

Dual Diagnosis: Beyond the Hyphen

***An Introduction to
the Mental Health Issues
of People Who Have an
Intellectual Disability***

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Philosophy & Perceptions: A Summary

- Crisis in the Community: Lack of trained personnel and agencies
- Same Words: Different Meanings (Case Manager)
- The Rubik's Cube of service provision: it's messy!
- Locus of Control and Responsibility for Change

Philosophy & Perceptions: A Summary

- “Womb to Tomb” vs. Short-Term Aggressive
- Everyone vs. The Most Severe
- Habilitation vs. Therapy (Broad vs. Narrow Service Definitions)
- Developmental vs. Functional
- Functional vs. Available

Philosophy & Perceptions: A Summary

- “Ill” vs. Behavior (Diagnosis Wars)
- Over-Protected vs. Under-Protected
- Over-Served vs. Under-Served
- Slow Progress vs. Chronic Recidivism
- Psycho-Social vs. Psycho-Medical

Philosophy & Perceptions: A Summary

- "Saints" vs. "Experts"
- Political liabilities and realities including "Sticker Shock"
- State/Local \$ vs. Medicaid

Why Working with People Who Have A Dual Intellectual Disability & Mental Illness Diagnosis is so Complex

1. 1/3 Intellectual Disability
2. 1/3 Mental Illness
3. 1/3 Effect MI has on ID
and ID has on MI
4. 1/3 Politics and Sick System

Similarities and Differences:

Intellectual Disability and Mental Illness

ID: Intellectual Disability refers to sub-average intellectual functioning. (IQ)

MI: Mental illness has nothing to do with IQ. A person who has a mental illness may be a genius or may be sub-average in cognitive function.

ID: Intellectual Disability refers to impairment in social adaptation.

MI: A person who is mentally ill may be very competent socially but may have a character disorder or other aberration.

Similarities and Differences:

Intellectual Disability and Mental Illness

ID: Incidence: 3 - 6% of general population.

MI: Incidence: 16 - 35% of general population.

ID: Intellectual Disability is present at birth or occurs during the period of development. (prior to age 22).

MI: Mental illness may have its onset at any age.

***Similarities and Differences:*****Intellectual Disability and Mental Illness**

ID: In Intellectual Disability, the intellectual impairment is permanent but training, adaptations, etc. can be utilized to minimize the impact of Intellectual Disability.

MI: Mental illness is often temporary, and in many instances is reversible, and is often cyclic.

***Similarities and Differences:*****Intellectual Disability and Mental Illness**

ID: Full development of the person's potential is highly probable with consistent and well-planned efforts and approximate the level of the general population as a function of the degree of Intellectual Disability.

MI: Mental illness is by definition not a developmental disability. However, research is proving a clear link with genetic and in-utero trauma, in addition to adverse developmental conditions as causes of some types of mental illnesses.

Similarities and Differences:

Intellectual Disability and Mental Illness

ID: A person who has Intellectual Disability can usually be expected to behave rationally at his or her cognitive/emotional operational level.

MI: A person who has a mental illness may vacillate between normal and irrational behavior, displaying degrees of each.

Five Causes Of Psychopathology In People Who Have Intellectual Disability

The late Dr. Robert Sovner listed five causes of psychopathology in persons with Intellectual Disability:

- 1. Learned maladaptive disorders**
- 2. Central nervous system dysfunction**
- 3. Childhood onset Pervasive Developmental Disorder**
- 4. Classic psychiatric disorder**
- 5. Medical/drug-induced disorder**



TWELVE PRINCIPLES RELEVANT TO DUAL DIAGNOSIS

1. People who have Intellectual Disability can experience the full range of psychiatric disorders.
2. Psychiatric disorders usually present as behavior that interferes with the quality of their lives and/or is a threat to their (or others) health, safety, liberty, rights, etc. (maladaptive)



TWELVE PRINCIPLES RELEVANT TO DUAL DIAGNOSIS

3. There are many different reasons for both Intellectual Disability and mental illness.
4. A sudden onset of a psychiatric disorder may look like an exaggeration of long-term maladaptive behavior.
5. Maladaptive behavior typically occurs along with a significant psychiatric issue(s).



TWELVE PRINCIPLES RELEVANT TO DUAL DIAGNOSIS

6. Severity is relative to the individual, the diagnosis, and the setting.
7. It is very difficult to determine what is "going on" with just one or two conversations/interviews.
8. It often is possible, but much more difficult, to diagnose significant psychiatric disorders in persons who have more severe disabilities.



TWELVE PRINCIPLES RELEVANT TO DUAL DIAGNOSIS

9. Maladaptive behavior is intended (consciously or unconsciously) by the consumer to serve a purpose. We may not understand and/or respond to that purpose as they desire. Increases in intensity and/or numbers of behaviors may be to try to communicate with us and/or get the outcome they desire.
10. State (Axis I) and trait (Axis II) disorders frequently coexist.

TWELVE PRINCIPLES RELEVANT TO DUAL DIAGNOSIS

11. Psychosocial stressors are frequently overlooked as potential factors in the presence of psychiatric-disorders in persons who have Intellectual Disability.
12. The "Global Assessment of Functioning" can be used with people who have Intellectual Disability as an indicator of severity of the psychiatric disorder.

Assessing Counterfeit Deviance

**Structural or Lack of Opportunity
Poor Models
Misapplied Modeling**

Assessing Counterfeit Deviance

Choice Error
Behavioral
Inappropriate Learning
Distraction or Frustration
Bio-Medical
Moral or Cognitive Vacuum
Otherwise Benign

DIAGNOSTIC
OVERSHADOWING

Phobia = 6" line _____

General Population = 2" line _____

Phobia Dominates

Phobia = 6" line _____

ID = 8" line _____

ID Dominates

Rules:

- 1) Diagnostic issues almost always complicate treatment decisions.
- 2) Treatment availability almost always affects diagnostic accuracy.

Symptoms: EX VS MINIMUS

Handout page 7

MANIFESTATION OF ?

Avoidance & withdrawal
Physiological arousal
Physiological illness
Over activity
Irritability, anger, rage
Disorganization of thoughts
Stereotypic behaviors
Self-stimulation
Self-injury fantasies
Delusions & hallucinations

Indicators for Predicting Crises/Some Symptoms

- Biology: Eating, sleeping, elimination, sexuality demonstrations (ESES), weight, puberty, dental problems, injury, illness
- Substance abuse – can be water
- Level of movement
- Changes in routines
- Increased responsibility

Indicators for Predicting Crises/Some Symptoms

- Dating/sexual relationships
- Loss - especially significant
- Emotions: lability, increased stress/anxiety
- Hypochondriasis/somatization
- Age mate passages (esp. siblings)
- "Parental" involvement

Indicators for Predicting Crises/Some Symptoms

- Change in self-governance or compliance, impulsivity, overly compliant
- Safety and self-preservation changes
- Aggression - self or others
- Unexpected refusals to participate in previously enjoyed activities
- Major decrease in intellectual or functional skill performance
- Unexplained increase in support request/beeper abuse

Indicators for Predicting Crises/Some Symptoms

Memory problems:

- Amnesia: Generalized inability to remember
- Aphasia: Inability to find the right words
- Apraxia – Inability to carry out a sequence
- Agnosia – Inability to recognize objects

Managing for Tension and Resistance

Tension =

Consumer wants something and we don't want them to have it.

Resistance =

We want the consumer to do something and they don't want to do it.

Managing for Tension and Resistance

Fundamental Motives

- Help Others
- Food
- Vengeance
- Order
- Independence
- Curiosity

Managing for Tension and Resistance

Fundamental Motives

- Attention
- Morality
- Social contact
- Physical exercise
- Sex

Managing for Tension and Resistance

Avoidance Efforts

- Rejection
- Pain
- Frustration
- Anxiety

Essential Motivation Based Person Centered Planning: Improving Outcomes by Reducing Tension & Resistance

- An effort to provide objective data to the resolution of “important to” and “important for”
- *The Values of the Person (P) & System of Supports (S) are Addressed*
- *Scores Represent Perceived Importance and Barriers to Both the Person and the System*
- *Multiple Data Points for Comprehensive Analysis*
- *Agreement...Still requires attention*

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The Institute Assessment of Essential Motivation, Tension, and Resistance
Version 1.1

	Person Scores			System of Support Scores			HTRR
	Importance (P)	X	Barriers (P) = MTRF (P)	Importance (S)	X	Barriers (S) = MTRF (S)	
1 Help Others							
2 Rejection Avoidance/Acceptance							
3 Vengeance							
4 Order							
5 Independence/Self-Determination							
6 Curiosity							
7 Attention							
8 Morality							
9 Social Contact							
10 Physical Activity							
11 Sexual Gratification							
12 Food							
13 Physical Pain Avoidance/Comfort							
14 Frustration Avoidance/Self-Regulation							
15 Anxiety Avoidance/Calmness							
Total All Scores							

MTRF = Motivation, Tension, Resistance Factor
HTRR = Harmony, Tension, Resistance Ratio

Scoring scale for "Importance"

1	3	5	7	9	10
Total Disinterest/ Not at all Important	Relatively Unimportant	Ambivalent/ Uncertain	Strong Value/ Desire	Essential Desire/Value	Strongest Possible Desire/Value

Scoring for "Barriers"

1	3	5	7	9	10
Virtually No Barrier	Minor Blockage	Moderate Blockage	Major Blockage	Very Severe Blockage	Complete Blockage

Initial Symptoms Of Assault

- Non-contextual fear
- Inability to trust
- Displaced anger and hostility
- Inappropriate sexual behavior
- Depression
- Guilt or shame
- Performance deterioration

Initial Symptoms Of Assault

- Somatic complaints
- Sleep disturbances
- Eating disorders
- Phobic or avoidant behaviors
- Regressive behavior
- Accident proneness
- Runaway behavior

Long Term Effects Of Assault

- Depression, feelings of isolation, and suicidal behavior
- Anxiety as a lifestyle
- Negative self-concept
- Impaired interpersonal relationships
- Vulnerability to re-victimization


Long Term Effects Of Assault

- Propensity to choose abusive mates
- Problems with sexual adjustment
- Substance/alcohol abuse
- Eating disorders
- Disassociative identity disorder



POST-TRAUMATIC STRESS DISORDER (p. 427)

- A. The person has been exposed to a traumatic event in which both of the following were present:



POST-TRAUMATIC STRESS DISORDER (p. 427)

- 1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others
- 2) the person's response involved intense fear, helplessness, or horror. Note: in children, this may be expressed instead by disorganized or agitated behavior

POST-TRAUMATIC STRESS DISORDER (p. 427)

- B. The traumatic event is persistently re-experienced in at least one of the following ways...

“As important as your past is, it is not as important as the way you see your future.” –Tony Campolo

BPD

- 1. Unstable and intense interpersonal relationships**
- 2. Impulsivity**
- 3. Affective instability**
- 4. Difficulty controlling angry feelings**
- 5. Suicidal/self-injurious behavior**
- 6. Identity disturbances**
- 7. Anhedonia**
- 8. Fear of abandonment**

Aggression

<u>Possible Cause</u>	<u>Intervention(s)</u>
1. Aggression as a symptom of medical illness.	<ul style="list-style-type: none"> * Have medical team assess and treat medical condition. * Teach person to request medical care.
2. Aggression as a medication side effect.	<ul style="list-style-type: none"> * Ask medical team to carefully review the medication and possibly discontinue and/or substitute medication.

<u>Possible Cause</u>	<u>Intervention(s)</u>
3. Aggression as a part of pre-seizure irritability.	<ul style="list-style-type: none"> * Ask medical team to review anticonvulsant regime to establish better seizure control.
4. Aggression related to irritability as a symptom of mania, depression, or organic mental syndrome.	<ul style="list-style-type: none"> * Treat with medication designed to address the specific disorder such as lithium for mania or carbamazepine for an organic mental syndrome. * Teach person anger management skills, including relaxation.

Possible Cause	Intervention(s)
5. Aggression as a symptom of rage attacks.	*Treat with propranolol or other centrally-acting beta blocker.
6. Aggression is associated with task-related anxiety.	*Teach cognitive/behavioral self-control skills to decrease anxiety. *Prescribe an anti-anxiety agent such as buspirone.

Possible Cause	Intervention(s)
7. Aggression is associated with a schizophrenia-related paranoid delusion.	* Treat psychosis with appropriate education. * Provide supportive psychotherapy and other related interventions.
8. Aggression is associated with inability to express needs.	* Teach functional communication skills.

Possible Cause	Intervention(s)
9. Aggression is a means for obtaining positive reinforcers.	<ul style="list-style-type: none"> * Enhance access to positive reinforcers. * Teach socially acceptable, alternative behaviors which enable the person to gain access to the reinforcers in a pro-social way.

Possible Cause	Intervention(s)
10. Aggression as a type of escape/avoidance behavior mental disorder).	<ul style="list-style-type: none"> * Adapt environment to minimize aversive stimuli (e.g., of an undesired task (when there is no other overcrowding). * Teach appropriate escape behavior. * Teach coping and stress management skills.

Creating the Appropriate Treatment/Learning Environment

Minimize:

- Random Stressors
- Aversive Stimuli
- Unnecessary Exposure to Overt Opportunities for Problems
- Destabilizing Factors
- Extensive Negative Role Model Exposure

... the Appropriate Treatment/Learning Environment

Maximize:

- Identification with Positive Role Models
- Positive Self-Esteem and Self-Image
- Internalization of Rules of Conduct
- Empathic Response Skills
- Recognition of Thinking Errors
- Pro-Social Skills

... the Appropriate Treatment/Learning Environment

- Moral Reasoning including:
 - telling the truth
 - overcoming negative peer pressure
 - escaping negative situations
 - dealing with dilemmas,
 - discerning illusion and reality,
 - etc.
- Work Skills
- Physical Activity
- Physical Wellness

... the Appropriate Treatment/Learning Environment

Necessary Ingredients:

- Comprehensive Staff Training
- Consistent Staff Interactions (behavior plans for staff)
- Quality "Clinical Supervision" for staff
- Interdependence of Clinical Advantages and Clinical Imperatives Maximized

... the Appropriate Treatment/Learning Environment

Informal Crisis Prevention Activities & Therapeutic Interventions

- Trust
- Coffee Shop Therapy
- Havens
- Progressive Experimentation & Safety Nets
- Skills

... the Appropriate Treatment/Learning Environment

- Backdrops
- Eliminate Things Likely to Precipitate the Behaviors
- Interrupt the Behavior

... the Appropriate Treatment/Learning Environment

Formal Crisis Prevention Activities & Therapeutic Interventions

- DBT Type Skills
- Anger Management
- Planned/Supported Distraction (Brushing, etc.)

National Dual Diagnosis Demonstration Projects:

Major Findings

- Poor social skills are a major cause of failure
- Increased staff training results in better outcomes.
- Data based clinical decision making is a necessity.
- Lack of effective leisure skills is a major source of problems.

National Dual Diagnosis Demonstration Projects:

- Integration/membership within the community is essential for positive outcomes.
- Vocational needs are more important than most expect.
- Medications can be substantially reduced when supports are in place.

National Dual Diagnosis Demonstration Projects:

- There are predictable and recognizable issues, which require clinical attention.
- Teaching staff how to “listen” to the individual is very important.
- Sexuality and historical abuse are major areas of concern.
- Teaching people how to “give back” to society results in improvements.
- Crisis planning prevented any admissions or returns to psychiatric hospitals or ID centers.

National Dual Diagnosis Demonstration Projects:

- It is not easy.
- It is not cheap.
- It results in improvements others believed impossible.
- Increased short-term intensive services/costs seems to indicate long-term savings over traditional programs.

6 CRA Core Concepts Related to Crises

1. A crisis must be seen from the perspective of the person.
2. The goal is calm – not control.
3. A crisis is not a teaching moment.
4. Prevention works
5. You must respect the whole person.
6. It's a life not a program

The 7 Corollaries

1. Good Person Centered Planning is prevention
2. Gentle is best
3. Informal is best
4. People communicate with their behavior
5. Boredom precipitates poor interactions
6. Listen or suffer - People vote with their feet and fists when we don't listen to their voices.
7. Kill Stupid

Co-occurring Disorders Guiding Principles

Abbreviated Version

- Co-occurring disorders shall be treated as multiple primary disorders
 - each disorder receives specific and appropriately intensive integrated treatment, as indicated.
- Integration of appropriate services and supports must occur throughout the entire system.

Co-occurring Disorders Guiding Principles

Abbreviated Version

- Co-occurring disorders are an expectation not an exception.
 - The whole system must be accessible to all types of co-occurring disorders.
- People with co-occurring disorders shall be supported in the least restrictive environment, in the community of their choice.

Co-occurring Disorders Guiding Principles

Abbreviated Version

- Demonstrations of appropriate attitudes and values must reflect state of the art thinking and best practices.
 - The development of knowledge and skills alone is not sufficient for establishment of appropriate attitudes and necessary outcomes.
 - Overt and covert biases about all aspects of co-occurring disorders must be systematically addressed.

Co-occurring Disorders Guiding Principles

Abbreviated Version

- The entire service delivery network must (be) person centered through the development of a system of care that is welcoming, accessible, integrated, continuous, and comprehensive and based upon the individual's choice.

Co-occurring Disorders Guiding Principles

Abbreviated Version

- People with co-occurring disorders and their significant others when appropriate shall be empowered to make treatment decisions.
 - They are protected to the extent possible from immediate harm to self or others.

Co-occurring Disorders Guiding Principles

Abbreviated Version

- The system recognizes and values the long-term cost effectiveness of providing best practice services and supports for persons with co-occurring disorders. It is therefore willing to fund best practices for this population to realize the many benefits, including the cost savings, that are inherent in this approach.

Co-occurring Disorders Guiding Principles

Abbreviated Version

- There are three levels of service coordination appropriate for treatment of people with co-occurring disorders.
 - The level of service coordination used...should match the level of need...
 - and should be based on the severity of the consumer's co-occurring disorders.
- The first level is informal consultation.
- The second level is formal collaboration.
- The third is integration of services.