Dual Diagnosis

Martha Marr

http://www.youtube.com/watch?v=SKCxwDF-SrI

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- Strength based introductions
- A few roels of perosn and the strengths they have that they bring to those roles

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A Credo for support

- http://www.youtube.com/watch?v=wunHDfZFxXw

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Acknowledgements

- Material developed – Innovations grant – CMHA Ottawa Branch - MCSS
- Dorothy M. GRIFFITHS, Chrissoula STAVRAKAKI, Jane SUMMERS
  "Dual Diagnosis "
- Martha's Experience

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Today is part of a larger picture of training . Goal is to enable staff , increase their competence and confidence in their roel supporting people with complex needs. Today is intro to some of the Diagnosis , interactions from having 2 diagnosis . Followed up by the online course then followed up by a part 2 where we spend time doing a Bio Psycho social interventions for some situations .

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Dual Diagnosis

- Mental Illness
- Developmental Disability
- Dual Diagnosis
- Special issues
- The Biopsychosocial Approach to working with dual diagnosis

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How many therapists does it take to change a light bulb?

- None. The light bulb will change itself when it's ready.
- Just one, but the light bulb really has to want to change.
- Just one, but it takes nine visits.

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How many psychiatrists does it take to change a light bulb?

- "How long have you been having this fantasy?"
- "Why does the light bulb necessarily have to change?"
- One, but he must consult the DSM-IV.

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How many psychoanalysts does it take to change a light bulb?

- "How many do you think it takes?"

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"You wouldn't feel guilty. You earned the fortune you inherited by giving her great happiness while she was alive."

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"Life isn't all that bad. You're still able to pay my bills, aren't you?"

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What is a Dual Diagnosis?

A Dual Diagnosis indicates the presence of a psychiatric illness as well as the presence of a developmental disability, occurring simultaneously in an individual – that results in ongoing mental health and cognitive challenges.

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Interministerial guidelines published January 2009

Two definitions of developmental disability

1. **MCSS (**Developmental Services Act): a condition of mental impairment, present or occurring during a person's formative years, that is associated with limitations in adaptive behaviour.
2. **MOHLTC** (DSM-IV-TR): characterized by significantly sub-average intellectual functioning (an I.Q. of 70 or below) with onset before age 18 years and concurrent deficits or impairments in adaptive functioning.

Developmental Disability

"A particular state of functioning that begins in childhood and is characterized by limitations in both intelligence and adaptive skills"

AAMR

❖ ADAPTIVE SKILLS

- Communication
- Self-care
- Home living skills
- social skills
- community use
- self direction
- health and safety
- functional academics
- Leisure
- Work

• Emphasize the person strengths, interests, gifts and talents adapt the environment so that they are used .

Developmental Disability

- Impaired ability to learn causing difficulty coping
- Usually present from birth
- Not the same as mental illness
- Milestones - Developmental delay

Developmental Disability

- What are some of the challenges you might expect to encounter if you are working with someone who has a developmental disability ?
  - Communication problems
  - Self injury
  - Issues re: self care, mobility, language
  - Hospitalization
  - Medication
  - Isolation

Developmental Disability

Limitations or impairments in two or more of the following adaptive skills:

- Communication
- Home living
- Community use
- Health and safety
- Leisure
- Self care

Developmental Disability

- Social skills
- Self direction
- Functional academics
- work

Developmental Disability

- I.Q. testing is not used to diagnose, rather to differentiate between levels of disability:
  - Mild = 50–55 to @ 70
  - Moderate = 35-40 to 50-55
  - Severe = 20-25 to 35-45
  - Profound = below 20-25

Developmental Disability

- Syndromes/disorders associated with developmental disability:
  - Developmental delay
  - Down Syndrome
  - Chromosomal abnormalities
  - Phenylketonuria
  - Fragile X Syndrome
  - Cerebral Palsy
  - Autism
  - Prader-Willi Syndrome

Developmental Disability

- Unique issues:
  - Vulnerabilities
    - Biological
    - Psychological
    - Social

Developmental Disability

- Biological Vulnerabilities:
  - More likely to have physical illnesses such as ear, nose, throat, congenital heart disease, gastrointestinal, seizure disorders, etc.
  - Less likely to be able to express their experiences of pain and discomfort due to communication difficulties
  - Higher risk of medical misdiagnosis
  - Greater sensitivity to certain medications

Developmental delay

- Childhood milestones met late or not at all
- Lift head .crawl/walk talk/ etc
- Difference between infant or toddlers current level of functioning and the expected Milestones for chronological age to the month

Down Syndrome

- Genetic disorder
- 10% of people with developmental disability have DS
- Increased vulnerability to eye heart lung skin and gastrointestinal disorders
- Usually short stature, round face, almond eyes, broad hands and feet
- Low muscle tone and hyper flexibility joints

Cerebral Palsy

- Disorder of movement and posture resulting form a non-progressive lesion in the brain acquired during childhood development
- Cerebral = Brain and Palsy = Paralysis
- Spastic rigid limbs
- Speech disorders poor coordination
- Difficulty with balance and unusual gait

Autism spectrum

- Disorder of Neurological condition
- Unknown cause
- Difficulty with language, social relationships, sensory stimulation, and cognitive processing
- 4 times more frequent in males
- Manifest prior to the age of 3
- Degree's vary greatly

Fragile X syndrome

- Genetic disorder most common inherited cause of developmental disability
- Affects 2X more makes than females
- Females with Fragile X can have normal range of intelligence males are more severely impacted
- Often a missed diagnosis
- Characteristics = stereo topic movements elongated face, large ears.
- Limned eye contact
- Difficulty with social relationships

Prader –willi syndrome

- Genetic disorder present at birth
- Excessive hunger and unusually large food intake
- Mild to severe intellectual disability X profound
- Small stature, low muscle tone, almond eyes small hands and feet , perpetual pre teen
- Poor emotional and social skills
- Test high for reading, writing , number skills and abstract thinking than their intellectual functioning

Phenylketonuria (PKU)

- Genetic disorder whereby an infant lacks the required enzyme to metabolize PKU
- If undetected leads to brain damage and development disability
- Heel - prick test at birth .. Can be treated with diet

Developmental Disability

- Psychological Vulnerabilities:
  - We all develop our personalities the same way: social interaction; play; how we relate and respond to others and how they relate and respond to us.
  - People with DD are often excluded from "normal" experiences
  - Stigma/negative social reactions
  - May not get opportunity to develop independent skills
  - More vulnerable to mood and anxiety disorders ?

Developmental Disability

- Social Vulnerabilities:
  - Social isolation
  - Artificial friendships
  - More prone to victimization and exploitation
  - More easily intimidated or coerced
  - Lack of opportunity to learn to value themselves and achieve social success

❖ Common mental illness with Types of Disorders

- Communication Disorders:
  - Means: anxiety, depressive, adjustment disorder
  - What Helps: alternate ways of communicating
- Pervasive Developmental Disorders:
  - Means: severe-pervasive impairment social interaction/communications skills, stereotype behaviour
  - 40% person with developmental disability
  - What Helps: helping support individual and caregiver in primary disability

… Common mental illness with Types of Disorders

- Attention Deficit and Disruptive Disorders:
  - Means: inattention, hyperactivity, impulsivity
  - Increase: likelihood of disruptive behaviour, anxiety, depression, sexual disorder
  - Hard to find: Dev. Dis. all ready have short attention spam-excessive motor activity – impulsivity
- Feeding Disorders:
  - Means : eating non-nutrive substances
  - Pica very common, but difficult to modify

… Common mental illness with Types of Disorders

- Eating Disorders:
  - Means: Anorexia, bulimia, binge eating
  - RARELY DIAGNOSE because INTENT
  - Compulsive over eating (Common)
- Tic Disorders:
  - Means: Rapid, recurrent, non rhythmic, stereotypes motor movement or vocalization
  - Does not include autism

… Common mental illness with Types of Disorders

- Elimination Disorders:
  - Enuresis:
    - no control of urine, day and night in bed or clothing
  - Encopresis:
    - repeated passage of faeces into inappropriate places
  - Greater disability, greater the frequency
  - Cause: neurological, anger, fear, agitation, lack of opportunity of appropriate training

… Common mental illness with Types of Disorders

- Mood Disorders:
  - Common in mildly and moderate
- Anxiety Disorder:
  - Observe behaviour for lower functioning
- Eating Disorders:
  - Common overeating
  - Prader-Willi = obsessive-compulsive eating

… Common mental illness with Types of Disorders

- Sleep Disorders:
  - Very common
  - Neurological deficit
- Adjustment disorders:
  - Psychological or physical trigger, last self-limiting time
  - Frequent with mild and moderate
- Delirium
  - Means: change of cognition due to medical condition/intoxication-withdrawal
  - some symptoms similar to schizophrenia

… Common mental illness with Types of Disorders

- Demantias
  - Means: loss of multiple cognitive deficits
  - Symptoms: memory impairment (3 kinds):
    - Apraxia (impaired motor activity)
    - Aphasia (deterioration language)
    - Agnosia (failure to identify, recognize objects), disturbance in executive functioning
  - Most be based on evident deterioration of pre-existing level of cognition

Mental Illness

Everyone experiences feelings of isolation, loneliness and emotional distress at times. These feelings are normal and are usually short-term and related to life events – we cope.

For some people these feelings are so intense that their ability to cope is overwhelmed and they cannot function in their social roles.

20 % of Canadians will experience a mental illness during their lifetime

Mental Illness

Mental illness is caused by a complex interplay between biological, genetic, environmental and personality factors.

- You can have more than one mental illness e.g. depression and anxiety
- More episodes of MI the greater the degree of disability

Mental Illness

- What are some of the challenges you might expect to encounter if you are working with someone who has a mental illness?
  - Symptoms of illness
  - Medication and compliance issues ?
  - Homelessness/ housing instability ?
  - Addiction ?
  - Family problems ?
  - Problems with criminal justice system ?
  - Unemployment ?
  - Lack of education ?
  - Poverty ?
  - Hospitalization ?

Mental Illness

The four major mental illnesses are:

- Schizophrenia
- Affective or mood disorder
- Anxiety Disorder
- Personality Disorders

AXIS II

- Disorders diagnosed in infancy, childhood or adolescence
- Developmental Disability:
  - Communication Disorders
  - Pervasive Developmental Disorders
  - Attention Deficit and Disruptive Behaviour Disorders
  - Feeding and Eating Disorders of Infancy or Early Childhood
  - Tic Disorder
  - Elimination Disorder

❖Degrees of Develop. Disability & potential risk of mental illness

- **1.** Mild: (85% of Dev. Dis. Pop.)
- "educable", to a 6th grade level
- social and communication skills
  - traumatic and adverse experience (rejection)
- **cause:** prior or after birth, infections, medical condition, traumas
- anxiety and mood disorders because academic and social expectation greater then cognitive limitation

Schizophrenia

- Schizophrenias are one of the most severe, chronic and disabling brain disorders
- Disturbances of thought (delusions and/or hallucinations), mood, sense of self and relationship to external world, language and communication, regressive and bizarre behavior.

Schizophrenia

- Types include:
  - Paranoid
  - Catatonic
  - Disorganized

Affects 1% of population

Much higher prevalence in the Developmental population

Schizophrenia

- Onset: late teens to mid-30's
- Preadolescent onset is rare
- Men and women are equally affected
- Males usually have earlier onset
- If onset is after the age of 45, person is usually female and likely to have a larger mood component

Schizophrenia

- Diagnosis
  - No lab test for schizophrenia
  - Clinical observation
  - Symptoms must be present for at least 1 month
  - Persistent for 6 months
  - Must be causing marked social, educational, or occupational dysfunction
  - Family history

Schizophrenia

- Symptoms:
  - Delusions and or hallucinations
  - Lack of motivation
  - Social withdrawal
  - Thought disorders
  - Bizarre behavior
  - Blunted affect

Dual diagnosis and Schizophrenia (What it might look like)

- Diminished self care
- Aggressive behaviour
- Uncontrolled yelling
- Difficulty dealing with others
- Labile affect (laugh or cry at inappropriate times)
- Behaviour indicating new fears or suspicion others
- Talking-to non existent objects or people
- Regression in language skills

Dual diagnosis and Schizophrenia (What it might look like)

- Appearance of new unusual mannerisms
- Quick glances or movements
- Complaints of strange smells
- Insecure statements " you are going to put me in jail/hospital /institution"
- Denying or admitting guilt related to delusional thoughts" I burned the house"

Affective or Mood Disorders

- Major Depression
- Bipolar Disorder
- Dysthymia
- Onset is adolescence to early adulthood
- Late diagnosis is common
- Ratio equal between males and females

Affective or Mood Disorders

Major Depression

- 8% of adults
- Higher rates for women (ratio 2:1)
- Symptom differences based on gender
  - Males = irritable, angry, discouraged
  - Females = feeling worthless, helpless, persistent sad mood

Major Depression

Symptoms:
- Mild, moderate or severe
- Difficulty coping
- Feelings of uselessness, hopelessness
- Anger or irritation

- Memory problems
- Difficulty concentrating
- Extreme restlessness or fatigue
- Sleep problems (too little or too much)
- Suicidal or homicidal thoughts
- Hallucinations or delusions

Dual diagnosis and Depression (What it might look like)

- Increased agitation
- Destruction of property
- Restlessness
- Increased SIB
- Spending more time alone/ refusing phone calls
- Lack of interest in Rec/ leisure
- Spontaneous crying
- Refusal of meals or agitation around meal times
- Fear
- Changes in sleep/ weight

Bipolar Disorder

Affects 1% of the population
- Sustained periods of depression alternating with periods of mania with normal mood in between.
- Mania: feeling high, euphoric or agitated

Symptoms of mania:
- elevated or expansive mood
- as mood gets higher:
  - extreme irritability
  - rapid emotional changes

Bipolar Disorder

- Grandiosity
- Excessive energy
- Decreased need for sleep
- Increased sex drive
- Poor judgment (risky behavior)
- Hallucinations or delusions
- racing thoughts/ flight of ideas/rapid speech
- over-reaction

(1 % of the population Mortality rate is 2-3 times higher)

Dysthymia

- Chronically depressed mood
- No long symptom-free periods
- Depression lasts most of the day
- More depressed days than not in past two years

Dual diagnosis and Bi-polar (What it might look like)

- SIB associated with irritability
- Attention deficits
- Inflated self esteem and grandiosity
- Repetitive speech/disorganized thoughts
- Easily provoked /Teasing others
- Suicide attempts
- Demands to have needs met
- Decreased need for sleep

Anxiety Disorder

Persistent, extreme or pathological anxiety

- A debilitating level of anxiety
- Feelings of fear in anticipation of events
- Self-judged inability to cope
- Rapid heart rate
- Elevated blood pressure
- Disturbances in mood or emotions

Anxiety Disorder

- Included are:
  - Panic Disorder (more common in women than men)
  - Generalized Anxiety Disorder
  - Obsessive Compulsive Disorder
  - Phobias
  - Post-Traumatic Stress Disorder

Dual diagnosis and Anxiety (What it might look like)

- Rocking body , rubbing hands
- Usually tied to post traumatic stress and history of abuse
- Aggression
- SIB
- Destruction of property
- Persistent talk on upcoming activities
- Hyperventilate/panic attacks

Personality Disorders

- A long-standing way of relating to self and environment that becomes so fixed and rigid it causes personal distress and impairs functioning.
- As a result of their maladaptive way of relating to the world, individuals with a personality disorder often struggle in social, occupational and educational roles.

Personality Disorders

- Personality develops in early infancy and childhood
- Personality traits become personality disorders when they become rigid and inflexible, impair functioning and cause distress.

Personality Disorders

- Characteristics:
  - Do not do well in social or occupational roles
  - Often demanding, intolerant, irrational, manipulative, inconsistent, opposing, threatening.
  - Sometimes violent or self-destructive
  - Passive aggressive behavior
  - Hypochondria
  - Defective sense of reality

Personality Disorder

- Types:
  - Paranoid personality disorder
  - Schizoid personality disorder
  - Histrionic personality disorder
  - Narcissistic personality disorder
  - Anti-social personality disorder
  - Borderline personality disorder
  - Dependent personality disorder

Dual diagnosis and personality disorders (What it might look like)

- Volatile nature of interpersonal relationships
- Impulsive goal directed which could include drinking binges or stealing
- Difficulty controlling anger/ verbal tirades
- Suicidal threats vulnerable to suicide
- Constant unreasonable demands placed on people in their network anger if not met
- Limited insight into behaviour/ illness

Impact of Mental Illness

- Education
- Occupation or career opportunities
- Personal relationships
- Stigma and discrimination

Dual Diagnosis

- What are some of the challenging behaviors you may encounter in working with someone with a dual diagnosis?

Dual Diagnosis

- Approximately 80,000 individuals in Ontario have a developmental disability
- Approximately 24,000 or 30 % have a mental health issue. Some researchers state the prevalence may be as high as 50-60%
- Psychiatric disorders are one of the main causes of a secondary disability in the developmentally disabled
- Often people with a developmental disability are not assessed for mental health issues or are misdiagnosed

Dual Diagnosis

- Most common MI in persons with developmental disability:
  - Mood Disorders
  - Anxiety Disorders
    - OCD
  - PTSD
  - Schizophrenia

Dual Diagnosis

- Signs and symptoms/ what to look for:
- Eating
- Sleeping
- Hyper/ under vigilance
- Changes in patterns of behavior (isolation, excitability, fixation)
- High index of suspicion given the prevalence rates
- Know your client

Dual Diagnosis

- Symptoms of undiagnosed mental illness can be perceived as many things e.g. aggression, self-harm behavior etc. and can result in challenging behavior.
- Challenging behavior can lead to:
  - Hospitalization
  - Housing instability
  - crisis

Lingo /terminology/acronyms

- Smi
- Severe and persistent
- Axis 1 2 3 4
- Dd
- Dh
- Mr
- Id
- concurrent disorders /cd harm reduction
- Life domains
- Adls psr pcs pcp srv oisd

I define me

- http://www.youtube.com/watch?v=opgUMJTXTYY

- Day 2

Innovations DVD

The Biopsychosocial Approach

- The evidence-based best practice approach to working with individuals who have a dual diagnosis
- A movement away from *managing* behaviors towards *understanding* behaviours.
- The BPS approach looks beyond the obvious and explores the origins of behaviour from a holistic viewpoint.

The Biopsychosocial Approach

- The application of the BPS model to dual diagnosis is innovative. In this approach, challenging behaviour is seen as a symptom of a larger issue and becomes the focus of multidisciplinary assessments into the origin of the behaviour.
- The term 'challenging behaviour' can refer to a variety of behaviours, however, behaviours that are targeted through intervention strategies are usually aggressive in nature.

The Biopsychosocial Approach

- *Challenging behaviour* is the external symptom of an often complex interplay between any number of biological, psychological and social factors.
- These factors are:
  - *BIOMEDICAL*
  - *PSYCHOLOGICAL*
  - *SOCIAL*

The Biopsychosocial Approach

- In the BPS model the "focus person" is supported by a multidisciplinary team. This team is made up of professionals from a variety of disciplines such as neurology, family medicine, psychiatry, occupational therapy, recreation therapy, social work as well as non- professionals such as the individual, family and friends.

The Biopsychosocial Approach

- Family an friends : support network, collateral information
- Social worker: advocacy, intervention, coordination of services , direct services, planning
- Nurse : assessment , treatment ,education, medical investigations
- Neurologist: Brain activity patterns
- Psychiatrist: assessment ,diagnosis, treatment
- Occupational Therapist: skills assessment , and development
- Recreation therapist leisure, and recreation
- Psychologist : Therapy

The Bio psycho social approach

- We must understand the function of behaviour
- Understand the context
- Triggers
- Personal vulnerabilities
- reinforcing factors
- Once we understand the context we can hypothesis the function and teach replacement behaviours that are more functional

Gussepe

- 43 year old male
- Grew up in institution – 30 years
- No major behavioral issues reported – communication frustrations tantrums .
- Blind
- Small stature C-spine scoliosis
- Moved to community to moderate support group home – did well of two years
- Then withdrawal, weight loss , tantrums, yelling screaming, sib's, crawl up on the window sill in sun and sleep for hours
- Unable to examine by GP

Gusseppe

- Acute hospitalization
- No thorough assessment
- Relevant tests not completed
- Began to stabilize somewhat (eat/sleep/med compliance)
- Some days still with SIB's and screaming
- Severe MR level
- Psych unit transferred to general bed unable to make a psych diagnosis
- Similar periods of stabilization and agitation
- Transferred to BPH DD unit – 3 months same pattern

You are Gusseppe's multi-discplinary team

- What Questions do you have re Gussepe ?
- What are some of your hypothesis ?
- What are your ideas

Bio (medical wellness)	Psycho (mental health)	Social (life domains)

Gussepe's action plan

What	When	Who	Time frame

The Biopsychosocial Approach

- Recap
- Challenging behaviour should be investigated not just managed
- Investigation should be based on a holistic approach and considered within the context of a persons unique abilities

Trauma

- Simple and Complex PTSD in people with Dual Diagnosis

"Yassir "

- Grew up ion Gaza strip saw war first hand . Was included in gangs who threw rocks at each other
- Immigrated to Canada via Jordan (Mom , Dad 2 brothers)
- Aggression verbal ad property
- Elopement – somewhat safe but not always
- Police knew him and would drive him home
- Seen as unpredictable and "Scary"
- Some placements – always broke down

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"YASSIR "

- Acute hospital admissions – in and out.
- Transitions from Moms house usually evoked aggression
- Some food hoarding
- Transfer to BPH DD unit - 3 years was stabilized at 1 year deemed ready for community. No placements No agency involved.
- Escalated quickly – Mom could catch it early and de escalate sometimes Described glare and rigidity as sign of escalation

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Dotmocracy

You are Yassir's-discplinary team

- What Questions do you have re Yassir?
- What are some of your hypothesis ?
- What are your ideas

Bio (medical wellness)	Psycho (mental health)	Social (life domains)

Yassir's action plan

What	When	Who	Time frame

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Stan

- male
- 22 yrs old
- 6' tall
- 2 siblings sister learning disability, Brother schizophrenia 19yrs at onset
- History of family breakdown- non functioning Mother struggles with addictions, natural father abusive, step father history of incarcerations – aboriginal influence
- CAS involved at age 4 all 3 children removed form the house when Stan 7 , different placements

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"Stan "

- Multiple assessments all disputing each other
- Disagreement on axis 1 only stand up is ADHD
- Mild developmental disability – also disputed
- Extreme cloak of competence – Can present verbally an negotiate life . Understanding is limited – cognitive testing on comprehension very low
- Recently weighed in at almost 400lbs. Steadily increasing form about 180 at 17 yrs old
- Many placements throughout CAS even sent to a treatment program outside of province
- Behaviorally described as " bugging behaviors"

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"Stan "

- Incarcerated many times – physical aggression, sexual acting out
- Suspected abuse as child physically and sexually not substantiated
- Pre mature grey hair
- Many labels and myths – most services run

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You are Stan's multi-discplinary team

- What Questions do you have re Stan ?
- What are some of your hypothesis ?
- What are your ideas

Bio (medical wellness)	Psycho (mental health)	Social (life domains)

Stan's Action plan

What	When	Who	Time frame

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High index of suspicion

- **Have more multiple and complex medical problems *Including epilepsy, vision/hearing impairment, dysphasia, dental disease, obesity, reflux disease, constipation, skin disease, musculoskeletal disorders.***
- ***Unrecognized & under treated health conditions including physical, dental and mental health .***
- ***lifestyle risk factors: (incl. poor nutrition, Vit. D deficiency, low levels of exercise, osteoporosis.***
- ***Mental illness (greater risk and fewer resilience factors)***
- ***medication: (include & over medication, polypharmacy.***

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Adjusting expectations

- (Recognize that the client is presenting symptoms rather than being difficult… a shift from being frustrated by the client to being sympathetic to their situation.)
- **Borderline Personality**
- **Bi Polar**
- **Anxiety**
- **OCD**
- Depression

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Strength based approaches

- DRO
- SRV
- PSR
- Wraparound – BERS Assessment
- Hope and Recovery
- Harm Reduction
- PCS
- Normalization
- Others CBT DBT

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Unique considerations when supporting people who live with a dual diagnosis

- Cloak of competence
- Cognitive testing – variance in abilities functioning
- Safe and unsafe situations – safeguarding
- Risk assessment- how to
- Trauma and abuse histories – stats
- Diagnostic overshadowing
- Adaptations for communication counseling
- High index of suspicion

Best practice list

- **Assessment for understanding :** severity/functional levels/adaptations skills, expectations. Chart Bio/psycho/social
- **Exhaust Resources :** access points navigation points
- **Mental Health assessment** : meaningful diagnosis diagnosis/symptoms, effective Intervention ,alternative models i.e medical/psychosocial/recovery/role of hope); potential impacts of pharmaceuticals .
- **evaluate outcome**: plan/strategy/intervention through observation, multi-source feedback, user feedback and documentation review
- **Relevant legislation/policy frameworks** (i.e. Mental Health and Health Care Consent Acts)

- **Biopsychosocial theoretical model:** impact of psychiatric/medical problems on behavior, presentation & assessment of psychiatric illness at various levels of disability; differential impact of environmental variables and medication; effective practice approaches with the range of challenging behaviors
- **effective collaboration:**cross-sectoral practice. Options for adaptation of intervention approaches to functional level and current life environments, positive behavioral approaches and crisis prevention/intervention and theory

- **Communication Skills:** with persons with a range of disability tailoring modalities and devices,colleagual and mediation skills to provide effective support, advocate & clarify
- **Alliance Development: with user & family** respecting the value of feedback, perspective and goals, to ensure mutuality and reciprocity in the relationship, shifting roles as necessary (from advocate, to coach, to personal care as required)

Integrated aproaches

- People need to be treated in Holistic psycho-therapeutic way in order to move towards rehabilitation from MH
- Role of hope in recovery, hope to person hope to their support network .
- Cognitive therapy or others can be adapted and modified to allow for the developmental disability
- Pictures, chaining events , cartoon bubbles, catastrophizing, role-plays and Allowing for concrete examples I.e. sandpaper can represent wrong , cotton balls can represent right. Etc etc journaling
- Choice making as a skill

Dual Diagnosis

- "If there is no treatment individuals deteriorate "
- "If a thorough assessment is met with treatment quality of life increases "
- The definition of a useful diagnosis is one that helps us with treatment so that a person gets better"
- Dr. Ruth Ryan