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Understanding Dual Diagnosis and Developing Competency in the Workforce

October 21, 2016
DoubleTree Suites by Hilton, Mt. Laurel, NJ

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Understanding Dual Diagnosis and Developing Competency in the Workforce

Dr. Robert J. Fletcher
Founder and CEO
NADD

October 21, 2016
Rutgers University
The Boggs Center on Developmental Disabilities
Mt. Laurel, NJ

Outline
- Definitions / Prevalence
- Characteristics of People with IDD/MI
- Assessment / Diagnosis Practices
- Therapy / Counseling
- Medication Principles
- Systems Collaboration
- Competency in the Workplace
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

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

• Conferences/Trainings
  • Journals
  • Webinars
• Consultation Services
• Book Publisher
• Accreditation and Certification
Definitions/Prevalence

Diagnostic Criteria of ID

**Intellectual Disability Criteria**

A. Deficits in intellectual functions
B. Deficits in adaptive functioning
C. Onset during the development period

Note: confirmed by both clinical judgment and standardized IQ testing.

American Psychiatric Association, 2013
American Psychiatric Association, 2013

**Intellectual Disability Criteria**

B. Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility.

Deficits in adaptive functioning can include:

- Self care
- Language
- Socialization
- Self-direction
- Money management
- Employment
- Friendship abilities
- Social judgment

Note: Adaptive functioning is assessed by both clinical evaluation and standardized measures.

American Psychiatric Association, 2013

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**Level of Intellectual Disability**

<table>
<thead>
<tr>
<th>Level</th>
<th>IQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>50-70</td>
</tr>
<tr>
<td>Moderate</td>
<td>35-49</td>
</tr>
<tr>
<td>Severe</td>
<td>20-34</td>
</tr>
<tr>
<td>Profound</td>
<td>Below 20</td>
</tr>
</tbody>
</table>

American Psychiatric Association, 2013
Autism Spectrum Disorder (ASD)

ASD is a neurodevelopmental condition that effects:

- Social Interaction
- Communication
- Interests
- Behavior

Signs and Symptoms of ASD

- Children and young people with ASD frequently experience a range of cognitive (thinking), learning, emotional and behavioral problems.

Prevalence of psychiatric disorders by age 16 in youth with ASD is 49% (Rosenburg, Law, & Law, 2011)

Note:
Other studies indicated prevalence of 50 – 70%
MI is a psychiatric condition that disrupts a person’s thinking, feeling, mood, ability to relate to others, and daily functioning.

- MI can affect persons of any age, race, religion, income, or level of intelligence.
- The DSM or the DM-IDD provide a classification system of diagnoses.

What Is Mental Illness (MI)?

- Mental illness is a biological process which affects the brain. Some refer to it as a brain disorder.
  - Mental Illness
  - Mental Disorder
  - Psychiatric Disorder

Concept Of Dual Diagnosis

- Co-Existence of Two Disabilities: IDD and Mental Illness
- Both IDD and Mental Health disorders should be assessed and diagnosed
- All needed treatments and supports should be available, effective and accessible
Adapted from Enfield and Aman 1995

### Conceptual Model of Dual Diagnosis

1. When behavior is abnormal by virtue of quantitative or qualitative differences from baseline
2. When behavior cannot be explained on the basis of development delay alone
3. When behavior causes significant impairment in functioning, and a change from baseline

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### Est. Prevalence of MI in IDD

Studies range from 13.9% to 75.2%

*(Buckles, Luthbason, Xerfi, 2013)*

Much variation due to:
- Differences in diagnostic criteria
- Samples examined
- Differences in definitions

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### Est. Prevalence of MI in IDD

40.9% of People with IDD have MI

*(Cooper et al, 2007)*

Method: Population-based study (N=1023) Comprehensive individual clinical assessment
Characteristics Of People With IDD/MI

• Fewer support networks and friendships
• Increased experiences of loss, rejection, isolation
• Increased likelihood of social distribution and segregation
• Low self-esteem
• Lack of control over one’s life

Fletcher, 2016

Characteristics Of People With IDD/MI

• Poorer coping skills and abilities to manage stress
• Poorer problem-solving and conflict resolution skills
• Biological vulnerabilities including sensory impairments
• Poor self-image and self-worth

Fletcher, 2016
• Often fall between the cracks, as service agencies feel ill-equipped to provide supports
• Can be left without support to help them manage life in the community. As a result, they may come into contact with the law and end up in jail or on forensic units in psychiatric hospitals
• Are often denied places in housing services because “their needs are too complicated.”

Canadian National Coalition on Dual Diagnosis, 2011

• May have been rejected by their family – or have rejected their family – and are without any support. These are the people who are most vulnerable to homelessness
• Lose opportunities to be productive citizens because of system failures.
• Can have behaviors that are out of control because there is little help

Canadian National Coalition on Dual Diagnosis, 2011

• High Vulnerability to Stress
  • The impact of a minimally stressful situation can be experienced as significant.

Hockey and MacLean, 2009
• Difficulty with Interpersonal Relationships
  • Individuals with IDD/MH typically have difficulty with interpersonal relationships
  • These interpersonal relationship problems can result in disruption in school, home, work, and social environments

Characteristics Of People With IDD/MI

NCI, 2016

Difficulty Working in the Competitive Job Market

People with IDD/MI often have difficulty working in a competitive employment. They may have frequent job changes interspersed with long periods of unemployment.

Characteristics Of People With IDD/MI

May have difficulty focusing, may have shortened attention span
• Difficulty in understanding some abstract concepts
• May have difficulty in considering alternative solutions. For example, may see things in “black and white” terms

Characteristics Of People With IDD/MI

Hartley and MacLean, 2009
Characteristics Of People With IDD/MI

- Being different from peers
- Losses rather than gains
- Social isolation although mainstreamed
- Rejected by peers
- Failure experiences dominate school histories
- Low social status

Heiman & Margalit, 1989

Characteristics Of Youth With ID/MI

- Difficulty establishing relationships
- Loneliness
- Lack of friends
- Frustration with existing relationships
- Decreased active involvement in social relations

Fletcher - 2005

Assessment & Diagnosis: Bio-Psycho-Social Model

BIO  PERSON  PSYCHO  SOCIAL

Fletcher - 2005
Vulnerability Factors for Developing Psychiatric Disorders in People with IDD

People with IDD are at increased risk of developing psychiatric disorders due to complex interaction of multiple factors:

- Biological
- Psychological
- Social
- Family

Vulnerability factors for psychiatric disorders:

Biological
- Brain damage/epilepsy
- Vision/hearing impairments
- Physical illnesses/disabilities
- Genetic/familial conditions
- Drugs/alcohol abuse
- Medication/physical treatments

Adapted from Engel, 1980

Royal College of Psychiatrists, 2001
Vulnerability factors for psychiatric disorders:

Psychological
- Rejection/deprivation/abuse
- Life events/separations/losses
- Poor problem-solving/coping strategies
- Social/emotional/sexual vulnerabilities
- Poor self-acceptance/low self-esteem
- Devaluation/disempowerment

Social
- Negative attitudes/expectations
- Stigmatization/prejudice/social exclusion
- Poor supports/relationships/networks
- Inappropriate environments/services
- Financial/legal disadvantages

Family
- Diagnostic/bereavement issues
- Life-cycle transitions/crises
- Stress/adaptation to disability
- Limited social/community networks
- Difficulties “letting go”
Best Practice Assessment: Bio-Psycho-Social Model

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

Fletcher, 2005

Best Practice Assessment: Bio-Psycho-Social Model

• 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

Fletcher, 2005

Medical Problems & Problem Behavior

• Why do medical causes of problem behaviors get missed?
• Why do we have to be……. Sherlock Holmes

Dr. Charlot
Medical Problems & Problem Behavior

Medical conditions can mask as behavioral problems.

Medical conditions are often underdiagnosed.

Charlot, 2011

Case Example of Dental Pain & SIB

- 28 year old female with ID referred to dental office for routine exam
- Mother noted that she began pulling out her hair
- Dental exam showed a fractured upper molar tooth, & tooth was extracted
- Mother subsequently reported that hair pulling ceased

Rada, 2013

The Trouble With Nonspecific Behavior Symptoms (Gardner 1996)

Aggression, SIB, Property Destruction

- They are not diagnostic
- They may not correlate with psychiatric symptoms
- Correlation may be coincidental
- Degree of influence is from minor to major

Gardner, 1996
Common Psychiatric Disorders

- Bipolar and related disorders
- Depressive disorders
- OCD and related disorders
- Anxiety disorders
- Trauma and stressor related disorders
- Schizophrenia Spectrum and other psychiatric disorders

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

Hughes, 2006
• 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 IDD (Lamon & Reiss, 1987)

### DSM Symptom for Depression

<table>
<thead>
<tr>
<th>DSM Symptom for Depression</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychomotor Agitation</td>
<td>Restlessness, fidgety, pacing</td>
</tr>
<tr>
<td></td>
<td>Increased disruptive behavior</td>
</tr>
<tr>
<td>Psychomotor Retardation</td>
<td>Sits for extended periods</td>
</tr>
<tr>
<td></td>
<td>Moves slowly</td>
</tr>
<tr>
<td></td>
<td>Takes longer than usual to complete activities</td>
</tr>
</tbody>
</table>

Hughes, 2006

<table>
<thead>
<tr>
<th>DSM Symptom for Depression</th>
<th>Presentation in Someone with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue/Loss of Energy</td>
<td>Needs frequent breaks to complete simple activity</td>
</tr>
<tr>
<td></td>
<td>Slumped/tired body posture</td>
</tr>
<tr>
<td></td>
<td>Does not complete tasks with multiple steps</td>
</tr>
<tr>
<td>Feelings of Worthlessness</td>
<td>Statements like &quot;I'm dumb,&quot; &quot;I'm retarded,&quot; etc.</td>
</tr>
<tr>
<td></td>
<td>Seeming to seek punishment</td>
</tr>
<tr>
<td></td>
<td>Social isolation</td>
</tr>
</tbody>
</table>

Hughes, 2006
### DSM Symptom for Depression: Presentation in Someone with ID

<table>
<thead>
<tr>
<th>DSM 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>

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**Weight Change/ Appetite Change**
- Measured weight changes
- Increased refusals to come to table to eat
- Unusually disruptive at meal times
- Constant food seeking behaviors

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

**Hypersomnia**
- Over 12 hours of sleep per day
- Naps frequently

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Hughes, 2006
Holistic 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, 2016

DM-ID-2: Two Manuals

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

Description of DM-ID

- An adaptation to the DSM-5
- Designed to facilitate a more accurate psychiatric diagnosis
- Based on Expert Consensus Model
- Covers all major diagnostic categories as defined in DSM-5
DM-ID-2

Description of DM-ID

• Provides information to help with diagnostic process
• Addresses pathoplastic effect of ID on psychopathology (how the disorder is manifested in people with ID)
• Designed with a developmental perspective to help clinicians to recognize symptom profiles in adults and children with ID

DM-ID-2

Description of DM-ID

• Empirically-based approach to identify specific psychiatric disorders in persons with ID
• Provides state-of-the-art information about mental disorders in persons with ID
• Provides adaptations of criteria, where appropriate

DM-ID-2

Description of DM-ID

Adaptation of the DSM-5 Criteria

1. Addition of symptom equivalent
2. Omission of symptoms
3. Changes in symptom count
4. Modification of symptom duration
Description of DM-ID

Adaptation of the DSM-5 Criteria

5. Modification of age requirements
6. Addition of explanatory notes
7. Criteria Sets that do not apply

Modification of DSM-5 Criteria
Change in Count and Symptom Equivalent

<table>
<thead>
<tr>
<th>DSM-5 Criteria</th>
<th>Applying Criteria for Mild to Profound ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Five or more of the following symptoms have been 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.</td>
<td>Four or more symptoms have been 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) irritable mood.</td>
</tr>
</tbody>
</table>

Therapy/Counseling
And Other Supportive Approaches
Myth: Persons with IDD 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 Applications: Psychotherapy approaches need to be adapted to the expressive and receptive language skills of the person.

Fletcher, 2011

Adapted Therapies

- Relationship between a client and a therapist/counselor
- Engaged in a therapeutic relationship
- To achieve a change in emotions, thoughts or behavior

Individual Psychotherapy

Individual psychotherapy aims to increase the person’s overall well being.

It is most effective when the therapist adapts the model to consider the cognitive ability of the person with intellectual/developmental disability.

Hollins & Sison, 2000
Adaptations
Intellectual activities that often pose challenges for people who have dual diagnosis:
- Speed
- Complexity
- Abstraction
- Generalization
- Length of sessions
- Frequency of sessions
- Involve other care providers

Adapted Therapies

Adapted Therapy Techniques

Adaptive Therapy Techniques
- Dialectical Behavior Therapy
- Positive Psychology
- Cognitive Behavioral Approaches
- Group Therapy
- Family Therapy
- Other

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

Robert Fletcher, DSW, ACSW, 2004
Considerations with Persons Who Have Mental Illness and IDD

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

Help People Better Cope With Daily Problems
- Listen
- Reflect
- Probe
- Support
- Facilitate problem solving
- Evaluate outcome

Active Listening
- Attentive
- Interested

Reflect
- Repeat a few words
- Reflect demonstrates active listening
Techniques for Promoting Mental Wellness

**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

**Facilitate problem solving**
- Explore alternative options
- Support acceptable solutions
Evaluate outcome

- Was outcome acceptable?
- Was it positive?
- What was learned?

Guiding Principles:

- Use language that promotes hope
- Raise expectations of what people are capable of accomplishing
- Stay focused on strengths

VALIDATING

Exploring is often combined with another communication technique known as validating. Validating involves confirming the person's emotions while attempting to gain further information.

An example of this is shown in the following scenario:

Jack: “Everybody around here hates me!”

Staff: “It sounds as though you are pretty angry. What happened?”

Fletcher, 2009

Hughes, 2006
EXPLORING

Exploring involves encouraging the individual to further explain whatever it is they are trying to communicate.

An example of this is shown in the following scenario:

Jack: “Everybody around here hates me!”

Staff: “Tell me what happened.”

Levitas and Gilson, 1989

Predictable Crisis and Prevention

- Confirmation/realization of diagnosis of ID
- Birth of siblings
- Starting school
- Puberty and adolescence

Levitas and Gilson, 1989

Predictable Crisis and Prevention

- Sex and dating
- Being surpassed by younger siblings
- Emancipation of siblings
- End of education

Levitas and Gilson, 1989
Predictable Crisis and Prevention

- Out-of-home placement and/or residential moves
- Staff/client relationships
- Loss of peers, friends & parents
- Medical illness & Psychiatric Illness

Myth: Medication Treatment is Used to Control Maladaptive Behaviors

Premise:
Medication-based therapies directly affect behavior.

Reality:
Behaviors such as self-injury and aggression are too nonspecific to be considered as direct targets for drug therapy.

Treatment implications:
The appropriate targets for medication therapy are the changes in neurophysiological function that mediate behavior associated with psychiatric disorders.

RATIONAL APPROACH TO PSYCHOPHARMACOLOGY

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Treatment implications:
The appropriate targets for medication therapy are the changes in neurophysiological function that mediate behavior associated with psychiatric disorders.
Pharmacotherapy is therapeutic and may be the first choice treatment for some psychiatric disorders:

- Major depression
- Mania states
- Schizophrenia

Medication treatment should be diagnostically related to a DSM 5 diagnostic and treatment guideline or the DM-ID.

Inter-Systems Collaboration

The Typical Picture:

- Failure to plan services
- Failure to fund flexible services
- Failure to obtain technical assistance
MH providers perceive that they do not have the skills to serve adults or children with a dual diagnosis

IDD providers do not understand the services that the MH sector offers

MH providers do not understand the services that the IDD sector offers

The Typical Picture:

<table>
<thead>
<tr>
<th>Dual Diagnosis Policy Barriers</th>
<th>Dual Diagnosis Policy Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MH System</strong></td>
<td><strong>IDD System</strong></td>
</tr>
<tr>
<td>- Short term episodic treatment</td>
<td>- Services/supports over</td>
</tr>
<tr>
<td>- Focus on psychiatric needs</td>
<td>lifetime</td>
</tr>
<tr>
<td>- Recovery model</td>
<td>- Emphasis on direct support</td>
</tr>
<tr>
<td>- Local authority</td>
<td>- Self-Determination</td>
</tr>
<tr>
<td>- Medication treatment</td>
<td>- State authority</td>
</tr>
<tr>
<td>- Consumer/Client/Patient</td>
<td>- Behavioral Support (PBS)</td>
</tr>
<tr>
<td>- Little Collaboration</td>
<td>- Self-Advocate/Consumer</td>
</tr>
</tbody>
</table>

Fletcher, Beasley, & Jacobson, 1999

Co-occurring disorders should be treated as multiple primary disorders, in which each disorder receives specific and appropriate services.

Collaboration of appropriate services and supports must occur as needs are identified.

Services provided to the individual are consistent with what the person wants and what supports are needed.
Services are determined on the basis of comprehensive assessment of the needs of each individual. Services are based on individual needs and not solely on either MH or IDD diagnosis. Emphasize early identification and intervention.

Involve the person and family as full partners.

Coordinate at the system and service delivery level.

Facilitating Positive and Cooperative Relationships
- Demonstrates ability to navigate recommendations between systems (e.g., psychiatrists and other health professionals, employment, residential settings)
- Demonstrates the ability to build positive and cooperative relationships with other health and mental health professionals
- Can work positively with multiple systems as a collaborative and cooperative member of the team
- Maintains professional and empathetic communication and partnership with family members and friends of individual
- Recognizes family members as integral partners in support and gathers input from them
- Demonstrates problem solving and teamwork skills
Intersystem Collaboration

PERSON

Mental Health
Child & Family Serv, Education
Vocation
Social Servs

IDD

Putting it all together
- Understand the efficacy of counseling/therapy
- Use a rational approach to medication tx
- Use an interdisciplinary term approach
- Be a team player using inter-systems model of care and treatment

Developing Competency in the Workforce
Value of Certification Programs

- Higher income for the individual
- A way to advance skills and careers
- Enhances a career ladder
- Health insurance companies often want certifications

Value of Certification Programs

Recognition that a person has:

- In-depth knowledge
- Demonstration of work experience
- Dedication to a profession
- Proven skill sets
- Competency
- Uphold a certain set of standards
- Fulfilled specific requirements
- Properly trained
10 Reasons to Seek Certification

1. Certification demonstrates commitment to your profession. Receiving a certification shows your peers, supervisors, and, in turn, the general public how committed you are to your chosen career, along with how well you perform set standards. Certification sets you apart as a leader in your field.

2. Certification enhances the profession's image. Association certification programs seek to grow, promote, and develop certified professionals who can stand “out in front” as examples of excellence in the industry or field.

3. Certification reflects achievement. A certified professional has displayed excellence in their field or industry and fulfilled set standards and requirements.

4. Certification builds self-esteem. Association certification programs create a standard for a particular profession, complete with performance standards, ethics and career paths. You'll see yourself as a certified professional who can control his or her own professional destiny and find a deep sense of personal satisfaction.

5. Certification establishes professional credentials. Since it recognizes your individual accomplishments, certification stands above your resume, serving as an impartial, third-party endorsement of your knowledge and expertise. And when the public looks for individuals qualified to perform certain services, they seek individuals – like you – who have achieved certification.

6. Certification improves career opportunities and advancement. Certification gives you the “edge” when being considered for a promotion or other career opportunities. Certification clearly identifies you as an employee who can adapt to changes in work, technology, business practices, and innovation.
7. Certification prepares you for greater on-the-job responsibilities. Since certification is a voluntary professional commitment to an industry or field of knowledge, it’s a clear indicator of your willingness to invest in your own professional development. Certified professionals are aware of the constantly changing environment their profession faces, and they possess the tools needed to anticipate and respond to that change.

8. Certification provides for greater earnings potential. As a certified professional, you can expect many benefits, but in today’s downsized, right-sized, top-turvy working world, salary increases speak for themselves.

9. Certification improves skills and knowledge. Achieving certification highlights your individual competence by confirming proficiency, knowledge and career commitment.

10. Certification offers greater professional recognition from peers. As a certified professional, you can expect increased recognition from your peers for taking that extra step in your professional development.

The NADD Accreditation / Certification Programs

- NADD Competency-Based Accreditation
- NADD Competency-Based Clinical Certification
- NADD Competency-Based Dual Diagnosis Specialist Certification
- NADD Competency-Based Direct Support Professional (DSP) Certification
For more information, please contact
Dr. Robert J. Fletcher
NADD
132 Fair Street, Kingston, NY 12401
Telephone 845 331-4336
E-mail rfletcher@thenadd.org
www.thenadd.org
Annotated Book List

Prepared by Robert Fletcher, DSW


This book provides the reader with insightful and useful ways to provide psychotherapy treatment for individuals who have intellectual disability (ID). It brings together all three modalities (individual, couple, and group), and a variety of theoretical models and techniques are discussed. The first section, Individual Therapy, offers a variety of approaches and techniques including dialectical behavioral therapy, positive psychology, mindfulness-based practice, and relaxation training. Also included in this section are chapters on specialty populations including victims of abuse, people who have Autism Spectrum Disorder, and people in mourning. The second section is a chapter on group therapy addressing trauma issues. The third section is on family and couple therapy. The fourth section covers chapters on research, ethics, and training. The individual authors are respected authorities in the field of providing psychotherapy treatment for persons with ID and all have contributed to the professional literature.

This book is a major contribution to the effort to make psychotherapy available to individuals who have ID and should serve to further stimulate interest in the provision of psychotherapy treatment for individuals who have ID co-occurring with significant mental health problems.


*Mental Health Approaches to Intellectual/Developmental Disability: A Resource for Trainers* is a landmark contribution to the field of support for persons with Intellectual or Developmental Disabilities (IDD) and Mental Health concerns. This book can be used by a myriad of different professionals and care providers for a variety of different purposes. It may be used: (a) to train others for professional development (train-the-trainer model), (b) as a resource guide for individual study, or (c) as a reference guide.

Proper support of mental wellness among persons with IDD requires a significant body of information and knowledge, and the authors of this book are happy to offer it as a means for educating professionals and care providers. The overall mission of this book is to provide an overview of mental health assessment, treatment, and supports for persons with IDD over the lifespan. The book is arranged in modules, allowing reader or trainer to select those topics that are of interest.

*The Diagnostic Manual-Intellectual Disability (DM-ID): A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability*, developed by the National Association for the Dually Diagnosed (NADD) in association with the American Psychiatric Association (APA), is a diagnostic manual designed to facilitate an accurate DSM-IV-TV diagnosis in persons who have Intellectual Disabilities and to provide a thorough discussion of the issues involved in reaching an accurate diagnosis. The *DM-ID* provides state-of-the-art information concerning mental disorders in persons with Intellectual Disabilities.

Grounded in evidence-based methods and supported by the expert-consensus model, the *DM-ID* offers a broad examination of the issues involved in applying diagnostic criteria for psychiatric disorders to persons with Intellectual Disabilities. The *DM-ID* includes a description of each psychiatric disorder, a summary of the DSM-IV-TR diagnostic criteria, a review of the research, and an evaluation of the strength of evidence supporting the literature conclusions, a discussion of the etiology and pathogenesis of the disorder, and adaptations of the diagnostic criteria, where applicable, for persons with Intellectual Disabilities.


Positive Identity Development is an exciting new approach to treatment for individuals with intellectual disabilities. This book provides a new theoretical perspective on treatment along with a variety of innovative tools. It rejects reducing adults with intellectual disabilities to a mere compilation of their behaviors and promotes the use of a positive, therapeutic approach to each unique individual.

Psychologists, social workers and therapists should be able to use the tools presented in this book to directly enhance the effectiveness of the treatment they provide to adults with intellectual disabilities.

This book promotes well-being on every level and explores a broad range of issues relevant to the life and mental health of adults with intellectual disabilities.

*Breaking Down Silos: Innovation in Dual Diagnosis Systems* takes a look at the complex issues faced by individuals with developmental disabilities and behavioral/mental health issues and their families. The book broadens the focus of dual diagnosis challenges to include not only issues of diagnosis and recognition but also an examination of challenges these individuals often face in navigating various systems, programs, and organizations. The book offers recommendations on building on existing program/system successes as well as needed changes to ensure access to needed services and positive health and life outcomes for individuals with behavioral/mental health needs and IDD.


With the release of *Mental Health and Intellectual Disability: A Training Manual in Dual Diagnosis*, Drs. McGilvery and Sweetland share decades of experience working with individuals diagnosed with an intellectual disability and co-occurring psychiatric disorders. Their well-practiced approach takes into account the extremely complex nature of working with dual-diagnosis. The authors provide in-depth information about the diagnostic process, hands-on treatment considerations, and their experience training thousands of people to work passionately with these individuals. An important contribution is their approach to addressing complicating factors in identifying appropriate psychiatric diagnoses, as well as the problem of the underreporting of psychiatric symptoms and disorders. Finally, those working in a variety of contexts with these individuals will benefit from the innovative approaches of looking at treatment and intervention strategies that can be immediately implemented.