperate to develop and implement a single integrated plan that addresses the individual's needs. The respective roles and responsibilities of the agencies/individuals involved should be specified in some detail. Clarity in role definition can prevent duplication or gaps in services.
- Individual, group, and/or family therapies that are conducted by trained individuals are appropriate components of an integrated treatment plan. Psychosocial interventions that are best practices for the general population are applicable for persons with MI/MR. The therapies should be provided in a manner that is consistent with the consumer's developmental level and communication skills. This may require some adaptation in technique from treatment approaches considered standard for persons without MR/DD. Fewer adaptations are typically needed for individuals with mild disability than with those with severe disability.
- Reducing psychosocial stressors and increasing social supports for the individual are appropriate goals in a comprehensive treatment plan.
- Intervention plans should consider changes in the environment that could be beneficial for the individual, such as reorganizing activity schedules, expanding choices, changing the physical properties of the environment, and scheduling of personnel. Such adjustments may improve the person-environment fit.
- Intervention plans should aim to strengthen positive behaviors, not just decrease problem behaviors.
- Intervention plans should start with the least intrusive intervention, while ensuring a safe and secure environment for all concerned. The intervention plan should represent a good fit in the context of the day-to-day life of the individual, and be practical and relevant, with a common understanding by the people involved on how to implement it. The use of more intrusive interventions may be needed depending on the severity of the behavior (e.g., aggression, self-injurious behavior). Thoughtful consideration should be given to how intrusive interventions are incorporated into the overall plan. Guidelines for review and modification of plans which include intrusive procedures must be specified. The careful monitoring of interventions is critical in these instances.
- To prevent harm to self and others, it is necessary to intervene in crisis situations. Appropriate contingency and crisis plans should be developed in advance to insure a prompt and effective response. The individual should be involved in the develop-

ment of the crisis plan as much as possible. Equal attention should be given to methods of crisis prevention.

- Families, teachers, staff, and dually diagnosed individuals need ongoing, not episodic, support. The integrated treatment plan should be able to be adapted to provide appropriate levels of support for fluctuating needs.
- Continuity of care is particularly important for individuals with dual diagnosis. The team approach can contribute to improved continuity of care.

Note:

1. This report uses the term "psychosocial treatment" to refer to psychotherapy, counseling, cognitive behavior therapy, behavior therapy, and procedures based on applied behavior analysis, as in Rush and Frances (2000).
2. Psychotropic medication: Any drug prescribed to stabilize, or improve mood, mental status, or behavior. (Reiss & Aman, 1998, p. 51)

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Health Care Financing Administration (1996). Psychopharmacological Medications Safety Precautions for Persons with Developmental Disabilities.

Reiss S, Aman MG (Eds.) (1998). *Psychotropic Medication and Developmental Disabilities: The International Consensus Handbook.* Nisonger Center for Mental Retardation and Developmental Disabilities, Columbus, OH.

Rush AJ, France A (Eds.) (2000). Special Expert Consensus Guideline Series: Treatment of psychiatric and behavioral problems in mental retardation. *American Journal on Mental Retardation,* 105.

Resources

In addition to practice guidelines found in the above reverences, the following practice guidelines are important resources in the use of psychotropic medication for the treatment of mental illness in persons with mental retardation.

American Academy of Child and Adolescent Psychiatry Practice Parameters
www.aacap.org/web/aacap/clinical/parameters.htm

American Psychiatric Association Online Clinical Resources: Practice Guidelines
www.psych.org/clin_res/prac_guide.html

Moore D (Ed.) (1998) *Substance Use Disorder for People with Physical and Cognitive Disabilities.* Treatment Improvement Protocol (TIP) Series # 29. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, National Clearinghouse for Alcohol and Drug Information, 1-800-729-6686, 301-468-2600

Project Med, Nisonger Center for Mental Retardation and Developmental Disabilities, Ohio State University, www.project-med.org

A Best Practice Model for Delivering Dual Diagnosis Services

Lead: David Wilkerson, LISW

Introduction

Best practice recommendations contained in this report have been developed by the Best Practices Subcommittee of the Ohio MH/MR Advisory Committee and they incorporate many common, effective service components described as effective by national and international dual diagnosis service programs (Davidson, Morris & Cain, 1999).

Individuals with developmental disabilities and co-existing mental health disorders (dual diagnosis) often require services that are delivered simultaneously by different service providers, various professional disciplines, and multiple service systems. The complex and varied needs of this population require that consumers, family, professionals, organizations and service systems work collaboratively in order to develop and coordinate treatment and supports for the individual in the community. When service planning is not coordinated, and collaboration does not occur among service providers, the individual is likely to fall through cracks in services, and the person's adjustment, growth and productivity in the community suffer as a result.

To bridge these clinical, institutional and organizational service gaps, communities must evaluate their existing methods of service delivery to this population, and develop strategies for incorporating best practice parameters in the following service areas:

- Evaluation/Assessment/Diagnosis of Psychiatric and Behavioral Disorders
- Integrated Service Planning
- Psychosocial and Psychotropic (Bio-psychosocial) Treatment

An agreed-upon set of service **values, a mission, and a philosophy of care** should drive services and treatment in the aforementioned service areas. Once best practice parameters are adopted by various community service systems, the delivery of services should follow an established, organized, comprehensive and practical method. This method of delivering services based on best practice parameters can be referred to as **the dual diagnosis service model**.

Recommendations

- Specially trained, multi-disciplinary dual diagnosis teams should serve as clinical hubs (nuclei) for the diagnosis, assessment, planning and treatment of psychiatric disorders in persons with developmental disabilities (see Figure 1 on next page).

These specialized teams should serve as local and regional resources for families, human service agencies, schools, etc., and provide outreach to all Ohio communities. Regional **Centers of Excellence** in dual diagnosis should be established to provide:

- **Consultation, training and information dissemination** related to best practices, appropriate service strategies and effective supports for this population. These centers should house the specialized teams and work to ensure consistency of best practices across the state and to improve the equity of service delivery across metropolitan and rural areas.
- Specialized dual diagnosis teams should not replace existing service systems and agencies. They should instead provide the initial diagnostic assessment, service planning and linkage to generic service agencies for identified high risk individuals, while simul-

Figure 1

Ohio Center of Excellence Model

taneously training and consulting with community agencies to enhance and improve their skills and capacities to serve this population.

- The Centers of Excellence and the dual diagnosis teams within them should be endorsed, promoted and funded jointly by the mental health and MR/DD systems. These Centers should maintain forums and communication to continuously improve the quality and consistency of dual diagnosis services statewide.
- Direct services provided by the Centers of Excellence should include diagnostic assessment, treatment programs, consultation and training. The services should be provided in demonstration of best practices with this population and within the context of providing training opportunities for the community.
- Staffing of Dual Diagnosis Teams should include, at a minimum, professionals from the medical, psychological and social work disciplines. Such staffing is in keeping with the bio-psychosocial needs of the individual.
- The main service areas of the Dual Diagnosis Teams should include assessment, treatment, consultation, training and education. Additionally, the Centers of Excellence in Dual Diagnosis should provide research, information dissemination and advocacy related to best practices.

Appendix A

Recommended Scales and Instruments of Assessment

(See individual scales for their intended purpose)

It should be noted that each of these scales and instruments has its advantages and disadvantages. Some produce valid and reliable results, and are in common usage. Others may not be standardized for the MI/MR population, or may be difficult to use (if not inappropriate to use) in certain ranges of retardation. Many of these require specialized education and training to administer. For some situations, it is necessary to give several measures to be able to accurately diagnosis, and then explain results of evaluation. It is very important that consideration is given to what will produce the most accurate and helpful information for each individual. This list is not intended to be inclusive, but gives the most commonly used measures.

Tests of Intelligence

1. WAIS-R, WAIS III, or WAIS-IV (accurate for mild MR range and above; consistently overestimates IQ below mild range)
2. Wechsler Intelligence Scale for Children, Rev. 3 (WISC)
3. Stanford-Binet, 4th ed. (underestimates intelligence at every level of MR for adult population. Is better with children in the MR range than it is with adults over the age of 22.)
4. Leiter International Performance Scale - Revised (a standardized, nonverbal performance test of intelligence for use with nonverbal, language-impaired, or foreign language persons. The Leiter and WAIS have high correlation in the mild MR range.)
5. Peabody Picture Vocabulary Test –III (consistently underestimates IQ, and should only be used in conjunction with other tests.)
6. Kaufman Brief Intelligence Test
7. Test of Non-verbal Intelligence – 2 (TONI-2)

Adaptive Behavior Scales

1. ABS (AAMD Adaptive Behavior Scale) (either R or S)
2. Vineland Adaptive Behavior Scale (can overidentify persons as MR)
3. ABC (Aberrant Behavior Checklist)
4. Behavior Rating Scale
5. CIS (Clinical Interview Schedule)
6. HBC (Schedule of Handicaps Behavior and Skills, Revised)
7. Inventory for Client and Agency Planning (ICAP) (overidentifies persons as MR)

Tools for Dual Diagnosis

1. PIMRA (The Psychopathology Inventory for Mentally Retarded Adults) (for individuals with better verbal skills)
2. REISS (Reiss Screen for Maladaptive Behavior) (12 years old and up)
3. BPI (Behavior Problem Inventory)
4. ABAS (Adaptive Behavior Assessment System)
5. DASH (Diagnostic Assessment for Severely Handicapped) (best for severely MR children)

Appendix A

Recommended Scales and Instruments of Assessment, continued

Neuropsychological

1. Woodcock-Johnson Psycho-educational Battery – Revised (a neuropsychological measure)
2. Bender-Gestalt Visual-Motor Test
3. Halsted Reitan Test Battery (a many task neuropsychological measure)
4. Luria-Nebraska
5. VMI (Visual Motor Integration Test) (may be more appropriate for the MR population than the BG with its more objective scoring criteria)
6. Strub and Black
7. Wechsler Adult Intelligence Scale-Revised and Wechsler Children Intelligence Scale

Personality

1. Draw a Person (House-Tree-Person) (Projective Drawings)
2. Rorschach
3. TAT (Thematic Apperception Test – MR)
4. Children's Apperception Test
5. Edwards
6. Jackson

Thinking / Delusions

1. Rotter Incomplete Sentence Blank
2. Clinical Interview

Mood

1. Beck Depression Inventory
2. Hamilton Rating Scale
3. ZUNG (Zung Self-Rating Anxiety Scale / Depression Scale)
4. Self Report Depression Questionnaire
5. Depression Self Report Scale
6. Brownfield
7. Beck Anxiety Checklist
8. Specific Mood Inventories for Children:

   Children's Manifest Anxiety Scale

   Louisville Fear Survey Schedule for Children

   Fear Survey Schedule for Children

   Test Anxiety Scale for Children

Alcohol and Substance Abuse

1. Alcohol Dependency Scale
2. Michigan Alcohol Screening Test
3. Addiction Severity Index
4. Alcohol Use Inventory
5. CAGE 4 Question Assessment
6. QUAD

Miscellaneous

1. Childhood Autism Rating Scale (CARS)
2. Gilliam Autism Rating Scale

3. Conners Rating Scale (ADD)
4. Dementia Scale for Down Syndrome

Other (not formalized instruments)

1. MDPS-BMA (Minnesota Developmental Programming System Behavior Management Assessment)
2. Self-Report Inventory – Mild to Borderline
3. Checklist for Compulsive Behaviors
4. OCD Severity Scale for Persons with Mental Retardation
5. Checklist of Observable Signs of Depression
6. Checklist of Observable Signs of Psychosis in Persons with Mental Retardation
7. Nonconvulsive Ictal Signs Checklist
8. Biographical Timeline
9. Sleep Chart
10. Behavioral Incident Chart
11. Bipolar Mood Chart
12. Psychotropic Drug Profile
13. The Psychiatric Consultation Information Form for Persons with Developmental Disabilities
14. Assessment Information Profile
15. DAS (Disability Assessment Schedule)
16. PAS-ADD Checklist
17. CANDID (level of met and unmet needs)
18. CSRI (Client Service Receipt Inventory)
19. QOLI (Quality of Life)
20. Malaise Inventory (burden on staff care givers/staff stress)
21. Problem Oriented List (residential – care)
22. Client – Career Satisfaction
23. Global Rating Scale for Improvement

Appendix B

Appropriateness of program interventions, recommendations regarding the need for psychiatric assessment or medication review

Full Evaluation

Content areas:

Identifying information

Referral source

Purpose of Evaluation

History/Background Information

- Include any and all developmental information, delays, family history
- Review of records, history of institutionalization, psychiatric history
- History of all intelligence testing

Assessment Procedures selected

Behavioral Observations

- Direct client contact/observation
- Staff interview

Interpretation of Data

- Intellectual assessment
- Adaptive (ADLs) [Report the relative strengths and deficits according to the person's intellectual functioning, i.e., the "actual" (observed) behaviors.]
- Perceptual motor functioning
- Social awareness
- Emotional/Personality testing
- Behavioral

Current Behavioral/Psychological Services/status/needs

Psychotropic Medications

Health considerations and contributing factors, including substance use

Reinforcers (include formal reinforcer menu if exists, include and update within current report)

Diagnostic Impression (DSM-IV). Include all five axes and/or ICD-9

Summary of Strengths and Needs

- Current Status and Strengths
- Needs and Recommendations, including psycho-neurological questions raised by evaluation

Conclusions

- Level of Care
- Competence
- Environmental considerations
- Optimal environment for individual
- Appropriateness of, or recommendations for, placement
- Appropriateness of psychotropic medications and program interventions

Appendix C

Recommendations regarding need for review of psychotropic medication

Content areas: (should include at least the following areas)

Identifying information

Purpose of re-evaluation

Brief History/Background Information (reference original report history)

Assessment Procedures selected

- Adaptive behavioral assessment/review

Behavioral Observations

- Direct client contact/observation
- Staff interview

Diagnostic Impression (current version of the DSM). Include all five axes and/or current version of the ICD

Updated Recommendations

- Regarding guardianship
- Regarding any newly identified needs or changes in level of functioning
- Regarding alternative placement
- Regarding behavioral programming
- Regarding any other interventions or supports which should be delivered , e.g., what kind and amount of structure or supervision in order to be successful in the environment of their choice
- Recommendations regarding changes in psychotropic medications

Appendix D

Guidelines for Integrative Team Report/ Clinical Assessment

Participants

Developmental, Social and Medical History

Psychiatric History

Summary of Team Findings:

- Psychosocial
- Psychiatric
- Psychological
- Occupational Therapy
- Speech and Hearing
- Other (e.g., Social Work)

Current Level of Functioning

- Strengths and weaknesses
- ADLs
- Social
- Community
- Work

Integrative Discipline Assessment Summary and Recommendations

- Comparison of recent and previous evaluations
- Areas of improvement
- Areas needing improvement
- Modification to current behavior plan
- Services needed (include those to be continued)
- Regarding any other interventions or supports which should be delivered, e.g., what kind and amount of structure or supervision, in order to succeed in the environment of their choice
- Medication changes

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