Best Practices in Dual Diagnosis: Assessment, Diagnosis, Treatment & Policy

Outline of Presentation

- NADD
- Concept of Dual Diagnosis
- Conceptual Model of Challenging Behavior
- Best Practices in Assessment and Diagnostic Procedures
  1. Depression
  2. PTSD
  3. Bipolar Disorder
  4. Aggression Violent Behavior
- Overview of the DM-ID
- Mental Health Interventions: Counseling/Psychotherapy
- Policy Issues

WHAT IS NATIONAL ASSOCIATION FOR THE DUALLY DIAGNOSED?

NADD

MISSION STATEMENT

To advance mental wellness for persons with developmental disabilities through the promotion of excellence in mental health care.

- NADD Bulletin
- Conferences/Trainings
- Research Journal
- Training & Educational Products
- Consultation Services

Best Practices in Dual Diagnosis: Assessment, Diagnosis, Treatment and Policy

Dr. Robert J. Fletcher
Founder and CEO
NADD
Indiana Association of Behavioral Consultants
Indianapolis, Indiana
October 29, 2008

• NADD is a not-for-profit membership association
• Established for professionals, care providers and families
• To promote the understanding of and services for individuals who have developmental disabilities and mental health needs
CONCEPT OF DUAL DIAGNOSIS

Co-Existence of Two Disabilities: Intellectual Disability and Mental Illness

Both Intellectual Disability and Mental Health disorders should be assessed and diagnosed

All needed treatments and supports should be available, effective and accessible

Terminology

Intellectual Disability
Mental Retardation
Developmental Disability
Intellectual Impairment
Learning Disability (UK)
Dual Diagnosis
Dual Disability
Co-Occurring MI-ID
Co-Existing Disorders

Diagnostic Criteria of Intellectual Disability

A. Significant sub-average intellectual functioning
   1. IQ of 70 or below
B. Concurrent deficits in adaptive functioning
C. The onset before age 18 years

DM-ID, 2007

Four Levels of ID

<table>
<thead>
<tr>
<th>Level</th>
<th>IQ Range</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild ID</td>
<td>55-70</td>
<td>85</td>
</tr>
<tr>
<td>Moderate ID</td>
<td>35-55</td>
<td>10</td>
</tr>
<tr>
<td>Severe ID</td>
<td>20-35</td>
<td>3</td>
</tr>
<tr>
<td>Profound ID</td>
<td>below 20</td>
<td>2</td>
</tr>
</tbody>
</table>

DM-ID, 2007

What is Mental Illness?

- Severe disturbance of:
  - thought
  - mood
  - behavior
  - and/or social
  - interpersonal relationships

- Common Disorders
  - Anxiety Disorders
  - Mood Disorders
  - Psychotic Disorders
  - Pervasive Disorders

DM-ID, 2007
Definition Of Mental Illness In Persons With Intellectual Disability

- When behavior is abnormal by virtue of quantitative or qualitative differences
- When behavior cannot be explained on the basis of development delay alone
- When behavior causes significant impairment in functioning

A Summary Of Similarities And Differences Between Intellectual Disability (ID) & Mental Illness (MI)

**ID:**
- refers to sub-average (IQ)
- present at birth or occurs before age 18

**MI:**
- has nothing to do with IQ
- may have its onset at any age (usually late adolescent)

- intellectual impairment is permanent
- adjustment difficulties are secondary to ID

ID:
- incidence: 1%-2% of general population
- present at birth or occurs before age 18

MI:
- incidence: 16%-20% of general population
- may have its onset at any age (usually late adolescent)

Statistics of MI in ID

- General Population: 300,000,000 (US Census, 2007)
- ID Population: 1% (AAIDD, 2007)
- ID/MI Population: 35% of those with ID (NADD, 2008)
- ID/MI in USA: 1,000,000 (Reiss, 1994)
- Two to four times of General Population

At-Risk Factors for Mental Illness in Persons with ID

- Incidence of Central Nervous System Impairment
- Reaction by Parents
- Effects of School
- Lack of Social Support
- Impaired Coping Skills
- Feelings of Defeat & Failure
**FOUR CONCEPTUAL MODELS OF CHALLENGING BEHAVIOR**

I. Four Conceptual Models:
   A. Communication Model
   B. Behavioral Model
   C. Psychiatric Model
   D. Multi-Modal Model (A-C)

Fletcher, 2008

The Relationship of Challenging Behavior and Intellectual Disability

A. Communication Model

- Views behavioral problems as reflecting "challenging behaviors" in persons who have deficits in language skills
- Behavioral problems due to communication deficits

Fletcher, 2008

A. Communication Model (continued)

- Assessment focuses on evaluation of skills, deficits and assets and elicits the communicative intent of the behaviors
- Treatment - teach communication skills

Fletcher, 2008

B. Behavioral Model

- Problem behaviors are viewed according to learning principles
- Assessment elicits the antecedent and consequences of the problematic behavior
- Treatment to focus on change in behavior though behavioral approaches, i.e., Behavioral Modification

Fletcher, 2008

C. Psychiatric Model

- Views problem behavior as a possible manifestation of a mental disorder
- Presentation of problem behaviors may be the associated with a psychiatric disorder

Fletcher, 2008

The Relationship of Challenging Behavior and Intellectual Disability
The Relationship of Challenging Behavior and Intellectual Disability

• Assessment based on a bio-psycho-social model
• Treatment to focus on underlying psychiatric disorders

D. Multi-Modal Model

BEST PRACTICES IN ASSESSMENT AND DIAGNOSTIC PROCEDURES

Best Practice Assessment: Bio-psychosocial Model

1. Review Reports
2. Interview Family
3. Interview Care Provider
4. Direct Observation
5. Clinical Interview

• Reason for Referral
• Presenting Problem
• History of Challenging Behaviors
• Family History
• Personal Developmental History
• Medical History
• Psychiatric History
• Social History
• Substance Abuse History
• History of Sexual/Physical Abuse
• Forensic History
Best Practices in Dual Diagnosis: Assessment, Diagnosis, Treatment & Policy

Eight Diagnostic Principles For Recognizing Psychiatric Disorders In MR Persons

• Persons with Intellectual Disabilities suffer from the full range of psychiatric disorders
• Psychiatric disorders usually present as maladaptive behavior
• The origin of psychopathology is multi-determined

Adapted from Sovner 1989

Eight Diagnostic Principles For Recognizing Psychiatric Disorders In MR Persons (continued)

• An acute psychiatric disorder may present as an exaggeration of longstanding maladaptive behavior
• Maladaptive behavior rarely occurs alone
• The severity of the problem is not necessarily relevant diagnostically

Adapted from Sovner 1989

Eight Diagnostic Principles For Recognizing Psychiatric Disorders In MR Persons (continued)

• The clinical interview alone is rarely diagnostic
• It is very difficult to diagnose psychotic disorders in persons with very limited verbal skills

Adapted from Sovner 1989

Minimal Data Collection

• Physical Health
• 24 Hours Sleep Chart (month cycle)
• Medication Changes
• Eating Patterns
• Environmental Changes
• Mood Charting
  • Symptoms and Behavioral manifestations

Nagy, McNelis 2001

24-Hour Framework

Sleep Patterns
Eating Patterns
Mood Patterns

24-Hour Framework

Possible Symptoms Of Mental Illness

• Change in Sleep Patterns/Sleep Disturbance
• Overall Energy Level
• Mood and Affect
• Changes in Self-Care
• Isolation
• Physical Complaints (Somarization)

Fletcher, 2006
Possible Symptoms Of Mental Illness

- Loss of skills (Regression)
  - Change in Bowel or Bladder Function
- Loss of interest in preferred things (Anhedonia)
- Change in attention and concentration
- Change in Sexual Behaviors

Possible Symptoms Of Mental Illness (continued)

- Autonomic Symptoms (Subjective and Objective)
  - Sweating
  - Reports of Palpitations
  - Nausea
  - Dilated Pupils
  - Constipation
  - Response to Stressful Situation
    - Withdrawal
    - Hyper-vigilance

Possible Symptoms Of Mental Illness (continued)

- Fear, Anxious Excessive Worry
- Hallucination and Delusions (Persecutorial)
- Restlessness
- Aggression
- Self-Abuse
- Property Destructions

Increased Likelihood Of Mental Illness

- Symptoms/behaviors present themselves in all setting
- Symptoms persist despite consistent appropriate behavior intervention
- Sleep, Appetite, or Sexual Behaviors are affected
- Change in behavior or symptoms, especially when abrupt and lasts more than a month

Mental Status Exam

1. General Description
   Quality
2. Emotional State
   Mood (Subjective)
   Affective (Objective)
   1. Quality
   2. Range
   3. Likelihood
   4. Significance
3. Speech
   Volume/latency/rhythm/pressure
4. Thought Process
   Form
   Content
   Perception
5. Cognitive State
   Orientation
   Memory
   Attention and concentration
   Abstraction
   Intelligence
6. Judgment & Insight
   Understand current situation

Four Variables that Influence the Diagnostic Process

<table>
<thead>
<tr>
<th>Factor</th>
<th>Definition</th>
<th>Clinical Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological Distortion</td>
<td>Cognitive thinking and impaired communications skills</td>
<td>Difficulty of patient to label own experiences</td>
</tr>
<tr>
<td>Psychosocial Masking</td>
<td>Impoverished social skills and life experience</td>
<td>Un Sophisticated Presentation</td>
</tr>
<tr>
<td>Cognitive Disintegration</td>
<td>Stress-reduced disruption of information processing</td>
<td>Bizarre Presentations</td>
</tr>
<tr>
<td>Baseline Rejection</td>
<td>Increase in severity of pre-existing cognitive deficits and maladaptive behavior</td>
<td>Difficulty in establishing stress balance</td>
</tr>
</tbody>
</table>
**Conceptual Framework**

- Develop a Bio-Psychosocial Approach
- Examine Medical Co-Morbidity
- Attempt to Understand how the Person Experiences the World
- Create a Hypothesis

---

**DEPRESSION**

**Depression**

- Psychiatric disorder that effects mind, body, and feelings
- May begin suddenly (triggered by loss or crises); can continue for months or years
- Single episode or multiple episodes (more common)
- Often unidentified and untreated

---

**Depression**

- Can significantly disrupt work, family relationships, social life, etc.
- Onset tends to be more insidious and changes less dramatic (Deb et al., 2001)
- Increased prevalence in some symptoms as compared to typical population (Matson, 1988)
- Depression is among the most common psychiatric disorders in persons with ID (Lamon & Reiss, 1987)

---

**Symptoms of depression vary from person to person but often include:**

- Sad or irritable mood
- Loss of interest in activities the person normally enjoys
- Significant decrease or increase in appetite
- Significant changes in sleeping patterns
- Significant changes in activity level
- Fatigue or loss of energy
- Difficulty concentrating
- Thoughts of death

---

**Other symptoms of depression may include:**

- Feeling empty or hopeless
- Loss of sexual desire
- Poor memory
- Increased physical discomfort like aches and pains
- Inattention to personal hygiene
### Best Practices in Dual Diagnosis: Assessment, Diagnosis, Treatment & Policy

#### Depression

<table>
<thead>
<tr>
<th>DSM-IV-TR Symptom for Depression</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depressed Mood</strong></td>
<td>- Frequent unexplained crying</td>
</tr>
<tr>
<td></td>
<td>- Decrease in laughter and smiling</td>
</tr>
<tr>
<td></td>
<td>- General irritability and subsequent aggression or self-injury</td>
</tr>
<tr>
<td></td>
<td>- Sad facial expression</td>
</tr>
<tr>
<td><strong>Loss of Interest in Pleasure</strong></td>
<td>- No longer participates in favorite activities</td>
</tr>
<tr>
<td></td>
<td>- Reinforcers no longer valued</td>
</tr>
<tr>
<td></td>
<td>- Increased time spent alone</td>
</tr>
<tr>
<td></td>
<td>- Refusals of most work/social activities</td>
</tr>
</tbody>
</table>

- Lowry, 1993

#### Fatigue/Loss of Energy

- Needs frequent breaks to complete simple activity
- Stumped/tired body posture
- Does not complete tasks with multiple steps

- Lowry, 1993

#### Feelings of Worthlessness

- Statements like “I’m dumb,” “I’m retarded,” etc.
- Seeming to seek punishment
- Social isolation

- Lowry, 1993

#### Insomnia

- Disruptive at bed time
- Repeatedly gets up at night
- Difficulty falling asleep
- No longer gets up for work/activities
- Early morning awakening

- Over 12 hours of sleep per day
- Naps frequently

- Lowry, 1993

#### Treatment Strategies

- Antidepressant medication
- Psychotherapy (individual and/or group)
- Regular exercise
- Regular scheduling of pleasurable activities
- Learning stress management strategies
- Social skill training
- Positive behavioral supports

- Fletcher, 2008
Posttraumatic Stress Disorder (PTSD)

- An emotional and psychological reaction
- Occurs in individuals who experienced or witnessed a traumatic event
- Individuals may feel their lives have changed
- What was once seen as a safe world is now seen as dangerous and unpredictable
- Symptoms last for more than a month
- Symptoms lead to problems at work as well as conflicts with friends and family

- Evidence suggests persons with lower levels of IQ are more susceptible to developing PTSD in response to a traumatic event (Reiss, 1994)
- Individuals with ID are more likely to encounter physical or sexual abuse during their lifetime than individuals without ID (Susser & Vainhagen, 1991)
- PTSD is considered to be a chronic anxiety disorder which is often cyclic and progressive
- The role of developmental level complicates diagnostic clarity
- The developmental level at which trauma occurs has a major impact on the capacity of the victim to adapt

- Mental health comorbidity is the rule rather than the exception (Brady, 1997)
  - 88% of men and 79% of women with PTSD had a lifetime history of at least one other disorder
  - Traumatic exposure disrupts the maturing organism’s development of self-regulatory processes. This disruption leads to chronic affect disregulation, destructive behavior toward self and others and distortions in concepts of self and others.
Posttraumatic Stress Disorder (PTSD)

- SIB is common in persons with ID and PTSD
- Violence and aggression are common in people with ID and PTSD

Traumatic events can occur to anyone and include such things as:
- Abuse
- Violent crime
- Rape or sexual assault
- Natural disasters
- Fires
- Car accidents
- Unexpected death of loved one

Symptoms of PTSD vary from one person to another, but may include:
- Recurring memories or flashbacks
- Nightmares
- Physical problems like headaches, nausea, and chest pain
- Feelings of sadness, hopelessness, or loneliness
- Aggression

In children, the symptoms of PTSD may include:
- Reliving the event through play
- Tantrums
- Difficulty separating from parents
- Thumb sucking or bed wetting

Possible treatment and support strategies for individuals with PTSD include:
- Individual or group psychotherapy
- Medications such as anti-anxiety medication, mood stabilizers, and antidepressants
- Anger management training
Posttraumatic Stress Disorder (PTSD)

Possible treatment and support strategies for individuals with PTSD include:

- Personal safety training
- Environmental/social modifications (e.g., low noise, privacy, etc.)
- Education of the individual, family, and support staff regarding PTSD

BIPOLAR DISORDER

- Causes mood swings
- Persons with Bipolar Disorder may have periods of mania, depression as well as normal moods
- During manic episode, person will display oversupply of confidence and energy

Bipolar Disorder

- Duration of mania or depressed cycle varies lasting for days to months
- Without treatment, job performance and relationships may suffer and dangerous behavior can occur

Two Types

1. Bipolar I
   - Characterized by one or more manic or mixed episodes
2. Bipolar II
   - Characterized by one or more major depressive episodes and at least one hypomanic episode
   - Hypomanic episode is a less intense episode of mania

Symptoms of Bipolar I Disorder may include:

- Feeling invincible or overconfident
- Extreme activity
- Sleeping less without feeling tired
- Irritability
- Racing thoughts
- Talking in a loud and fast manner
- Being easily distracted
- Delusions about having special abilities
### Bipolar Disorder

#### DSM IV-TR Symptoms of Mania

**More Talkative/Psychomotor Restlessness**
- Increased singing
- Increased swearing
- Perseverative speech
- Screaming
- Intruding in order to say something
- Non-verbal communication increases
- Increase in vocalizations

**Distractibility**
- Decrease in work/task performance
- Leaving tasks uncompleted
- Inability to sit through activities (e.g., favorite TV show)

**Agitation/Increase in Goal Directed Behavior**
- Pacing
- Negativism
- Working on many activities at once
- Fidgeting
- Aggression
- Rarely sits

**ExcessivePLEASURABLE Activities**
- Increase in masturbation
- Giving away/spending money

**Euphoric, Elevated or Irritable Mood**
- Smiling, hugging or being affectionate with people who previously were not favored by the individual
- Boisterousness
- Over-reactivity to small incidents
- Extreme excitement
- Excessive laughing and giggling
- Self-injury associated with irritability
- Enthusiastic greeting of everyone

**Decreased Need for Sleep**
- Behavioral challenges when prompted to go to bed
- Constantly getting up at night
- Seems rested after not sleeping (i.e., not irritable due to lack of sleep as is common in depression)

**Inflated Self-esteem/Grandiosity**
- Making improbable claims (e.g., is a staff member, has mastered all necessary skills, etc.)
- Wearing excessive make-up
- Dressing provocatively
- Demanding rewards

**Flight of Ideas**
- Disorganized speech
- Thoughts not connected
- Quickly changing subjects
Bipolar Disorder

**Treatment Strategies**
- Mood stabilizing and antidepressant medication
- Psychotherapy with a focus on understanding and managing the disorder
- Environmental and social modification (i.e. increase supervision to insure safety)
- Positive Behavioral Supports

**AGGRESSION AND VIOLENT BEHAVIOR**

**Functional Significance Of Problem Behavior**
- Medical Illness
- Psychiatric Illness
- Problem of Communication

**Aggression: Cause and Intervention**

**Possible Cause**
1. Aggression as a symptom of medical illness
2. Aggression as a medication side effect

**Intervention(s)**
1. Treat medical condition
2. Review the medication regime

**Possible Cause**
3. Aggression related to irritability as a symptom of mania or depression
4. Aggression is associated with task-related anxiety

**Intervention(s)**
3. Treat with medication designed to address the specific disorder
4. Teach cognitive/behavioral self-control skills to decreased anxiety

**Possible Cause**
5. Aggression is associated with inability to express needs

**Intervention(s)**
5. Treat psychosis with appropriate medication – Provide supportive psychotherapy and other related interventions
6. Teach functional communication

Provide counseling to express needs
Best Practices in Dual Diagnosis: Assessment, Diagnosis, Treatment & Policy

Aggression: Cause and Intervention (continued)

Possible Cause
7. Aggression is a means for obtaining positive reinforcers
8. Aggression as a type of escape/avoidance behavior of an undesired task

Intervention(s)
7. Enhance access to positive reinforcing
   Provide counseling for pro-social behavior
8. Adapt environment to minimize aggressive stimuli, i.e., over-reacting
   Counseling to identify source of problem and explore socially acceptable behaviors

Lowry & Sovner, 1991

Impact of Aggression

• Individual
  - more restricted environment, unstable
  - reduced family involvement
• Caregiver
  - stress, burnout, injury
• Society
  - increased cost of hospitalization or incarceration

J. Gentile, 2008

Bio-Psycho-Social Formulation

A complete gathering of information through client interview, discussion with family members and/or caretakers, review of clinical records, and contact with collaborating agencies that leads to a formulation, diagnoses and treatment plan.

J. Gentile, 2008

Limitations of DSM System

• Diagnostic Overshadowing (Rosss, et al, 1982)
• Applicability of established diagnostic systems is increasingly suspect as the severity of ID increases (Rush, 2000)
• DSM and ICD Systems rely on self report of signs and symptoms

Fletcher, 2008

Scope of the Problem

• Aggressive behavior is present in 15 % of persons with MR/DD (Harris, 1993; Sigafoos, 1994)
• It is multi-determined and influenced by biological, psychological and social factors (Davidson, Cain 1994)
• Psychiatric and behavioral interventions must be tailored to needs of the individual.

J. Gentile, 2008

Overview of the Diagnostic Manual for Persons with Intellectual Disabilities DM-ID

J. Gentile, 2008

Dr. R. Fletcher - NADD 15
Limitations of DSM System (continued)

- Neither system addresses the issue of problem behaviors (Fletcher, et al, 2008)
- Neither system addresses behavioral phenotypes (Fletcher, et al, 2008)
- Neither system addresses the inclusion of ID issues within diagnostic categories
- Neither system addresses the effects that ID have on overt presentation of symptoms (pathoplastic affects) of psychopathology (Fletcher, et al, 2008)


Developed By
National Association for the Dually Diagnosed (NADD)

In association with
American Psychiatric Association (APA)

Partial Funding from the Joseph P. Kennedy, Jr. Foundation
Published by the NADD Press, 2007

DM-ID: Two Manuals

Diagnostic Manual – Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability


DM-ID: Editors

Robert J. Fletcher, DSW, ACSW, Chief Editor
Chief Executive Officer
National Association for the Dually Diagnosed, Kingston, NY

Earl Loschen, MD
Professor Emeritus, Department of Psychiatry
Southern Illinois University School of Medicine, Springfield, IL

Chrisoulla Stavrakaki, MD, PhD
Professor, Department of Psychiatry
University of Ottawa, Ontario, Canada

Michael First, MD
Professor of Clinical Psychiatry
Department of Psychiatry
Columbia University, New York, NY
Editor of the DSM-IV-TR

Description of DM-ID

- An adaptation to the DSM-IV-TR
- Designed to facilitate a more accurate psychiatric diagnosis
- Based on Expert Consensus Model
- Covers all major diagnostic categories as defined in DSM-IV-TR

Description of DM-ID (continued)

- Provides information to help with diagnostic process
- Provides clear examples of how items should be interpreted
- Addresses pathoplastic effect of ID on psychopathology
- Designed with a developmental perspective to help clinicians to recognize symptom profiles in adults and children with ID
<table>
<thead>
<tr>
<th>Description of DM-ID (continued)</th>
<th>Description of DM-ID (continued)</th>
<th>Expert Consensus Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Empirically-based approach to identify specific psychiatric disorders in persons with ID</td>
<td>• Information on how to recognize challenging behaviors</td>
<td>• All chapters co-authored by a group of experts</td>
</tr>
<tr>
<td>• Provides state-of-the-art information about mental disorders in persons with ID</td>
<td>• Information on how to differentiate behavioral problems from psychiatric disorders</td>
<td>• Peer reviews conducted</td>
</tr>
<tr>
<td>• Provides adaptations of criteria, where appropriate</td>
<td></td>
<td>• Advisory Board</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence Based Model To Evaluate Cited Research</th>
<th>Two Special Added-Value Chapters</th>
<th>Assessment and Diagnostic Procedures: Chapter 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Cochrane Rating Convention</td>
<td>• Assessment and Diagnostic Procedures</td>
<td>Special Consideration</td>
</tr>
<tr>
<td>• Type I Evidence: Good systematic review and meta analysis</td>
<td>• Behavioral Phenotype of Genetic Disorders</td>
<td>Language That Is Understandable</td>
</tr>
<tr>
<td>• Type II Evidence: Randomized controlled study</td>
<td></td>
<td>• Use simple language</td>
</tr>
<tr>
<td>• Type III Evidence: Well designed interventional study</td>
<td></td>
<td>• Create short sentences</td>
</tr>
<tr>
<td>• Type IV Evidence: Well-designed observational studies</td>
<td></td>
<td>• Check back with person for understanding</td>
</tr>
<tr>
<td>• Type V Evidence: Expert opinion, influential reports</td>
<td></td>
<td>• Use of examples</td>
</tr>
</tbody>
</table>

**Special Consideration**

- Use simple language
- Create short sentences
- Check back with person for understanding
- Use of examples
**Assessment and Diagnostic Procedures: Chapter 2**

- **Assessment of Medical Conditions**
  - Constipation → distress
  - Hypothyroidism → depressive symptoms
  - Hyperthyroidism → manic episode
  - Diabetes → behavioral side effects

**Behavioral Phenotype of Genetic Disorders: Chapter 3**

<table>
<thead>
<tr>
<th>Genetic Disorder</th>
<th>Proposed Behavioral Phenotype</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angelman Syndrome</td>
<td>Prader-Willi Syndrome</td>
</tr>
<tr>
<td>Cri-du-Chat (5p-) Syndrome</td>
<td>Rubenstein-Taybi Syndrome</td>
</tr>
<tr>
<td>Down Syndrome</td>
<td>Smith-Magenis Syndrome</td>
</tr>
<tr>
<td>Fetal Alcohol Syndrome</td>
<td>Tuberous Sclerosis Complex</td>
</tr>
<tr>
<td>Fragile-X Syndrome</td>
<td>Velocardiofacial Syndrome</td>
</tr>
<tr>
<td>Phenylketonuria</td>
<td>Williams Syndrome</td>
</tr>
</tbody>
</table>

**DM-ID Diagnostic Chapter Structure**

- Review of Diagnostic Criteria
  - General description of the disorder
  - Summary of DSM-IV-TR criteria
  - Issues related to diagnosis in people with ID
- Review of Literature/Research
  - Evaluating level of evidence

**DM-ID Diagnostic Chapter Structure (continued)**

- Application of Diagnostic Criteria to People with ID
  - General considerations
  - Adults with Mild to Moderate ID
  - Adults with Severe or Profound ID
  - Children and adolescents with ID

**DM-ID Diagnostic Chapter Structure (continued)**

- Etiology and Pathogenesis
  - Risk Factors
  - Biological Factors
  - Psychological Factors
  - Genetic Syndromes
Figure 1: Adaptation of DSM-IV-TR Criteria

- Adaptation of DSM-IV-TR Criteria
  - Modification of age requirements
  - Addition of explanatory notes
  - Criteria Sets that do not apply

Figure 2: Adaptation of DSM-IV-TR Criteria

- Omission of Symptoms

Figure 3: Adaptation of DSM-IV-TR Criteria

- Change in Count and Symptom Equivalent

Figure 4: Adaptation of DSM-IV-TR Criteria

- Major Depressive Episode
  - Five or more symptoms present during the same 2-week period and represent a change from previous functioning. At least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure or (3) irritability mood.
Adaptation of DSM-IV-TR Criteria

**Modification of Symptom Duration**

**Intermittent Explosive Disorder**

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for ID (Mild to Profound)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Several discrete episodes of failure to resist aggressive impulses that result in serious assaults or destruction of property.</td>
<td>A. Frequent episodes that last for at least two months of failure to resist aggressive impulses that result in serious assaults or destruction of property.</td>
</tr>
</tbody>
</table>

**Modification of Age**

**Antisocial Personality Disorder**

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for Individuals with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:</td>
<td>A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:</td>
</tr>
<tr>
<td>B. The individual is at least age 18 years</td>
<td>B. The individual is at least age 18 years</td>
</tr>
<tr>
<td>C. There is evidence of Conduct Disorder with onset before age 15 years</td>
<td>C. There is evidence of Conduct Disorder with onset before age 18 years</td>
</tr>
</tbody>
</table>

**Addition of Explanatory Note**

**Manic Episode**

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for Mild to Profound ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. A distinct period of abnormally persistent elation, expansive or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary)</td>
<td>A. No adaptation.</td>
</tr>
</tbody>
</table>

**Schizophrenia Subtypes**

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria Mild-Moderate ID</th>
<th>Adapted Criteria Severe-Profound ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perinatal Type</td>
<td>A. Preoccupation with one or more delusions or frequent auditory hallucinations.</td>
<td>A. No adaptation.</td>
</tr>
<tr>
<td>B. None of the following is prominent: disorganized speech, disorganized or catatonic behavior, or flat or inappropriate affect.</td>
<td>B. No adaptation.</td>
<td></td>
</tr>
</tbody>
</table>

**Field Study of the Clinical Usefulness of the DM-ID**

<table>
<thead>
<tr>
<th>Item</th>
<th>Level of Intellectual Disability</th>
<th>Frequency (n)</th>
<th>% YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the DM-ID help you avoid using the NOS category?</td>
<td>Mild ID (n=335)</td>
<td>64.4</td>
<td>68.4</td>
</tr>
<tr>
<td>Did the DM-ID allow you to come up with a more specific psychiatric diagnosis for this patient?</td>
<td>Moderate ID (n=337)</td>
<td>54.9</td>
<td>56.6</td>
</tr>
<tr>
<td>Did the DM-ID help you avoid using the NOS category?</td>
<td>Severe/Profound ID (n=333)</td>
<td>74.9</td>
<td>74.9</td>
</tr>
</tbody>
</table>

**Table 1:** Clinician Impressions of DM-ID for new patients, previously seen (follow-up) patients, and both groups combined (All)

<table>
<thead>
<tr>
<th>Item</th>
<th>Level of Intellectual Disability</th>
<th>Frequency (n)</th>
<th>% YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the DM-ID help you avoid using the NOS category?</td>
<td>Mild ID (n=335)</td>
<td>64.4</td>
<td>68.4</td>
</tr>
<tr>
<td>Did the DM-ID allow you to come up with a more specific psychiatric diagnosis for this patient?</td>
<td>Moderate ID (n=337)</td>
<td>54.9</td>
<td>56.6</td>
</tr>
<tr>
<td>Did the DM-ID help you avoid using the NOS category?</td>
<td>Severe/Profound ID (n=333)</td>
<td>74.9</td>
<td>74.9</td>
</tr>
</tbody>
</table>

**Table 2:** Clinician Impressions by Level of Intellectual Disability (YES)
Field Study of the Clinical Usefulness of the DM-ID

<table>
<thead>
<tr>
<th>Item</th>
<th>Psychotic</th>
<th>Mood</th>
<th>Anxiety</th>
<th>PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the DM-ID make you more confident?</td>
<td>71.6</td>
<td>72.8</td>
<td>81.8</td>
<td>86.6</td>
</tr>
<tr>
<td>Did it allow you to arrive at an appropriate psychiatric diagnosis?</td>
<td>39.8</td>
<td>50.7</td>
<td>78.7</td>
<td>48.8</td>
</tr>
<tr>
<td>Did the DM-ID allow you to arrive at an appropriate psychiatric diagnosis for this patient?</td>
<td>41.5</td>
<td>57.7</td>
<td>49.9</td>
<td>52.3</td>
</tr>
<tr>
<td>Did the DM-ID allow you to arrive at a more specific diagnosis than you would have with the DSM-IV-TR?</td>
<td>21.6</td>
<td>37.0</td>
<td>42.5</td>
<td>22.4</td>
</tr>
<tr>
<td>Did the DM-ID help you avoid using the NOS category?</td>
<td>63.8</td>
<td>56.1</td>
<td>61.4</td>
<td>51.8</td>
</tr>
</tbody>
</table>

* N = 496, as many diagnostic categories had insufficient sample size for meaningful comparisons

Table 3: Clinician Impressions by Diagnostic Category (% YES)

MENTAL HEALTH INTERVENTIONS: COUNSELING/PSYCHOTHERAPY

PSYCHOTHERAPY/ COUNSELING

- RELATIONSHIP BETWEEN A CLIENT AND A THERAPIST
- ENGAGED IN A THERAPEUTIC RELATIONSHIP
- TO ACHIEVE A CHANGE IN EMOTIONS, THOUGHTS OR BEHAVIOR

MENTAL HEALTH INTERVENTIONS: COUNSELING/PSYCHOTHERAPY

GENERAL SIMILARITIES BETWEEN LIFE ISSUES FACED BY ADOLESCENTS WITHOUT ID AND ADULTS WITH ID

- BOTH USUALLY DEPENDENT ON OTHERS
- BOTH TEND TO BE IN SUPERVISED SETTINGS
- BOTH HAVE COGNITIVE LIMITATIONS IN TERMS OF:
  - PROBLEM SOLVING
  - IMPULSE CONTROL
  - CONCRETE THOUGHT

GENERAL SIMILARITIES BETWEEN LIFE ISSUES FACED BY ADOLESCENTS WITHOUT ID AND ADULTS WITH ID

- BOTH STRUGGLE WITH ISSUES OF:
  - INDEPENDENCE
  - PEER GROUP
  - IDENTITY CHOICES
  - VOCATIONAL
  - SEXUAL IDENTITY
  - AUTHORITY ISSUES
- BOTH REFERRED TO THERAPY BY OTHERS

MYTH: PERSONS WITH ID ARE NOT APPROPRIATE FOR PSYCHOTHERAPY

PREMISE: IMPAIRMENTS IN COGNITIVE ABILITIES AND LANGUAGE SKILLS MAKE PSYCHOTHERAPY INEFFECTIVE.

REALITY: LEVEL OF INTELLIGENCE IS NOT A SOLE INDICATOR FOR Appropriateness of therapy.

TREATMENT IMPLICATIONS:

PSYCHOTHERAPY APPROACHES NEED TO BE ADAPTED TO THE EXPRESSIVE AND RECEPTIVE LANGUAGE SKILLS OF THE PERSON

Robert Fletcher, DSW, ACSW, 2004

Strohmer & Prout, 1994

Dr. R. Fletcher - NADD
### Counseling & Psychotherapy: Who is Appropriate for Therapy? A Developmental Perspective

<table>
<thead>
<tr>
<th>WITHOUT ID</th>
<th>WITH ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-7 years old</td>
<td>6-7 years old</td>
</tr>
<tr>
<td>cognitive level</td>
<td>cognitive level</td>
</tr>
<tr>
<td>Mild ID</td>
<td>Mild ID</td>
</tr>
<tr>
<td>Borderline ID</td>
<td>Borderline ID</td>
</tr>
</tbody>
</table>

Strohmer and Prout, 1994

### Problems that Clients with Borderline ID and ID Want to Address in Therapy

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal Concerns</td>
<td>22%</td>
</tr>
<tr>
<td>General Psychological Functioning</td>
<td>18%</td>
</tr>
<tr>
<td>Work</td>
<td>12%</td>
</tr>
<tr>
<td>Sexuality</td>
<td>6%</td>
</tr>
<tr>
<td>Family</td>
<td>5%</td>
</tr>
<tr>
<td>Residential Living &amp; Adjustment</td>
<td>5%</td>
</tr>
<tr>
<td>Behavior</td>
<td>4%</td>
</tr>
<tr>
<td>Financial &amp; Material Resources</td>
<td>4%</td>
</tr>
<tr>
<td>Accepting &amp; Coping with Disability</td>
<td>4%</td>
</tr>
<tr>
<td>Dealing with Authority Figures</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>16%</td>
</tr>
</tbody>
</table>

Wittman, Strohmer, and Prout, 1989

### Types of Stress Experienced by Persons with Intellectual Challenges

1. Ordinary situations which are not typically stressful to the general population
   - A. Social Interactions
   - B. Meeting New People
   - C. Going to Public Places
2. Stress from difficult to manage situations for all people, even more stress for people with disabilities
   - A. Major changes in one’s life
     1. Job
     2. DEATH IN FAMILY
     3. HOME RELOCATION
   - B. Adult Expectations
     1. HETEROSEXUAL ACTIVITIES: DATING, SEX
     2. Money Management
     3. Living Independently
     4. Employment

Dunst, 1999

### Issues and Barriers Concerning Psychotherapy for Persons with MR

- Mental health professionals perceive maladaptive behavior as a function of.
- Many assume that persons with ID are immune from mental illness.
- Professional bias in viewing intellectual disability as a barrier to psychotherapy.
- Dichotomization of ID and mental health regulatory entities.

Robert Fletcher, DSW, ACSW, 2004

### Limited Literature & Research in Psychotherapy for Persons with ID

- Earlier studies suggested that psychotherapy yielded no or minimal benefit (Eysenck 1952, 1965)
- Recent studies point to positive findings (Lipsey & Wilson, 1993; Prout & Nowak-Orabik, 2003)
- Research needs more empirically based models of investigation (Prout et al, 2000)
- Lack of methodological rigor (Prout et al, 2003)

Robert Fletcher, DSW, ACSW, 2004

---

Dr. R. Fletcher - NADD
**PRINCIPLES FOR ACHIEVING A THERAPEUTIC RELATIONSHIP**

- Empathetic Understanding
- Respect and Acceptance of client
- Therapeutic Genuineness
- Concreteness
- Accept the client’s life circumstances
- Be consistent
- Confidentiality
- Draw the client out
- Express genuine interest in your client
- Be aware of your own feelings

**CONSIDERATIONS IN THERAPY WITH PERSONS WHO HAVE MENTAL ILLNESS AND ID**

- Watch for pleasers
- Slow progress
- Multiplicity of problems
- Reliability of reporting
- Difficulty relating to analogies
- Problems with terminating

**CONFIDENTIALITY**

- What is discussed in therapy must be kept private
- Care providers may bring pertinent information to the therapist. The information will be discussed with person in a manner he/she can understand

**CONFIDENTIALITY**

- Nothing discussed in therapy will be released without the person’s permission
- With the client’s permission, the therapist will work collaboratively other care providers

**Attention Span Difficulties**

- Individuals with intellectual disabilities often experience difficulty initiating and maintaining attention or eye contact (i.e., Fragile X)
  - Persons with ID may have difficulty focusing on therapeutic topics (i.e., talking about an upcoming visit with family that is unrelated to the interview)

**Acquiescence**

- Refers to the tendency to agree with any statement an interviewee is given
- Use of item reversal techniques
- Avoid “leading” questions
  - “But you knew what you were doing, right?”
- Request clarification or examples often

Dr. R. Fletcher - NADD
<table>
<thead>
<tr>
<th>Social Desirability</th>
<th>Refers to the desire to give responses that an interviewer (particularly one of higher “status”) would consider a “good” response</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Psychotherapy with ID Population</th>
<th>Research indicates that successful therapeutic interventions are more likely if a flexible, innovative approach is adopted</th>
</tr>
</thead>
</table>

| Longer Episode of Care | Increased length of treatment  
|------------------------|-----------------------------|
|                        | Allow for addition of preparatory/educational stages  
|                        | Allow for longer time to ensure that skills have transferred to the natural environment |

| Flexible Sessions       | Traditional treatment model (1 hour, 1x weekly) may not be a good fit  
|-------------------------|--------------------------------------------------------------------------|
|                        | May not be able to remember important issues from one session to the next  
|                        | May not be able to tolerate hour sessions  
|                        | Home visits may be needed to ensure skill transfer |

| Simplification of Interventions Used | Reduce the complexity of techniques used  
|--------------------------------------|--------------------------------------------------------------------------|
|                                      | Breakdown interventions into smaller chunks  
|                                      | Utilize shorter session length if necessary |

| Recommendations | Use directive methods  
|-----------------|--------------------------------------------------------------------------|
|                 | Use techniques including  
|                 | - Suggestion  
|                 | - Persuasion  
|                 | - Reassurance  
|                 | - Validation  
|                 | - Support |
## Multidisciplinary Team Approach
- Involve appropriate MRDD staff
- Involve residential providers
- Involve family/guardian

## Multifaceted Role of Therapist
- Therapist
- Case manager
  - Support residential/habilitation providers
  - Education/training re: relevant MH issues
  - Regular communication with all team members
- Team Coordinator
- Crisis Worker
- Community outreach/education

## Preparation for the Process
- The individual may not understand the purpose of psychotherapy – or how it is different from services they receive from other treatment providers
- Providing training/education and support can enhance their participation and satisfaction with mental health services

## Preparation for the Process
- Reassurance that they are not being “punished”
- Education about what psychotherapy is:
  - Why people go
  - What happens in session
  - What people talk about

## Practice Points
- Need to educate the referring source
  - Explain purpose and nature of therapy
    - Develop relationship
    - Forum for individual to share feelings in a safe environment
- Provide education regarding purpose of therapy
- Normalize/validate feelings without judgment
- Avoid power struggles
Communication Issues

- Often the systems involved define the expression of emotion as a “problem”
- May have experiences of being actively discouraged from expression of emotion (redirected versus encouraged to express feelings)

Key Points

- Be flexible/adapt techniques
- Modify mode of psychotherapy to accommodate person’s individual strengths and weaknesses
- Use of expressive language appropriate to the person’s receptive language level
- Multidisciplinary team approach is essential
- Psychotherapy is a best practice.

Techniques for Promoting Mental Wellness

- **Listening**
  - Attentive
  - Interested
- **Reflect**
  - Repeat a few words
  - Reflect demonstrates active listening

- **Probe**
  - Ask direct questions
  - Avoid interrogation
  - How and what questions are usually easier to answer than why questions

- **Support**
  - Supportive statements indicate understanding
  - Express that you care
  - Acknowledge having been in a similar situation
TECHNIQUES FOR PROMOTING MENTAL WELLNESS

FACILITATE PROBLEM SOLVING
- EXPLORE ALTERNATIVE OPTIONS
- SUPPORT ACCEPTABLE SOLUTIONS

EVALUATE OUTCOME
- WAS OUTCOME ACCEPTABLE?
- WAS IT POSITIVE?
- WHAT WAS LEARNED?

STAGES OF PSYCHOTHERAPY WITH PERSON WHO HAVE ID

I. INITIAL STAGE
- THERAPY GOALS ESTABLISHED
- GROUND RULES
- RAPPORT DEVELOPED

II. MIDDLE STAGE
- SOLIDIFIED THERAPEUTIC RELATIONSHIPS
- THERAPIST IS EMPATHIC
- EMOTIONS ARE EXPRESSED
- PROBLEMS ARE IDENTIFIED
- ALTERNATIVE SOLUTIONS

III. TERMINATION STAGE
- EXPLORE PAST LOSSES
- REVIEWS GAINS MADE DURING THERAPY
- EXPLORE FEELINGS OF TERMINATION

GUIDING PRINCIPLES:
- USE LANGUAGE THAT PROMOTES HOPE
- RAISE EXPECTATIONS OF WHAT PEOPLE ARE CAPABLE OF ACCOMPLISHING
- STAY FOCUSED ON STRENGTHS

Levitas and Gilson, 1989

Robert Fletcher, DSW, ACSW, 2004

Robert Fletcher, DSW, ACSW, 2004
TECHNIQUES FOR PROMOTING MENTAL WELLNESS RECOVERY MODEL

- BUILD EVERYONE’S HOPE, BECAUSE HOPE IS THE ENERGY THAT MOVES TRANSFORMATION FORWARD
- MOVE PEOPLE TO THE “HELPER” ROLE AS SOON AS POSSIBLE

Levitas and Gilson, 1989

TECHNIQUES FOR PROMOTING MENTAL WELLNESS RECOVERY MODEL

- CELEBRATE ACCOMPLISHMENTS
- FIND WAYS TO LISTEN TO OUR CONSUMERS

Levitas and Gilson, 1989

PREDICTABLE CRISIS

- CONFIRMATION/REALIZATION OF DIAGNOSIS OF ID
- BIRTH OF SIBLINGS
- STARTING SCHOOL
- PUBERTY AND ADOLESCENCE

Levitas and Gilson, 1989

PREDICTABLE CRISIS

- SEX AND DATING
- BEING SURPASSED BY YOUNGER SIBLINGS
- EMANCIPATION OF SIBLINGS
- END OF EDUCATION

Levitas and Gilson, 1989

PREDICTABLE CRISIS

- OUT-OF-HOME PLACEMENT AND/OR RESIDENTIAL MOVES
- STAFF/CLIENT RELATIONSHIPS
- INAPPROPRIATE EXPECTATIONS
- AGING, ILLNESS AND/OR DEATH OF PARENTS

Levitas and Gilson, 1989

PREDICTABLE CRISIS

- DEATH OF PEERS OR LOSS OF FRIENDS
- MEDICAL ILLNESS
- PSYCHIATRIC ILLNESS
- OTHER

Levitas and Gilson, 1989
GROUP THERAPY FOR PERSONS WITH ID/MI

THERAPEUTIC EFFECTS OF GROUP THERAPY

- Helps decrease feelings of inadequacy, isolation and defeat
- Promotes peer support
- Fosters a sense of security
- Promotes group cohesiveness
- Establishes sense of trust

THERAPEUTIC EFFECTS OF GROUP THERAPY

- Fosters meaningful relationships
- Increases relationship skills
- Promotes problem solving skills
- Enables learning through observation

POLICY ISSUES: Barriers and a framework for cross-systems collaboration

Typical Model

Interactive Model

Tomasulo, 1998
**Dual Diagnosis Policy Issues**

**Individuals with MI and ID are among the most challenging persons served by both MH and ID Service Delivery Systems**

**The Typical Picture:**
- Failure to plan services
- Failure to fund flexible services
- Failure to obtain technical assistance

**The Typical Picture:**
- Failure to provide adequate training and technology transfer
- Failure to share and assume joint responsibility
- Failure to articulate a policy

**Dual Diagnosis Policy Issues**

- MH providers perceive that they do not have the skills to serve adults or children with a dual diagnosis
- DD providers do not understand the services that the MH sector offers
- MH providers do not understand the services that the DD sector offers

**People with MI and ID typically require:**
- More intensive support
- Greater level of supervision
- Staff with higher level of skill

**People with MI and ID typically require:**
- Professional staff with specialized clinical experience
- Comprehensive service coordination
- Presence of consistent backup support
- Living requirements with fewer people

*Dr. R. Fletcher - NADD*
### Best Practices in Dual Diagnosis: Assessment, Diagnosis, Treatment & Policy

**Dual Diagnosis Policy Issues**

<table>
<thead>
<tr>
<th>MH System</th>
<th>DD System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short term episodic treatment</td>
<td>Services/supports over lifetime</td>
</tr>
<tr>
<td>Focus on psychiatric needs</td>
<td>Emphasis on direct support</td>
</tr>
<tr>
<td>Recovery model</td>
<td>Skill development</td>
</tr>
<tr>
<td>Local authority</td>
<td>State authority</td>
</tr>
</tbody>
</table>

*Fletcher, 2006*

---

**Service Planning And Policy**

- Plan services strategically among various systems
- Design flexible service models that can change over time as individual needs change
- Obtain technical assistance
- Provide training to enhance agency and practitioner competencies
- Provide incentives for assuming and sharing responsibility

*J. Jacobson, 2003*

---

**Five Aspects Of A Coordinated Care System**

1. Collaboration
2. Comprehensiveness
3. Flexibility
4. Continuity
5. Leadership and Partnership

*Adapted from Kline, et al, 1993*

---

**Coordinated Care System**

1. **Service Collaboration:**
   - System level – linkage
   - Program level – integrated
   - Individual level – person-centered coordination

*Adapted from Kline, et al, 1993*

---

**Coordinated Care System**

2. **Comprehensiveness**

   **No One System Can Serve All People with MH/ID**
   - Mental Health
   - MH/DD
   - Child & Family
   - Health
   - Education
   - Social Services
   - Substance Abuse
   - Criminal Justice

*Adapted from Kline, et al, 1993*

---

**Coordinated Care System**

*Fletcher, 2007*
### Coordinated Care System

#### 3. Flexibility
- Flexible enough to modify traditional approaches
- Sufficient flexibility for:
  - Increase time/resources in assessments
  - Cross training
  - Modification of traditional approaches

Adapted from Kow, et al, 1993

#### 4. Continuity
- Keep an eye on:
  - Changing needs
  - Changing systems
  - Propensity for behavioral problems
  - Need for long term treatment & supports
  - Need to focus on multiple systems in different contexts over a life span

Adapted from Kow, et al, 1993

#### 5. Leadership and Partnership
- Partnership across systems
- Need leadership to facilitate coordination
- Ensure accountability
- Political Will

Fletcher, 2008

---

### Public Policy Recommendations

#### Foster interagency collaboration and cooperation
- Collaborate across disciplines
- Participate in joint forums for service and treatment recommendations

Fletcher, 2008

#### Create a forum designed to promote interagency collaboration
- Develop common cross-systems goals
- Develop written interagency agreement specifying roles and responsibilities of various agencies

Fletcher, 2008

#### Know when specialized services make sense
- Pilot initiatives and measure outcomes
- Plan ahead for funding:
  - Blended Funding
  - Braided Funding
  - Shared Resources

Fletcher, 2008
NO QUICK FIX

THANK YOU

Dr. Robert J. Fletcher
National Association for the Dually Diagnosed (NADD)
132 Fair Street - Kingston, NY 12401
(845) 331-4336
Email: info@thenadd.org
www.thenadd.org