The NADD Accreditation and Certification Programs:
Standards for Quality Services

THE NADD

COMPETENCY-BASED

DUAL DIAGNOSIS

SPECIALIST

CERTIFICATION

PROGRAM

NADD
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EXECUTIVE SUMMARY

It is estimated that more than a million people in the US have a dual diagnosis of intellectual or development disability (IDD) and mental illness (MI). These individuals have complex needs and present service delivery challenges to professionals, programs, and systems. Staff face challenges in providing appropriate services for individuals who experience mental illness and an intellectual disability

NADD Competency-Based Specialist Certification Program

NADD, an association for persons with developmental disabilities and mental health needs, developed the NADD Competency-Based Specialist Certification Program to improve the quality and effectiveness of services provided to individuals with a dual diagnosis through the development of competency-based professional standards and through promoting ongoing professional development.

A Specialist in the field of dual diagnosis is defined as an individual who delivers, manages, trains and/or supervises services for persons with intellectual/developmental disabilities and mental health needs. Staff working in units of county, state or provincial government, QIDPs, program directors, program supervisors, case/care managers, program specialists, supports coordinators, peer specialists, trainers and others are examples of roles that can apply for the DDS.

Dual Diagnosis Specialist certification through the NADD Competency-Based Certification Program validates and provides assurance to people receiving services, professional colleagues, and employers that a specialist has met the standards established by NADD for providing services to individuals with IDD/MI. Certification attests to the Specialist's competency in providing these services. In addition to the prestige this Certification provides, it may benefit the Specialist through greater employment opportunities, job security, and promotions. The certification is portable; staff moving to a different region bring their certifications with them and do not have to demonstrate or re-document their competence simply because they have moved.

Competency Areas

The specialist seeking certification will be required to demonstrate mastery of the following six competency areas:

1. Multimodal bio-psycho-social approach
2. Application of emerging best practices;
3. Knowledge of therapeutic constructs;
4. Respectful and effective communication;

5. Knowledge of dual role service delivery & fiduciary responsibilities; and
6. Ability to apply administrative critical thinking.

Pre-Requisites for Certification: Training, Experience, References
To be considered for certification, Specialists must meet educational and experiential qualifications (or equivalent thereof.) Determination resides with the NADD Competency-Based Certification Program. It is preferred that the applicant have a combination of education and experience in the field of intellectual/developmental disabilities and/or mental health. A post secondary degree, however, is not necessary, and the review committee may recognize other types of accreditation and certifications.

Experience can include volunteering, internships, and externships in addition to employment. In addition to providing copies of the applicant's curriculum vitae, the applicant must submit reference letters from three people able to provide a reference about the applicant's skills, knowledge and values, and experience with persons who have a dual diagnosis.

Work Sample
Once the application has been reviewed and the applicant has been found to meet the prerequisites, the applicant will receive instructions to submit a work sample that demonstrates his or her work in the area of dual diagnosis.

Interview
The final component of the certification process is an interview, which may occur in person, at a NADD conference, via web-based video conferencing, or by telephone. The applicant 's work sample will be reviewed during the interview. Applicants should keep in mind the competency areas noted when organizing their response. The interview shall also include resolution of any questions raised during other parts of the application process.

Credential
Specialists who receive NADD certification will be entitled to use "NADD-DDS" as a credential.

Cost
The cost of the NADD Competency-Based Certification is $275.00. This non-refundable application/exam fee of $275.00 must accompany the application package. The NADD Competency-Based Certification is good for two years. The renewal cost is $75.00. There is a continuing education requirement of

10 hours every 2 years in areas related to Mental Wellness and Mental Health for persons with IDD.

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Dual Diagnosis SPECIALIST CERTIFICATION WORK GROUP

The NADD Dual Diagnosis Specialist Certification Program was developed using an expert-consensus model. This work group of experts met for over 12 months working to identify appropriate competency areas and to design a fair and comprehensive program for evaluating the competencies of a specialist to properly serve individuals with intellectual and developmental disabilities who also have mental health needs.

Certification Program Directors

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Co-Chairpersons

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INTRODUCTION

Dual Diagnosis Prevalence and the Unique Needs of Those with a Dual Diagnosis

Individuals who have both mental illness and intellectual/developmental disability are considered to have a dual diagnosis. More than a million people in the United States have both mental illness and intellectual/developmental disability.[1] It has been estimated that individuals with IDD are two to four times more likely than those in the general population to experience psychiatric disorders,[2] with up to 40 percent having psychiatric symptoms – including mental, behavioral and personality disorders.[3][4]

The Challenge of Service Delivery

These individuals have complex needs and present service challenges to the professionals and systems providing treatment and support services. Specialists face the difficulty of supporting individuals whose treatment is extremely complex. Although psychiatric disorders in persons with IDD are common, they are frequently not appropriately identified or well supported. Specialists often see challenging behavior or behavioral problems confound the optimum delivery of services. In order to provide adequate support for this group of people, Specialists need an understanding of how to modify existing services and support approaches in order to meet individualized needs of person with a dual diagnosis. These areas of understanding include: multi-modal/bio-psycho-social approach, utilization of case-formulation model, application of emerging best practices, knowledge of therapeutic constructs, respectful and effective communication, knowledge of dual role service delivery and fiduciary responsibilities, and ability to apply administrative critical thinking.

NADD

Founded in 1983, NADD is a not-for-profit membership association established for professionals, care providers and families to promote understanding of and services for individuals who have developmental disabilities and mental health needs. The mission of NADD is to advance mental wellness for persons with developmental disabilities through the promotion of excellence in mental health care. NADD is recognized as the leading organization providing conferences, educational services, and training materials concerning individuals with intellectual/developmental disabilities and mental illness to many thousands of people in the United States and world-wide. Through the dissemination of cutting edge knowledge, NADD has been influential in the development of community based policies, programs, and opportunities in addressing the mental health needs of persons who have

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[1] Steven. Reiss, *Human Needs and Intellectual Disabilities: Applications for Person Centered Planning, Dual Diagnosis, and Crisis Intervention* (New York: NADD Press, 2010), 50

[2] C.M. Nezu, A.M. Nezu. & M.J. Gill-Weiss, *Psychopathology in Persons with Mental Retardation, Clinical Guidelines for Assessment and Treatment* (Champaign, IL: Research Press, 1992).

[3] Sally-Ann Cooper, Elita Smiley, Jillian Morrison, Andrew Williamson, & Linda Allan, "Mental Ill-Health in Adults with Intellectual Disabilities: Prevalence and Associated Factors," *British Journal of Psychiatry* 190 (January 2007), 27-35.

[4] B.J. Tonge & S.L. Einfeld, "The Trajectory of Psychiatric Disorders in Young People with Intellectual Disabilities," *Australian and New Zealand Journal of Psychiatry* 34 (2000), 80-84.

intellectual/developmental disability and has been an international leading force advocating on behalf of individuals who have mental illness and intellectual/developmental disability. In furtherance of its mission to advance mental wellness for persons with intellectual/developmental disabilities, NADD has spent significant time and effort identifying the service needs of individuals with intellectual/developmental disability and mental illness, and has worked to identify and support appropriate service programs for these individuals. NADD has been involved in identifying and promoting best practices in the support of these individuals. NADD developed the NADD Accreditation and Certification Programs as part of its continuing efforts to improve the lives of individuals with intellectual disability and mental illness.

Certification

What is certification?

Certification is a review process designed to establish standards of practice. Certification identifies the skills, knowledge, and attributes needed in a particular field. The NADD Competency-Based Dual Diagnosis Specialist Certification Program is designed to review and assess the competence of professionals who provide services to individuals who have co-occurring intellectual/developmental disability and mental illness. These professionals may deliver, manage, train and/or supervise services for persons with intellectual/developmental disabilities and mental health needs. Professionals working in units of county, state or provincial government such as: QIDPs, program directors, program supervisors, case/care managers, program specialists, supports coordinators, peer specialists, trainers and others are examples of roles professionals may hold who qualify for the NADD Specialist Certification process.

Why Certification?

- To provide a workforce and system with a demonstrated level of expertise in serving individuals with MI/ID
- To assure that public and private healthcare dollars are purchasing effective services
- To assist families/advocates to make informed choices about services

Why Competency Based?

- A license or degree does not predict competency
- Competency evaluations can provide a reliable, valid assessment of the ability of the individual or program to perform tasks or duties required
- A competency-based system recognizes the importance of knowledge, skills, abilities, personality traits, and other characteristics in performing the required tasks or duties
- Competency is defined as meeting best practices

What are the benefits of certification?

Benefits for the Specialist:

Certification through the NADD Competency-Based Certification Program validates the expertise of the professional and provides assurance to people receiving services, colleagues, and employers, that a Specialist has met the standards established by NADD for providing services to individuals with IDD/MI. Certification attests to one's competency in providing these services. In addition to the prestige this certification provides, it may benefit

the Specialist through greater employment opportunities, job security, and promotions. The certification is portable; specialists moving to a different region bring their certifications with them and do not have to demonstrate or re-document their competence simply because they have moved.
The names and contact information of NADD certified specialists will be posted on the NADD Accreditation and Certification Program website (unless they request that this information not be posted).

Benefits for the consumer or purchaser of services
Dual Diagnosis Specialist certification through the NADD Competency-Based Certification Program will indicate that a Specialist has met the standards established by NADD for providing services to individuals with IDD/MI. People receiving services, parents, vendors, regulators, and insurance companies can be assured specialists who have earned the NADD certification have demonstrated competence in the area of services and supports for people with a dual diagnosis.

Benefits for the field
The goal of Specialist certification through the NADD Competency-Based Certification Program is to improve the quality and effectiveness of services provided to individuals with a dual diagnosis through the development of competency-based professional standards and through promoting ongoing professional development. One of NADD's main objectives is to "raise the bar" in services delivered for people who have a dual diagnosis. We believe that as a result of the NADD Competency-Based Dual Diagnosis Specialist Certification Program, services will be provided by specialists who have a high level of competence. We believe Specialists will strive to achieve this level of expertise in order to receive NADD certification. As more Specialists within North America become NADD certified, the quality of services provided should be significantly improved.

Credential

Specialists who receive NADD certification will be entitled to use "NADD-DDS" as a credential.

Development of Standards

A committee of experts developed the standards for assessing competency using an expert-consensus methodology.

Competency Areas

The specialist seeking certification will be required to demonstrate mastery of the following six competency areas:

1. **Multimodal bio-psycho-social approach:**
    - **a.** The NADD Dual Diagnosis Specialist is familiar with the bio-psycho-social/multi-modal approach and;
    - **b.** The NADD Dual Diagnosis Specialist incorporates recovery and resiliency to be able to develop a service plan;

- **c.** The NADD Dual Diagnosis Specialist identifies the inter-relationships among a person's biological, social, and psychological domains.
- **d.** The NADD DD Certified Specialist has an understanding of the holistic approach
- **e.** The NADD Dual Diagnosis Specialist can formulate information to enable delivery of accurate/relevant medical, psychological, psychiatric, behavioral information to other Specialists or caregivers/supporters;
- **f.** The NADD Dual Diagnosis Specialist appreciates the environmental, contextual, and individual learning styles; and
- **g.** The NADD Dual Diagnosis Specialist utilizes the above model to guide all service/treatment planning.

2. **Application of emerging best practices**
   - **a.** The NADD Dual Diagnosis Specialist demonstrates understanding of assessments, their purpose, when they may be needed, and how to obtain them and;
   - **b.** The NADD Dual Diagnosis Specialist understands the connection between assessment and service delivery

3. **Knowledge of therapeutic constructs**
   - **a.** The NADD Dual Diagnosis Specialist demonstrates an understanding of trauma and how it affects the brain and body;
   - **b.** The NADD Dual Diagnosis Specialist demonstrates an appreciation of neuro-sensory issues;
   - **c.** The NADD Dual Diagnosis Specialist has an understanding of genetic underpinning and advances to guide treatment; and
   - **d.** The NADD Dual Diagnosis Specialist demonstrates knowledge of psychotherapeutic skills that can be useful.

4. **Employ respectful and effective communication in rapport building**
   - **a.** The NADD Dual Diagnosis Specialist assures that the person is "in the driver's seat"; and
   - **b.** The NADD Dual Diagnosis Specialist understands the importance of communication between stakeholders and supporters that is relevant to the person's care and well being

5. **Demonstrate knowledge of dual role service delivery & fiduciary responsibilities**
   - **a.** The NADD Dual Diagnosis Specialist is able to report on progress of the person in relationship to therapeutic goals and outcomes;
   - **b.** The NADD Dual Diagnosis Specialist identifies the connection between funding and good care;
   - **c.** The NADD Dual Diagnosis Specialist has an ability to work with clinicians and other stakeholders if outcomes are not being achieved.

6. **Ability to apply administrative critical thinking**.
   - **a.** The NADD Dual Diagnosis Specialist recognizes the importance and need for staff and families to understand the multimodal approach;
   - **b.** The NADD Dual Diagnosis Specialist demonstrates understanding of training needs for DSPs/teams/families to implement treatment/support plans;
   - **c.** The NADD Dual Diagnosis Specialist has the ability to assess and resource effective strategies in meeting persons wants and needs;

d. The NADD Dual Diagnosis Specialist is able to signal that behavior plans may be too complicated to be implemented; and
e. The NADD Dual Diagnosis Specialist is able to identify when a plan may not meet the needs of the person.

APPLICATION PROCEDURE

Pre-requisites

Education
Professionals may present a Master's level degree in a related field with one year experience, a Bachelor's level degree in a related field with 2 years experience or 60 credit hours in the field of ID or Mental health and 3 years of related experience.
Post secondary education is not required; however, a thorough explanation of the experience base must accompany the application as equivalence determination resides with the NADD Competency-Based Certification Program. The review committee may recognize other types of accreditation and certifications as pre-requisites.

Experience
The applicant will have experience in support of persons with intellectual/developmental disabilities and mental health issues (Dually Diagnosed). This can include volunteerships, internships and externships. For applicants without a post secondary degree other similar credentialing or accreditation or combinations thereof and experience may be accepted.

Ethical Behavior
The applicant's signatures in the Principles section of the application form is required and shall denote the candidate's commitment to ethical behavior.

Any disciplinary events, lawsuits past or pending, suspension of privileges from care facilities or professional organizations or any actions by state/province or other licensing body related to complaints or actions against a individual must be reported and reviewed by the committee.

NADD has established a process for receiving complaints regarding ethical behavior of people who have received this certification. (See "Complaints against NADD-Certified Specialists," below.)

Any intentional misrepresentations or falsehoods submitted by an applicant would be sufficient to deny certification as an unethical act.

NADD Membership
Specialists seeking certification are required to be members of NADD at the time they apply for certification. Continued membership in NADD is required for the duration of the NADD certification. A NADD organizational membership may satisfy this requirement if the specialist is an employee of the organization which has a NADD membership. NADD is the leading North American expert in providing professionals, educators, policy makers, and families with education, training, and information on mental health issues relating to persons with intellectual or developmental disabilities. In order to stay abreast of issues involved in service delivery and remain knowledgeable about best practices in the field, a Dual Diagnosis Specialist would need the benefits of a NADD membership.

Application

The application and supporting materials should be mailed to:
NADD Competency-Based Dual Diagnosis Specialist Certification Program
12 Hurley Avenue
Kingston, NY 12401

Application Check List

The following should be included in the application package:

- Completed application form
- Signed Principles statement
- In the Experience Confirmation section, provide dates of employment and contact information for all jobs that are being used to meet the experience requirement.
- Provide proof of current NADD membership
- Copy of Curriculum Vitae (CV)
- Three letters of reference
- Nonrefundable Application/Exam Fee

Receipt of Application
When the application package is received at the NADD office, it will be reviewed to ascertain that all items in the Application Checklist have been included. The applicant will be informed of all missing or incomplete items and will be requested to provide the missing information.

Once all items have been received, the application will be deemed to be complete and will be reviewed to determine whether the applicant meets the prerequisites for certification.

Work Sample

Once the application has been reviewed and the applicant has been found to meet the prerequisites, the applicant will receive instructions to submit a work sample that demonstrates his/her work in the area of dual diagnosis. Refer to Appendix C: Work Sample Guidelines for more information. Review of the work sample is based on the guidelines in this manual. The applicant should review the guidelines to ensure that the submitted content includes consideration of each of the six targeted competency areas.
The work sample should be three to five pages in length and should demonstrate the following:

1) Ability to communicate effectively
    a. If you are an administrator, provide an example of how you have effectively communicated the need for change in the system for which you have responsibility.
    b. If you are a trainer, provide an example of how you have changed training content to meet the receptive communication needs of trainees.
    c. If you are a case manager or service or support coordinator, provide an example of how you have been able to communicate clearly and effectively with people you serve.

   d. If you are a peer support specialist, provide an example of how you have helped to bridge communication between individuals being served and others providing services and supports.
   e. If you have another role, not mentioned here, provide an example of how your ability to communicate has enhanced life for individuals with IDD/MI.

2) Understanding of programmatic issues having an impact on individuals with dual diagnosis
   a. If you are an administrator, provide an example of how your understanding of programmatic issues (e.g., limited payment mechanisms, dysfunctional administrative rules) brought about change to enhance life for individuals with dual diagnosis.
   b. If you are a trainer, provide an example of a programmatic issue about which you have trained people so that the lives of service recipients are enhanced.
   c. If you are a case manager or service or support coordinator, provide an example of how you overcame programmatic issues to acquire something needed for the people you serve.
   d. If you are a peer support specialist, provide an example of how you helped somebody you serve get what they needed.
   e. If you have another role, not mentioned here, provide an example of how your understanding of programmatic issues has helped improve lives.
3) Understanding of inter-systems issues and how differences can be resolved
   a. If you are an administrator, provide an example of a policy or process change for which you were responsible, and explain how it improved services and supports for individuals with IDD/MI.
   b. If you are a trainer, please provide an example of at least three training sessions you have conducted, and how those improved services and supports for people with IDD/MI.
   c. If you are a case manager or service or support coordinator, please provide example of facilitating services to meet the bio-psycho-social needs of at least three individuals with differing needs from both the mental health and developmental disabilities systems.
   d. If you are a peer support specialist, provide an example of how you have helped bridge the gap between systems to assist the people you serve.
   e. If you have another role, not mentioned above, describe that role, and provide at least three examples of how your work has improved services and supports for individuals with MIDD.

NADD will assign two examiners to review the level of competency demonstrated in the work sample. If the work sample is found to be acceptable, the interview will be scheduled. The examiners may require submission of additional information – including, in some cases, resubmission of the work sample – before they approve scheduling of the interview.

Interview

The final component of the certification process is an interview, which may occur in person, at a NADD conference, via web-based video conferencing, or by telephone. The applicant must supply a work sample and have it approved in order to move to this level of the certification process. The same two examiners who reviewed the work sample will participate in the interview. The interview shall also include resolution of any questions raised during other parts of the application process. Interviews will generally follow the outline below.

1. Discussion of applicant's training and experience in dual diagnosis, jobs, position, program
2. Review of capacity and work with (or support of) individuals with dual diagnosis
3. Discussion of one project/program/service plan/training that involves dual diagnosis.
4. Discussion of change in the life (or lives) of a person with dual diagnosis—what would that be?
5. Discussion of systemic change where you work—what would that be?
6. Discussion of work sample submitted with application. This discussion will include all the elements of the outline in Appendix C and should demonstrate the following:
   a. Multi-modal/bio-psycho-social approach;
   b. Application of emerging best practices;
   c. Knowledge of therapeutic constructs;
   d. Respectful and effective communication;
   e. Knowledge of dual role service delivery & fiduciary responsibilities;
   f. Ability to apply administrative critical thinking.
7. Behavioral Question Section of Interview
8. Resolution of specific questions arising from application materials
9. Review expectations, procedure, and timetable for certification process

Candidates can expect the interview to include additional topics or areas that are consistent with current practice. Some topics might include: self-determination, consumer decision-making/problem solving, person-centered planning, assessment, financial implications, operational structure, etc.

Scoring and Evaluation

For both the work sample and interview, the applicant's competence in each of the six competency areas (Multi-modal/bio-psycho-social approach, Application of emerging best practices, Knowledge of therapeutic constructs, Respectful and effective communication, Knowledge of dual role service delivery & fiduciary responsibilities, Ability to apply administrative critical thinking) will be evaluated using the following scale:

1 = Insufficient evidence of competence in this area of Best Practice
2 = Evidence of minimal competence in this area of Best Practice
3 = Evidence of average competence in this area of Best Practice
4 = Evidence of above average competence in this area of Best Practice
5 = Evidence of a superior level of competence in this area of Best Practice

Candidates are required to demonstrate at least an average level of knowledge (a score of at least 3) in all competency areas. In the event that the two examiners cannot agree upon

whether the candidate achieved a passing score (3's and above) or a failing score (1's, 2's), the examiner from the same discipline as the candidate shall make the decision.
The candidate will receive a copy of his or her score sheets, which will provide feedback regarding perceived areas of competence.

Retaking the Exam
Candidates who do not receive certification are entitled to retake the exam within one year at a reduced $75 reapplication fee (to cover the cost to NADD). Within the year, there will be no need to redo the application nor resubmit supporting materials, except to the Work Sample if the candidate did not pass the Work Sample portion of the certification.

Cost

The cost of the NADD Competency-Based Certification is $275.00. A non-refundable application/exam fee of $275.00 must accompany the application package.
The NADD Competency-Based Certification is good for two years. The renewal cost is $75.00.

Continuing Certification

Requirements to Maintain Specialist Certification
Once a professional has received NADD Competency-Based Dual Diagnosis Specialist Certification, the Specialist must:

Maintain his or her NADD membership.
Renew his or her certification every two years. This includes meeting the ongoing education and training requirement (see below) and paying the renewal fee.
Continue practice in an ethical manner (see below for the procedure for Complaints Against NADD-Certified Specialists).

Renewing Certification
Once a Specialist has received NADD Competency-Based Dual Diagnosis Specialist Certification, the professional must maintain the certification status by renewing certification every two years.

Approximately three months before the certification is scheduled to expire, NADD will send the Specialist an electronic reminder that his or her certification will be expiring together with instructions on how to renew the certification and how to document complying with the continuing education requirement.

Any certification that has not been renewed within six months after its expiration date is subject to revocation.

Ongoing Education and Training Requirement
All Specialists shall obtain 10 hours of ongoing education and training every 2 years of certification status in areas related to the competency areas listed previously. Similar areas are acceptable as well, such as wellness, behavior support, or educational strategies. In-house training is acceptable for ongoing education and training. Attending conferences, special training sessions, teleconferences, or web based learning are all acceptable.

One hour of ongoing education and training is equivalent to 60 minutes of instructional time, exclusive of breaks, lunches, or homework time.

It is the responsibility of the applicant to provide verifiable information of the training received to be considered for continuing education credit. For example, an applicant must provide the date, topic, content, sponsoring or training organization, trainer, and number of hours for each continuing education claimed. Information about the location, sponsor, topic of training, content overview, date, may be submitted as verification of training offered. Attendance at NADD conferences and webinar is an excellent source of training.

CONDITIONS THAT MAY RESULT IN CERTIFICATION REVOCATION

The NADD Competency Based Dual Diagnosis Specialist Certification may be revoked for

Failure to maintain NADD membership
Failure to renew certification
Unprofessional conduct (see below section on Complaints regarding NADD-Certified Specialists)

In the event that a certification is revoked, the Specialist will no longer be entitled to use the NADD-DDS credential.

If a certification has been revoked, a Specialist who desires NADD certification would need to re-apply as though this were a new application, including submitting portfolio, curriculum vitae, letters of support, work sample, and interview. A professional whose certification has been revoked for unprofessional conduct may be prohibited from re-applying for a specified period of time or may be prohibited from ever re-applying depending upon the findings of the Ethics Review Committee.

Complaints Against NADD-Certified Dual Diagnosis Specialists

Complaints about the professional conduct of specialists who have received the NADD Competency-Based Specialist Certification should be addressed to:

Ethics Review – Specialist Certification
NADD
12 Hurley Avenue
Kingston, NY 12401

When a complaint is received, the NADD Dual Diagnosis Specialist will be immediately notified and asked to respond to the complaint in writing. The Specialist will have 30 days to file a response. A copy of the response will be provided to the complainant. An Ethics Review Committee will be convened to review the complaint. The Ethics Review Committee will have 45 days to review the complaint and may request additional information from either party. The Ethics Review Committee will meet to review their findings. A complaint that is judged to be valid may result in the accused Specialist's certification being suspended for a specified period of time (1 to 3 years) or in the certification being permanently revoked. Both parties will be informed of the Ethics Review Committee determination in writing.

Disclaimer

Certification is voluntary. It is not intended to replace licensure. Any value or credence given to certification by an employer, a person receiving services, an agency, or a third party payer is entirely at their discretion and should be based upon knowledge of the certification standards and upon NADD's position in the field of dual diagnosis.

Appendices

Appendix A
Competency Areas

COMPETENCY STANDARD 1:
Multi-modal/bio-psycho-social approach

OVERVIEW

The Multimodal Contextual approach requires an understanding of the concept of the biomedical, psychological, and environmental approach. The development of treatment/approach options for persons with intellectual/developmental disabilities and mental illness requires an understanding of who the person is and of the context in which he or she is interacting with others and with his or her environment. This includes the person's biology (e.g. genetic syndrome, medical condition, psychiatric illness), psychology (e.g. past traumas, stressors, past and present, loss issues, strengths, resiliency, functional analysis of behavior) and the past and present environments the person has navigated. This includes, but is not limited to, the places where the person lives or has lived, social and familial connections, and relationships. The developmental history in regard to all of these components has a great impact on who the person is currently and is needed in helping the individual determine his or her needs. The biopsychosocial concepts must be understood to enable those in the person's environments to incorporate supports that will help the person meet his or her needs holistically. These are associated with the interplay between biological needs, psychological needs, behavioral needs and the environment. The multimodal approach considers all of these aspects of a person to help the person effectively meet his or her needs.

As a candidate for certification, it is necessary to be able to recognize and identify the bio-psycho-social needs of a person and know how to create an environment that helps the individual meet those needs efficiently and effectively. Identification of the person's strengths is paramount in developing a comprehensive plan that will lead to a preferred quality of life. Combined with the innate needs of all human beings also being considered, we can formulate positive supports to help the person meet those needs.

Additionally, it is important to understand medical, psychological, and psychiatric vulnerabilities, so that they can be addressed to help avoid challenging behavior. Untreated/undiagnosed pain, sensory dysregulation, trauma, or mental illness can compromise a person's ability to regulate his or her behaviors and may disrupt cognitive processes, emotional processes, and behavioral processes.

All behavior has a purpose, and understanding the whole person helps us understand what the behavior is intended to accomplish. With this understanding of the function of behavior, we can assist with supports so that the person can achieve his or her needs in a less disruptive way. The multimodal approach integrates behavioral, cognitive, psychiatric, and environmental interventions as they are warranted. It is recovery oriented and person-centered by teaching the person skill sets (e.g. problem solving, personal proactive techniques to avoid crisis) that will help maintain mental and social wellness.

The multimodal approach was developed by Dr. William Gardner as a refinement of the bio-psycho-social approach to assist in working with people with intellectual disabilities and mental illness. In this context, the role of the candidate will be to identify services/supports/resources needed and lead in coordination of services to rule in or out diagnoses, and assist teams in

following through with treatment that has been recommended by professionals such as physicians, therapists, behavior specialists, occupational therapists, etc.

It is essential that the candidate understand what might be needed from professionals and how to help them formulate a single plan with the person.

Specific Skill Set Requirements
The essential role of the Dual Diagnosis Specialist is to understand the input of experts diagnosticians, clinicians, and significant people in the person's life and assist the team in developing a comprehensive support approach, incorporating the learning, emotional, cognitive/perceptual, environmental and coping mechanisms of the person being served with the bio-psycho-social approach to challenging behaviors.

The Dual Diagnosis Specialist understands that there are biological cause of behavior, such as,

- Chronic/acute pain or illness
- Genetic influences
- Psychiatric vulnerabilities and strengths
- Unique learning styles
- Behavioral phenotypes

The Dual Diagnosis Specialist has the ability to review data tracking systems that help convert symptoms and behaviors into observable, quantifiable data.

The Dual Diagnosis Specialist identifies psychological causes of behavior such as

- Understanding the vulnerabilities and strengths of the person being served
- Recognizing essential skill deficits that contribute to or maintain behaviors which are non-productive
- Being aware of the person's history and how that may interplay with the proposed supports
- Looking at the living and day programming sites along with interpersonal social relationships that may affect the success of the program.

AREAS OF KNOWLEDGE AND SKILL
The following areas of knowledge and skill have been identified as benchmarks for satisfying Competency Standard 1: Multi-modal/biopsychosocial approach.

BENCHMARK 1A: The Dual Diagnosis Specialist is familiar with the bio-psycho-social/multi-modal approach.

Benchmark1A Performance Indicators

1. *Incorporates knowledge that the person had undergone trauma in developing a service plan.*
2. *Incorporates knowledge that the person has sensory-neurological needs in developing a service plan.*
3. *Incorporates knowledge that co-morbid medical and psychiatric conditions must be addressed in developing a service plan.*

4. *Incorporates knowledge that the complexity of the person's social emotional and environmental needs are addressed in developing a service plan.*

BENCHMARK 1B: The Dual Diagnosis Specialist incorporates recovery and resiliency to develop a service plan.

Benchmark 1B Performance Indicators

1. *Utilizes recovery concepts in* the development of *a service plan.*
2. *Uses resiliency in developing a service plan.*

BENCHMARK 1C: The Dual Diagnosis Specialist identifies the inter-relationships among a person's biological, social, and psychological domains.

Benchmark 1C Performance Indicators

1. *Incorporates a person's biological, social, and psychological domains in developing a service plan.*

BENCHMARK 1D: The Dual Diagnosis Specialist has an understanding of the holistic approach.

Benchmark 1D Performance Indicators

1. *Demonstrates the value of assessing the whole person, past and present, and knowledge tools such as: a biographical timeline, essential lifestyle plan or other assessments that tells the entire story of the person's past and current life; their positive attributes, motivations and preferences, goals, needs, dreams, and plans.*

BENCHMARK 1E: The Dual Diagnosis Specialist can formulate information to enable delivery of accurate/relevant medical, psychological, psychiatric, behavioral information to other clinicians or caregivers/supporters.

Benchmark 1E Performance Indicator

1. P*resents the following areas of information:*
   a. *Medical influences: present concerns, past issues, any medical etiology including neurological issues such as autism, seizure disorders or a traumatic brain injury.*

   b. *IDD Etiology, pre, peri and post natal difficulties, developmental history, presence of neglect and/or trauma history, identification of any genetic syndromes present*

   c. *Social, emotional and environmental stressors that are present currently and have been experienced in the past: history of trauma, neglect, abandonment, loss, academic, relationship problems, and work issues.*

   d. *Psychiatric disorders: present and past diagnoses with a description of the symptom presentation that is occurring currently.*

e. Behavioral presentation: a very specific overview of the behaviors that are presently being seen, i.e. crying, destruction of property, self harm etc.

BENCHMARK 1F: The Dual Diagnosis Specialist appreciates the environmental, contextual, and individual learning styles.

Benchmark 1F Performance Indicators

1. *Identifies learning style. Discusses person's use of visual cues, auditory cues, reading, modeling, show and do methodology. Explains what has been tried in regard to helping the person to learn and includes techniques that work best for the person*.

BENCHMARK 1G: The Dual Diagnosis Specialist utilizes the above model to guide service/treatment planning.

Benchmark 1G Performance Indicators

1. Demonstrates inclusion of this best practice model to guide the person's services and treatment planning

References:

Gardner, W. I., Griffiths, D. M., & Hamlin, J.P. (2012). Biopsychosocial features influencing aggression: A multimodal assessment and therapy approach. In J. K. Luiselli (Ed.),*The handbook of high-risk challenging behaviors in people with intellectual and developmental disabilities* (pp. 83-102). Baltimore: Brookes Publishing.

Gardner, W. I., Dosen, A., Griffiths, D. M., & King, R., (2006). *Practice guidelines for diagnostic, treatment, and related support services for persons with developmental disabilities and serious behavior problems.* Kingston, NY: NADD Press.

Reiss, S. (2010). *Human needs and intellectual disabilities: applications for person centered planning, dual diagnosis, and crisis intervention*. Kingston, NY: NADD Press.

COMPETENCY STANDARD 2:

Application of emerging best practices

OVERVIEW

Best practice standards demonstrate the integration of the best available research in the context of the characteristics, culture, and preferences of the individuals served. These are practices that have been shown to be of benefit to persons with MI/IDD. Evidence based practices consist of interventions that have been scientifically researched and studied. They can be replicated successfully and have been shown to produce measurable and sustained beneficial outcomes. Practices that are evidence based have sound theoretical underpinnings that explain why they work, procedures to evaluate outcomes, standards for conducting and evaluating staff training, procedures for maintaining quality and fidelity to the model of treatment delivery, and a written manual containing protocols for service delivery. These practices should incorporate the expertise of the practitioner, the best available evidence from scientifically sound research, and the concerns, expectations, values, and goals of the consumer.

AREA OF KNOWLEDGE AND SKILL

The following areas of knowledge and skill has been identified as a benchmark for satisfying Competency Standard 2: Application of emerging best practices.

BENCHMARK 2A: The Dual Diagnosis Specialist demonstrates understanding of assessments, their purpose, when they may be needed and how to obtain them.

Benchmark 2A Performance Indicators

1. *Identifies appropriate assessments and person-centered tools.*
2. *Articulates rationale or purpose for use of assessments.*

BENCHMARK 2B: The Dual Diagnosis Specialist understands the connection between assessment and service delivery.

Benchmark 2B Performance Indicators

1. Explains how suggestions and recommendations are incorporated in planning and implementation.

References

Buntix, W., & Schalock, R. (2010). Models of disability, quality of life, and individualized supports: implications for professional practice in intellectual disability. *Journal of Policy & Practice in Intellectual Disabilities*, *7*(4), 283-294.

Fletcher R.; Loschen, E.; Stavrakaki, C.; & First, M. (Eds.). (2007). *DM-ID Diagnostic manual – Intellectual disability:* A *Clinical Guide of Diagnosis of Mental Disorders in Persons with Intellectual Disability*. Kingston, NY: NADD Press.

Reiss, S. (2010). *Human needs and intellectual disabilities: Applications for person centered planning, dual diagnosis, and crisis intervention.* Kingston, NY: NADD Press.

COMPETENCY STANDARD 3:
Knowledge of therapeutic constructs
OVERVIEW
Persons with dual diagnoses benefit from all forms of therapy. Individuals may have intellectual limitations and neurosensory issues, as a result of which they are vulnerable to trauma and the vast array of mental illnesses. Additionally, research has heightened our understanding of genetic causes of many developmental disabilities and associated mental illnesses, and has assisted in our understanding of best practice approaches. Knowledge of psychotherapeutic techniques matched to the person's unique needs will lead to an outcome of improved wellness and heightened quality of life.

AREAS OF KNOWLEDGE AND SKILL
The following areas of knowledge and skill have been identified as benchmarks for satisfying Competency Standard 3: Knowledge of therapeutic constructs

BENCHMARK 3A: The Dual Diagnosis Specialist demonstrates an understanding of trauma and how it affects the brain and body.

Benchmark 3A Performance Indicators

1. *Demonstrates knowledge of high incidence of trauma*
2. *Understands how trauma may be expressed*
3. *Describes service from a trauma informed perspective*

BENCHMARK 3B: The Dual Diagnosis Specialist demonstrates an appreciation of neurosensory issues.

Benchmark 3B Performance Indicators

1. *Explains neurosensory disorders such as autistic spectrum disorders, attention deficit hyperactivity disorder or attention deficit disorder and how they effect the psychological well being or hamper the growth and well being as the person develops*
2. *Includes forms of treatment, from occupational, physical and speech therapies, to vision rehabilitation therapy, biomedical treatments, dietary interventions, applied behavior analysis, psychological therapy, and a host of other approaches, depending on the unique needs of the individual.*
3. *Describes how the results of finding a successful combination of treatments can include improved behavioral self-control, normalized perceptual processes, better academic performance, improved reading, and more stable emotional experience.*

BENCHMARK 3C: The Dual Diagnosis Specialist has understanding of genetic underpinning to guide treatment.

Benchmark 3C Performance Indicators

1. Knows the potential for psychiatric and behavioral effects associated with particular genetic disorders (i.e., behavioral phenotypes) including Prader-Willi syndrome, Fragile X, and Down syndrome.

2. Understands approaches to treatment are based on individualized strengths and vulnerabilities associated with the disorder and may include behavioral management, family interventions, and pharmacological interventions.
3. Discusses how interventions may make a difference in developmental course and behavior, including psychological, speech/language, and occupational therapy.

BENCHMARK 3D: The Dual Diagnosis Specialist demonstrates knowledge of psychotherapeutic skills.

Benchmark 3D Performance Indicators

1. *Models appropriate behaviors and techniques for dealing with problems*
2. *Affirms positive results and encouraging the client*
3. *Offers alternative choices*
4. *Understands use of artwork, role-play, social stories, music, and relationship building.*

References:

Fletcher, R.J. (Ed.) (2011). *Psychotherapy for individuals with intellectual disability*. Kingston, NY: NADD Press.

Fletcher, R., Loschen, E., Stavrakaki, C., & First, M. (Eds.). (2007). *Diagnostic manual – Intellectual disability (DM-ID): A textbook of diagnosis of mental disorders in persons with intellectual disability*. Kingston, NY: NADD Press.

McGilvery, S., & Sweetland, D. (2011).*Intellectual disability and mental health: A training manual in dual diagnosis*. Kingston, NY: NADD Press.

COMPETENCY STANDARD 4:

Respectful and effective communication

OVERVIEW

Respectful and effective communication is that which conveys one's thoughts, needs, and desires to others in ways that they can readily understand, and in ways that assure others that their thoughts, needs, and desires are considered as important as those of the one speaking or writing.

AREAS OF KNOWLEDGE AND SKILL

The following areas of knowledge and skill have been identified as benchmarks for satisfying Competency Standard 4: Respectful and effective communication.

BENCHMARK 4A: The Dual Diagnosis Specialist ensures that the person is "in the driver's seat."

Benchmark 4A Performance Indicators

1. *Understands what the individual wishes to have as goals and can communicate those to others*
2. *Understands the processes/methods preferred by the individual in reaching goals and can communicate those to others*
3. *Demonstrates empathic communication with the individual*
4. *Ensures that the individual is consulted before anything is committed to paper*

BENCHMARK 4B: The Dual Diagnosis Specialist understands the importance of communication between stakeholders and supporters that is relevant to the person's care and well being.

Benchmark 4B Performance Indicators

1. *Identifies who is important both to and for the individual*
2. *Is able to communicate what is important to and for the individual with key stakeholders identified*
3. *Assures that others can reiterate, in their own words, what is important to and for the individual*
4. *Assures that regular key communication is shared with the individual and those important to and for him or her.*

References:

Balandin, S. (2007). The role of the case manager in supporting communication. In C.M. Bigby, C. Fyffe, & E. Ozanne *Planning and support for people with intellectual disabilities : Issues for case managers and other professionals*. London: Jessica Kingsley Publishers.

Gentile, J., & Gillig, P. (2012). Interviewing Techniques. In J. Gentile & M. Gilig (Eds.), *Psychiatry of intellectual disability: A practical manual*. Hoboken, NJ: Wiley.

O' Dell, R. (2013). The under investigated influence of direct support professionals on healthcare decision making among adults with intellectual disabilities. *NADD Bulletin*, *16*(1), 14-19.

COMPETENCY STANDARD 5:
Knowledge of dual role service delivery & fiduciary responsibilities
OVERVIEW
Professionals who serve persons with intellectual and developmental disability and mental health disorders need to understand the link between service delivery and being fiscally responsible. Abilities should include the skill necessary to assess the level of care needed, knowledge of resources available internally and externally, and how to find and access funding for those resources. There should be understanding of how to develop outcomes that are objective and measureable, along with the required documentation to the support provision of the service.

AREAS OF KNOWLEDGE AND SKILL
The following areas of knowledge and skill have been identified as benchmarks for satisfying Competency Standard 5: Knowledge of dual role service delivery & fiduciary responsibilities

BENCHMARK 5A: The Dual Diagnosis Specialist is able to report on progress of the person in relationship to therapeutic goals and outcomes.

Benchmark 5A Performance Indicators
1. *Is able to assess whether the treatment goals and outcomes will be measurable and relevant*
2. *Reports on progress by utilizing documentation that meets the specific fiduciary requirements*

BENCHMARK 5B: The Dual Diagnosis Specialist identifies the connection between funding and good care
Benchmark 5B Performance Indicators
1. *Understands the services available under the funding stream and has ability to recognize which treatment will have the most significant impact.*
2. *Is able to maximize service within the parameters of funding by defining clear-cut attainable goals.*

BENCHMARK 5C: The Dual Diagnosis Specialist has an ability to work with clinicians and other stakeholders if outcomes are not being achieved
Benchmark 5C Performance Indicators
1. *Is aware of resources and has knowledge of other specialties and supports that will enhance the client's treatment.*
2. *Recognizes the complex systems and team approach that is needed in treating someone with a dual diagnosis*.

References:

Bigby, C, Fyffe, C. & Ozanne, E. (2007). *Planning and support for people with intellectual disabilities : Issues for case managers and other professionals*., London: Jessica Kingsley Publishers.

McFalls, D. (2012). The cost of supporting a person with intellectual disability and serious and persisent mental illness: Results of a PA survey (Executive Summary). *NADD Bulletin*, *15*(2), 26-27.

O'Brien, J. (2006). *Perspectives on "most integrated" services for people with developmental disabilities*. Syracuse, NY: Responsive System Associates, Center on Human Policy, Syracuse University.

Schalock, R. L., Gardner, J. F., & Bradley, V. J. (2007). *Quality of life for people with intellectual and other developmental disabilities. Applications across individuals, organizations, communities, and systems.* Washington, DC: American Association on Intellectual and Developmental Disabilities.

COMPETENCY STANDARD 6:

Ability to apply administrative critical thinking

OVERVIEW

It is important that administrators have an understanding of the multimodal approach to meeting the bio-psycho-social needs of people served, and have ability to use observation and data to determine if the needs of individuals served are being met efficiently and effectively and with cultural competence. This requires that they be able to think critically about programmatic approaches, needed resources, and, most importantly, outcomes for individuals served. The administrator should be knowledgeable about how to bring about systemic changes in approaches used, how to measure and discriminate among the effects of interventions, and how to use the data about outcomes to assess effectiveness and drive change.

Benchmark 6A: The Dual Diagnosis Specialist recognizes the importance and need for staff and families to understand the multimodal approach.

Benchmark 6A Performance Indicators

1. *Understands and appreciates the importance of the multi-modal approach in assessing and helping to meet an individual's needs.*
2. *Is able to marshal resources to train both staff and family members in the interrelationship of the elements of the assessment and plan*
3. *Is able to organize and assess data to determine if goals are met efficiently and effectively.*

Benchmark 6B: The Dual Diagnosis Specialist demonstrates understanding of training needs for DSPs/teams/families to implement treatment/support plans.

Benchmark 6B Performance Indicators

1. *Understands principles of adult learning and has ability to adapt material to meet individual needs*
2. *Is able to relate basic elements of treatment/support plans to diverse groups*
3. *Is able to organize and synthesize information from assessment/support plan so that it becomes useful*

Benchmark 6C: The Dual Diagnosis Specialist has the ability to assess and resource effective strategies in meeting individuals' wants and needs.

Benchmark 6C Performance Indicators

1. *Identifies unmet needs based on communication and environmental assessments*
2. *Recognizes balance in what is important "to and for" the individuals, as well as their strengths, talents, and interests*
3. *Recognizes quality of life issues including relationships, social supports, safety and security, mental and physical health, religion/spirituality, and happiness*
4. *Facilitates effective and efficient internal and external communication and collects and analyzes complete and accurate data in order to identify needs.*

Benchmark 6D: The Dual Diagnosis Specialist is able to let providers know that behavior plans may be too complicated to be implemented.

Benchmark 6D Performance Indicators

1. *Assesses plans via direct observation of implementation, interviewing DSPs/family/team and individuals and monitoring data*
2. *Understands the connection between data and the plan and how to utilized changes in data to make decisions*
3. *Uses baseline data a reference for tracking change*
4. *Identifies changes in behavior/symptoms as early signs of difficulty or success and communicates with DSPs/family/team*

Benchmark 6E: DD Specialist is able to identify when a plan may not meet the needs of the person

Benchmark 6E Performance Indicators

1. *Understands the connection between multimodal assessment and the plan*
2. *Understands the person's behavior in terms of communicative intent*
3. *Recognizes that changes or lack of changes in behavior/symptoms may indicate that needs are not being addressed and communicates need for reassessment*

References:

Agosta, J., Fortune, J., Kimmich, M., Melda, K., Smith, D., Auerbach, K., *& Taub, S. (*2009*). Ten issues for states to consider in implementing individual or level-based budget allocations.* Portland, OR: Human Services Research Institute.

Cox, J. (2012). Legal issues for treatment providers and evaluators. In J. Gentile & M. Gilig (Eds.), Psychiatry of intellectual disability: A practical manual. Hoboken, NJ: Wiley.

Dart, L., Gapen, W., & Morris, S. (2002). Building responsive service systems. In D.M. Griffiths, C. Stavrakaki, & J. Summers (Eds.), *Dual diagnosis: An introduction to the mental health needs of persons with developmental disabilities* (pp. 283-323). Sudburg, ON: Habilitative Mental Health Resource Network.

Pokrzywinski, J., & Powell, R. (2003). A brief review of systems-level issues in behavior support plan adherence. *NADD Bulletin*, 6(6), 101-111.

Appendix B

The NADD Competency-Based Specialist Certification Program
Application Form

I. Personal Information

Name: _____
Address: _____
City/State(Province)/Zipcode_____
e-mail: _____
Daytime phone: _____
Cell phone: _____
Home phone: _____
NADD Membership
Are you an individual member of NADD? [ ] Yes [ ] No
NADD Membership Number: _____
Does your organization have a NADD organizational membership? Yes [ ] No [ ]
NADD Organizational Membership Number: _____
(If you do not know, contact NADD office.)

II. Education and/or Credential

You may hold (1) a Masters degree in a related field (and one year of experience), (2) a Bachelor's degree in a related field(and 2 years of related experience), (3) 60 credit hours in a related field (and 3 years of related experience) or (4) credential from a professional governing body.

Post secondary education is not required; however, a thorough explanation of the experience base must accompany the application as equivalence determination resides with the NADD Competency-Based Certification Program. The review committee may recognize other types of accreditation and certifications

1. **Education.** I have the following education:
[ ] Master's level, Please specify: _____
[ ] Bachelor's level, Please specify: _____
[ ] 60 credit hours, Please specify: _____
[ ] no Post secondary education

2. **Certification.** I hold the following certification (*Please attach a copy of your certification)*:
[ ] _____
[ ] _____
[ ] Other, please specify _____

Credential Information:

State or Province: _____
License Number: _____
Professional Governing Body: _____
Credential/Number: _____
Expiration Date: _____

III. Experience

You must have experience in support of persons with intellectual/developmental disabilities and mental health issues. This can include internships and externships.

How many years of experience do you have working with persons with intellectual/developmental disabilities and mental health issues? _____

Experience confirmation:

For those experiences which you are counting toward your experience requirement, please provide the following information. Use additional pages if necessary.

Organization/Place Worked:_____
Address:_____
Dates worked: _____
Contact person (supervisor): _____
Phone: _____ email: _____

Organization/Place Worked:_____
Address:_____
Dates worked: _____
Contact person (supervisor): _____
Phone: _____ email: _____

Organization/Place Worked:_____
Address:_____
Dates worked: _____
Contact person (supervisor): _____
Phone: _____ email: _____

Organization/Place Worked:_____
Address:_____
Dates worked: _____
Contact person (supervisor): _____
Phone: _____ email: _____

Organization/Place Worked:_____
Address:_____
Dates worked: _____
Contact person (supervisor): _____
Phone: _____ email: _____

Please attach your curriculum vitae.

IV Ethical Behavior
Have you ever been convicted of a crime? [ ] Yes [ ] No
Have you ever been the subject of a lawsuit? [ ] Yes [ ] No
Have you ever been the subject of a disciplinary hearing? [ ] Yes [ ] No
If yes to any of the above questions please provide the details, on a separate page, of any crimes, past or pending lawsuits or disciplinary events.

Principles
All candidates for the NADD Competency-Based Dual Diagnosis Specialist Certification commit themselves to the following principles:

- Specialists discharge their responsibilities in accordance with standards of practice in their field.
- Specialists recognize the collaborative nature and unique role of the interdisciplinary team in providing quality services for individuals with intellectual/developmental disabilities and mental illness
- Specialists respect the inherent dignity and worth of the individual.
- Specialists strive to ensure that services are culturally relevant to the individuals receiving services.
- Specialists build on the strengths and capabilities of individuals.
- Services are person-centered. They are informed by the individual's values, hopes, and aspirations and are designed to address the unique needs of individuals.
- Specialist's services promote self-determination and empowerment.
- Specialists uphold professional standards of conduct and accept appropriate responsibility for their behavior.
- Specialists maintain their professional independence and avoid situations of conflict of interest that may affect the discharge of their responsibilities towards the individuals who receive their services.
- Specialists take measures to resolve real and apparent conflicts of interest.
- Specialists act with integrity in their relationships with colleagues, families, significant others, other organizations, agencies, institutions, referral sources, and other professions in order to maximize benefits for the person receiving services.
- Specialists respect the privacy of persons being served and maintain confidentiality at all levels in accordance with professional standards of practice as well as state/province and federal (American or Canadian) law.
- Specialists engage in professional development.

By my signature, I affirm that:
I have read and am committed to the principles listed above.

Signed: _____ Date: _____

Application should be mailed to:
NADD Accreditation & Certification Programs
12 Hurley Avenue
Kingston, NY 12401
Payment method:

☐ Check enclosed (Please make checks payable to : NADD.)

☐ Please charge my credit card ☐ MasterCard ☐ VISA ☐ Discover
Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
Exp. Date: __ __ / __ __ Signature: _____

Appendix C

Work Sample Guidelines

Work Sample Outline
The work sample should be 3 - 5 pages double-spaced. The citations do not count toward the page limitation. The work sample should include the following elements:

A. Relevant Background information - include problem addressed
B. Structure/format for addressing the issue(s)
C. Characterize the course of the service delivery
D. Issues that arose and how these were addressed
E. Description of the outcome.
F. Citation of at least two journal articles within the past 5 years regarding service delivery/training/ etc. of people with a dual diagnosis.

The work sample should demonstrate the following:

1) Ability communicate effectively
    a. If you are an administrator, provide an example of how you have effectively communicated the need for change in the system for which you have responsibility.
    b. If you are a trainer, provide an example of how you have changed training content to meet the receptive communication needs of trainees.
    c. If you are a case manager or a service or support coordinator, provide an example of how you have been able to communicate clearly and effectively with people you serve.
    d. If you are a peer support specialist, provide an example of how you have helped to bridge communication between individuals being served and others providing services and supports.
    e. If you have another role, not mentioned here, provide an example of how your ability to communicate has enhanced life for individuals with IDD/MI.

2) Understanding of programmatic issues having an impact on individuals with dual diagnosis
    a. If you are an administrator, provide an example of how your understanding of programmatic issues (e.g., limited payment mechanisms, dysfunctional administrative rules) brought about change to enhance life for individuals with dual diagnosis.
    b. If you are a trainer, provide an example of a programmatic issue about which you have trained people so that the lives of service recipients are enhanced.
    c. If you are a case manager or a service or support coordinator, provide an example of how you overcame programmatic issues to acquire something needed for the people you serve.
    d. If you are a peer support specialist, provide an example of how you helped somebody you serve get what they needed.
    e. If you have another role, not mentioned here, provide an example of how your understanding of programmatic issues has helped improve lives.
3) Understanding of inter-systems issues and how differences can be resolved
    a. If you are an administrator, provide an example of a policy or process change for which you were responsible, and explain how it improved services and supports for individuals with IDD/MI.

b. If you are a trainer, please provide an example of at least three training sessions you have conducted, and how those improved services and supports for people with IDD/MI.
c. If you are a case manager or a service or support coordinator, please provide example of facilitating services to meet the bio-psycho-social needs of at least three individuals with differing needs from both the mental health and developmental disabilities systems.
d. If you are a peer support specialist, provide an example of how you have helped bridge the gap between systems to assist the people you serve.
e. If you have another role, not mentioned above, describe that role, and provide at least three examples of how your work has improved services and supports for individuals with IDD/MI.

Prior to submission of the work sample, the applicant should ensure the work sample includes consideration of each of the targeted areas and demonstrates incorporation of the competency areas. The applicant may use one case for the entire work sample or a different case for each of the 3 questions.

NADD will assign two examiners to review to work sample. The work sample will be reviewed to determine whether the candidate demonstrates competency. If the work sample is found to be acceptable, the interview will be scheduled. The examiners may require submission of additional information – including, in some cases, resubmission of the work sample – before they approve scheduling of the interview.

Appendix D

Interview Guidelines

1. Discussion of applicant's training and experience in dual diagnosis, jobs, position, program
2. Review of capacity and work with (or support of) individuals with dual diagnosis
3. Discussion of one project/program/service plan/training that involves dual diagnosis.
4. Discussion of instance where applicant effected change in the life (or lives) of a person with dual diagnosis.
5. Discussion of systemic change applicant initiated in the work environment.
6. Discussion of work sample submitted with application. This discussion will include all the elements of the outline in Appendix C and should demonstrate the following:
   a. Multi-modal/bio-psycho-social approach;
   b. Application of emerging best practices;
   c. Knowledge of therapeutic constructs;
   d. Respectful and effective communication;
   e. Knowledge of dual role service delivery & fiduciary responsibilities; and
   f. Ability to apply administrative critical thinking.

7. Behavioral type questions

   Targeted answers
   1. Details that would include language around noted competency areas on the guide:
      a. Multi-modal/bio-psycho-social approach;
      b. Application of emerging best practices;
      c. Knowledge of therapeutic constructs;
      d. Respectful and effective communication;
      e. Knowledge of dual role service delivery & fiduciary responsibilities;
      f. Ability to apply administrative critical thinking.
   2. Demonstration of critical thinking and a person-centered value system
   3. Demonstration of knowledge of systems or services issues that could be improved to increase the quality of services for persons with dual diagnosis.

Appendix E

NADD Competency Based Specialist Certification Program
Letter of Recommendation Directions

Instructions to the Applicant: Please provide this form to three (3) colleagues and/or present or past supervisor(s) who are able to comment upon your skills, knowledge, values, and level of competency concerning the provision of services to individuals who has intellectual and developmental disabilities co-occurring with mental illness. Upon receipt of your reference letters, please forward them, in sealed envelope that you received together with the rest of your application material.

Instructions to Reference Person: Please give the applicant your letter of reference in a sealed envelope. Please sign your name across the envelope seal.

Dear Reference Person:
Thank you for providing a reference letter for an applicant to the NADD Competency-Based Dual Diagnosis Specialist Certification Program. The panel reviewing the application places strong consideration upon the reference letter of colleagues and supervisors in making its determination. We suggest several points of focus in your letter of recommendation:

1. How long have you known the applicant and in what context?
2. Please provide a statement about the applicant's work which includes references to his/her knowledge, skills, values, and level of competency
3. Please provide information regarding the applicant's demonstration of professionalism and transdiscplinary activity
4. Please describe any other personal qualities and/or professional contributions that distinguish this applicant as a Specialist working with individuals who have a dual diagnosis
5. Please indicate any potential concerns regarding professional certification of this individual

Appendix F

Sample Work Samples

Sample Work Sample

Administrative Perspective

Amy Shemoel

Over the course of my professional life, my positions have encompassed several roles within the field. I have been part of administrative teams, been directly involved in staff training and have successfully worked with both internal and external teams supporting individuals facing developmental disabilities and behavioral health challenges. For the purpose of this sample, I will be primarily discussing my role as Program Director navigating a sudden decision to close a facility serving more than 160 people, nearly all with co-occurring intellectual disabilities and mental health diagnoses.

Though in fact there had been administrative indications that a decision to relicense the building from an LP/ICF-IDD (Large Intermediate Care Facility-Intellectual and Developmental Disabilities) to a skilled nursing facility was imminent, the announcement to staff was sudden and disruptive. I quickly realized the need to maintain our focus on meeting the clients' needs without minimizing the impact of job insecurity on the workforce. Most of the CNA and nursing staff had no experience with community based residential programs, and many questions arose over the weeks immediately following the announcement. My role involved talking to staff individually, as well as pulling teams together, to present the types of services and supports that would be in place for the people being moved. I answered honestly about the benefits and potential limitations of each type of service and because of my understanding of smaller, community based programs, I was also able to clearly communicate information regarding professional opportunities in those settings. Having experienced downsizing and privatization with previous employers, I was in a unique position to support the staff worried about their livelihoods with information about various resources and provider agencies.

Even more than the impact on the staff, the relicensing decision forced many of the people who had lived in the facility for decades to be moved with little warning. Most of the residents were given virtually no time to adjust to the changes. The process forced choices that were often barely understood by the people impacted. The loss of everything familiar including the relationships with caregivers was predictably difficult (Gardiner, Iarocci & Moretti, 2017).

I was a primary contact person for families/guardians as well as the multiple state and private partners who were involved in the closure. I was intentional when meeting with teams and assured new options were presented positively and fairly. Being familiar with the services, I was able to give families/clients concrete information about how social, medical and behavioral health needs would be met.

While some people were already involved in transitions and were excited by the opportunities provided, other families expressed frustration at the sudden disruptions occurring as the facility downsized – from multiple changes in roommates, changes in staffing patterns, to having strangers in the facility. It was no surprise the residents felt they had little control over the situation. Nevertheless, by listening, addressing specific concerns and frequent misunderstandings, correcting misinformation, taking time to explain the agencies and processes, and advocating for the residents, transition processes moved forward relatively calmly.

Many of the people with whom I worked had severe communication difficulties, and it fell to our staff to find ways to explain what was happening. Using a variety of communication tools from simplifying language, to pictures, gestures, facial expressions, and some simple or adaptive sign language (Carrick & Randle-Phillips, 2017), I made it a priority to assure each person was informed and had been given the opportunity to ask questions and raise concerns. Over the years, I have learned to not underestimate the extent to which people, regardless of

disability, understand. One woman with whom I worked had a goal to learn her rights. I read the rights to her, reworded the rights, used visual supports and modeled the information and, likewise, accepted responses in any format. Yet there was limited improvement in her data. However, when she went to visit a sister at another facility and found the conditions not to her expectations, she was able to recite the rights violations fluently and assertively. Another resident with whom I worked did not have a reliable communication system, though she could gesture, use expression and vocalize. Her family regularly said, in front of her, that she "had been born dead and should have been left dead". During her 1st annual meeting, sitting at a large table, as I talked about her successes and the things she had learned, she scooted her chair closer and closer to me so that by the end of the meeting our chairs were touching. In another situation working with a man who was at risk for more restrictive placement, in consultation with the Indiana Resource Center on Autism, I led a team in the development of a communication system that included not only visual cues, but strategies for how to use verbal speech. With these tools in place, and extensive staff training, we were able to help him better understand his environment and dramatically decrease the intensity and frequency of aggressive behavior. These types of experiences have driven home the profound impact of what is said to and about a person and how critical it is to pay attention to both to how a person takes in information as well as how that person expresses him/herself.

Beyond working to address communication needs, the vast majority of the people who lived at the facility mentioned above also needed support managing their behavioral health. Both as a Client Advocate for the agency and Program Director for one of the units, I had the responsibility to review the behavior support plans for content and to assure compliance with state and federal standards. Even before the impact of the closure was felt, I became increasingly

aware of the need shift our focus from the reactive interventions and move towards a greater understanding of the antecedents and underlying functions of the behaviors, seeking ways to intervene early and effectively to ameliorate the impact of triggers. One of the men with whom I worked was diagnosed with profound developmental disabilities, psychiatric diagnoses of intermittent explosive disorder and obsessive-compulsive disorder, and was on the autism spectrum. Behavioral concerns included randomly entering others' rooms, destroying their property, taking other items, screaming, throwing himself to the floor, and physical aggression. He had to be moved from the unit he had lived on for years when he began to be hurt by peers trying to protect their own property. He was transferred to the floor I oversaw with no opportunities to acclimate nor be introduced to his new roommate, peers, or staff. My review of his behavior support plan found it to be lacking both an assessment of the function of the behavior and proactive strategies designed to help communicate to him which was his room and place, what were his things, or how to ask for help getting the things he wanted (Wainer, Drahota, Cohn, Krns, Lerner, Marro, 2017). I revised his behavior support plan with a heavy emphasis on those factors. I had to not only train the staff on the plan, but also explain the shift from reacting to "bad" behavior to trying to find ways that would support him. I was able to present this to both his guardian and his Human Rights Committee and had the revisions approved. There was some initial improvement noted, and with additional functional analysis, ways to further improve the support plan were identified. Though moves took place before the revised plan was approved, I was able to meet with the provider agency considering accepting him, train them on the plan and the reasoning behind the plan and the pending revisions. As recommended, the provider agreed to have supports in place prior to the transition (Carrick & Randle-Phillips, 2017).

In many ways, I have had to learn more at Meridian Health Services than I have had to learn in many years. So much of the emphasis in the residential settings where I had worked relied almost exclusively on behavior management and antecedent-behavior-consequence types of programs. We worked with psychiatrists for medications but rarely with counselors or therapists and there was a strong shift away from medical models in addressing behavioral challenges faced by the people in our services. I have come to deeply appreciate how understanding the diagnoses informs strong programming decisions. Coupling this understanding with my knowledge of services within the Bureau of Developmental Disabilities Services systems, has been essential in enabling me to explain to waiver case managers, behavior consultants and residential providers how our services can be utilized to enhance supports already in place for the people we serve. It has truly made me better at developing creative and meaningful program interventions for the people in our services.

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Sample Work Sample

Behavior Specialist

Brad Wyner

Background: Agency X, Phil, and his team

I was working as a QIDP/case manager for Agency X (a non-profit provider of residential services for people with intellectual/developmental disabilities) for one year when I was asked by the executive director to become the agency's Behavior Support Specialist. It was a relatively new role, and we were still figuring out what scope of the job. One of my first duties was to join Phil's team. The consultants we had engaged to help us improve our approach to supporting complex individuals had just recommended that we discharge Phil, and I was to coordinate the team effort to figure out how to meet his needs. Over the next two years, as a member of Phil's team, I facilitated effective communication between members of the team, helped to sort through myriad programmatic issues, and worked with colleagues to navigate through inter-systems issues, along the way discovering that emerging best practices around trauma and relationships could promote exceptional outcomes for unique individuals.

Phil had lived at Agency X's ICF for children since his early teens. Now in his late 20's, he still resided in the children's facility, because no other setting had been willing to admit him. He had nearly moved to a community waiver setting a year previously, but his team was waiting for a decrease in self-injurious behavior that never came. Self-injury was the primary issue in Phil's life; according to the grandmother that raised him, he began hitting himself in the head before the age of two, and it has been his major challenge ever since. Self-injury can have many causes, and Phil's SIB was often understood in the context of its early emergence, as described by MacLean and Dornbush (2012): "Self-injurious behavior (SIB) is a devastating condition associated with intellectual and developmental disabilities (IDD). Efforts to understand its development are focused on early childhood when the behavior first emerges. Limited

prevalence data on SIB during early childhood are currently available." The causes and maintaining factors could be related to any of Phil's complex challenges, as Minshawi et al note in 2014, "there appears to be multiple and often co-occurring processes involved in the emergence, presence, and maintenance of SIB."

On paper, Phil's was diagnosed with autism, mild cerebral palsy, stereotypic movement disorder, disruptive behavior disorder NOS with severe self-injurious behavior, mood disorder NOS, and profound intellectual disability. In person, he is strikingly tall, with a mop of red hair, an unusual way of walking and holding his body, and a unique look in his eye – a colleague once described it as "Phil is always just exploring his world." He is unquestionably charismatic, and people seem to be attracted to him. Phil has no spoken language, and never became proficient with any adapted communication system. Most of his school records focus on preventing self-injury, and our efforts as his residential provider were similar. The previous 6 months had been tremendously challenging for Phil. He was recovering from serious self-inflicted injuries, but healing was slowed down by re-injury and wound infections. It appeared that he would self-injure more when in physical pain, and it had become a cycle with no end in sight. The challenges fed each other, much like the symptoms of depression in youth with autism explored by Fung et al in 2015: "it is the interactions among individual vulnerabilities and stressors that are related to the presentation of mental health problems." Phil was clearly in crisis, as described by McMorris in 2013, citing Roberts (2000):"We view crisis as 'an acute disruption of psychological homeostasis in which one's usual coping mechanisms fail and there exists evidence of distress and functional impairment.'"

Agency X was in the middle of a consultation with a reputable out-of-state agency, helping us to develop new behavior support procedures as part of a corrective action. (Agency X,

overall, was under new management; I had joined an agency that was re-inventing itself because it had no other choice but to close). Our consultants' recommendation was that Phil needed to be discharged to a setting that could do intensive behavior modification work; they recommended an institute out of state, the same setting that had discharged Phil to us when he was a teenager. We began the formal application process with that institute. Informally, a member of the institute's leadership team mentioned off the record that he remembered Phil, because they never quite figured out what was going on with him. One of my colleagues advocated that since no one knew what to do to help Phil, perhaps it would be best if he stayed with us, where at least the staff knew him and loved him. Having participated in much concurrent planning when I worked in foster care & adoption (pursuing plan A and plan B at the same time), I agreed that we should continue to apply to the out-of-state institute, while simultaneously working on practical, local options.

This was where I entered the day-to-day work as a member of Phil's team. Phil's case was known to the director of our state's Department of Developmental Disabilities, and there seemed to be some inter-agency will to see what we could do for him locally. The children's ICF was down-sizing into several smaller homes, and Phil would be moving to a new home in the community, in an HCBS waiver setting. To facilitate this change, Tom, an experienced psychologist employed by our county Board of Developmental Disabilities joined Phil's team as a consultant.

A trans-disciplinary team effort

Phil was physically miserable. His wounds were healing slowly and becoming re-infected. His diet was limited due to food allergies and a history of choking. He was on a long, ever-changing list of psychiatric medications. We, his provider agency, were re-inventing

ourselves, and still second guessing our new policies and procedures as we figured out how to improve our practice. There were so many concerns going on at once that Phil's team was paralyzed into inaction. The newly re-formed team attacked the pile of issues, and we found a new rhythm: Tom helped us focus on each unique issue and pursue all possible solutions down to the detail; I communicated with the team in between meetings to make sure that we were following up on each detail. Tom was shining the light on what needed work, and I was making sure that the essential steps were executed along the way.

During this time period, I was helping individual team members (therapists, residential managers, case managers) to keep track of their essential tasks, and using a variety of friendly reminders to help make progress between meetings. If something wasn't done because the key person didn't have time, we figured out how to shift their other duties to make the time. Some people seemed to want to be left to accomplish their own tasks in their area of expertise; others seemed to enjoy collaborating along the way to stay motivated. As I learned how each individual team member was best motivated to complete their tasks, I was able to individualize my reminders and prompts. Communication was the key — helping people to keep their eye on the goals at hand without being overwhelmed by the enormity of the overall challenge.

As team meetings continued roughly every 3 weeks, I began to push colleagues to respect each other's knowledge, and to try to see the whole context of the work, across each other's specialties. Phil needed us to be a trans-disciplinary team, "a cohesive clinical team benefiting from expertise in different disciplines, working together in a highly integrated manner." (Klin et al., 2005) In a more traditional *inter*-disciplinary team, each specialist presents their own expertise; in a *trans*disciplinary approach, team members look to understand each other's field and work together to come to a consensus that fully integrates all perspectives. The occupational

therapist seeks to understand how the speech-pathologist's recommendations will practically work, and how the residential manager might implement the staffing patterns to make them effective, and how the client might process all of it emotionally. It is not enough for us to say, "well the PT is the expert when it comes to walking, so I will stay out of that conversation;" members of a trans-disciplinary team seek to become as competent as possible in understanding each other's field, and how all of the pieces fit together in the life of the person being served. For years, Phil has made little to no progress in each of his areas of struggle; perhaps if we kept communicating across disciplines — mindful of the whole context of Phil's biological, psychological, and social needs — we would be able to find lasting solutions that have so far eluded Phil's team.

H Pylori, psychiatry, and the neurosequential model

During the first stages of our trans-disciplinary process, we caught what was probably the luckiest break of the entire process. Polly, my predecessor as Agency X's Behavior Support Specialist, had spent a great deal of time reading about different causes of self-injurious behavior in people with autism. She was not able to accept that this was simply going to be Phil's struggle for life; I distinctly remember her saying many times, "people don't just wake up hitting their head hundreds of times in the middle of the night; there's something else going on there." One of the final things that Polly did before I took over was to suggest that we test Phil for h. pylori infection. She had noticed that Phil's self-injury would subside a bit when he was taking antibiotics for a skin infection, and h pylori was a digestive ailment that people with I/DD get more frequently than the rest of the population, and which has occasionally been associated with self-injurious behavior in those with autism (Kitchens et al, 2007). Agency X's director of nursing ordered the test, and it came back positive. Our trans-disciplinary team had its first major

victory, and Phil began an extended treatment of antibiotics and antacids. Though I can claim no particular role in the diagnosis and treatment of h pylori, it was an essential turning point in Phil's story, and I would be remiss to omit it from the telling.

One particular area I took the lead in was psychiatry. Phil had been a resident of our children's ICF since his early teen years. Like other ICF residents, he pays for psychiatric services with his Medicaid card, in the traditional "card for service" model. Though there are psychiatric professionals who specialize in the dually diagnosed population, their patient capacity currently does not meet the patient demand, as noted by Russel et al in 2011: "Despite the need, few community-based intervention models have been developed and disseminated to serve individuals with IDD and mental health needs." Exacerbating the limited number of experienced clinicians is the dollar amount of Medicaid reimbursement; a psychiatrist experienced with IDD knows she/he needs to take a long time to ask a variety of questions in order to come to a solid understand of what a might be happening with a patient who can't directly state what they are feeling, and investing the time to reach the necessary level of detail usually means that the clinician is working at a financial loss. That can be true with any dually diagnosed individual; for Phil, who seems to have multiple physical and psychological issues at once, even the nature diagnoses is hazy. Since coming to Agency X, there have been a variety of psychiatrists who attempted to meet the demand of Agency X's patients by doing batch clinical consults with the nursing team. In 15 years, Phil had never been seen by a psychiatrist who truly specialized in the dually diagnosed population. We weren't confident that his medications were addressing the right issues; his medication list was so long that it was conceivable that polypharmacy was causing more issues than it was treating. Our team was experiencing the gap in mental health supports for people with autism described by Williams and Haranin's in 2016:

"services may not be of sufficient intensity or specificity to meet the needs of this population," alongside "divided funding streams that separate developmental disability from mental health service delivery." While there is a dearth of supports available for children, often the situation is even worse for adults. A parent quoted by McMorris sums up the situation, "after 21, they think life doesn't exist." (2013)

It was generally known that there was one psychiatrist in Cityville who truly specializes in patients with I/DD — Dr. Stephen. At the same time, it was generally known that Dr. Stephen wasn't able to take new patients. I did see him on occasion at appointments for some of my other clients. One day, I stayed after an appointment to tell him about a unique case that I knew (Phil), to see if I could persuade him to become involved. The mystery of a young man who would hit himself in the head while sleeping seemed to pique the doctor's interest. We were able to get the county board to share the cost of a consultation, side-stepping the system gap in highly competent psychiatric services, and scheduled Dr. Stephen to make a house call to see Phil. We left the consultation with a solid action plan to slowly reduce polypharmacy, a plan that Phil is still following today, with a nurse practitioner from Dr. Stephen's office as his ongoing clinician.

Our trans-disciplinary team had been meeting for several months, addressing the myriad of detailed issues that were affecting Phil. Our team leader, psychologist Tom, had arrived at a recommendation to address Phil's over-all quality of life, and to help him successfully transition to a new home: Bruce Perry's neurosequential model of treatment. As described by Perry & Dobson (2013), the neurosequential model is a "multidimensional assessment 'lens' designed to guide clinical problem solving and outcome monitoring." One can see the neurosequential model being useful for someone like Phil, who's challenges seem to lie outside of the "box" of traditional diagnoses: "As has been well documented over the last 20 years, intrauterine

substance use, neglect, chaos, attachment disruptions, and traumatic stress all impact the development of the brain and result in complicated and heterogeneous functional presentations in children, youth, and adults. Furthermore, the timing, severity, pattern, and nature of these developmental insults have variable and heterogeneous impact on the developing brain. The result is a complex clinical picture with increased risk of physical health, sensorimotor, self-regulation, relational, cognitive, and a host of other problems. The current DSM neuropsychiatric labels do not capture this complexity."

Guided by the neurosequential model, Tom helped us to develop a series of activities that would activate Phil's brainstem, diencephalon, limbic system, and eventually, cortex. Guided by Phil's demonstrated preferences and interests, we would train Phil's staff to engage him frequently with back rubs, singing, moving together, seeking eye contact, and Phil's favorite way of interacting with others, clapping together. (He physically prompts people to clap in a specific rhythm, pushing others to speed up and slow down to get the tempo "right.")

As a team, we continued to follow the rhythm that we had established in previous months: Tom was identifying the important work, and I was following up with the rest of the team to assure they were able to follow through with tasks. Therefore, I took on the task of taking the concepts of the neurosequential model and neuroplasticity, and communicating it to Phil's direct support staff in a way that was meaningful and useful. After some trial and error, I landed on this as the key message: "All of the things that you know that Phil likes (singing, clapping, back rubs) aren't just fun for him — they are healing his brain. Keep doing them, and keep him interacting with you for as long and as deep as you can." For staff that had been told in the past that singing and clapping with Phil wasn't age appropriate, this was a revelation.

6 good months, the importance of sleep, and moving forward

After we treated p. pylori, began peeling back medications based on Dr. Stephen's recommendations, and simultaneously began training staff to interact with Phil based on neurosequential model, Phil had an almost total cease of self-injury for 6 months. His wounds had healed, he was gaining weight, and he was often seen walking around the offices of Agency X greeting office staff, and showing them how he would like them to clap.

Perhaps, we said in team meetings, it was the h. pylori all along. However, right around the new year, Phil had another downward slide. He returned to his previous level of self-injury. We re-tested for h pylori, and it was negative. We repeated the test again: still negative. There was something else going on.

We could see that Phil slept differently when he was struggling than during his good 6 months, and posited that perhaps one of the medications that we had reduced had affected his sleep. We began to explore this hypothesis with his psychiatrist, and continued the trans-disciplinary team process, knowing that Phil would soon move to his waiver home, whether he was healthy or not. A month after we restored his evening dose of Trazodone, Phil began to sleep better. His self-injury slowly decreased.

As we moved forward, my role was to help keep everyone's focus on what really mattered. When an assessment to determine staffing levels came back with an unpractically low result, some voices pointed to that as a signal that Phil couldn't succeed in wavier settings. However, I prompted colleagues to keep an eye on what really mattered — assuring that Phil had the staffing levels he needed — and prompted the team to focus on what we could do assure appropriate staffing levels despite the results of the assessment. Phil had experienced so many challenges, with successes so few and far between, some of his support team seemed to have in their muscle memory a slow trod toward doom. If we could breathe through the struggle and

focus on addressing individual barriers, rather than be overwhelmed by the size of the overall challenge, we could make small steps in the right direction.

Giving staff permission to love, and replacing helmets with hugs

When Phil had begun to seriously injure himself again, one of his long-time support staff was advocating to get him better made mechanical restraints. The pattern: Phil would hit his forehead against objects until he drew blood; to protect his head, his staff put a helmet on him. Phil would become even more upset as people tried to get the helmet on, trying to pry it off with his hands. In the past, the solution was to get Phil mitts that covered his hands so that he couldn't pry off the helmet. However, Phil would try to use his teeth to pull the mitts off his hands. To address this, he was put in "arm splints" so that he couldn't get his hands to his mouth. In their attempt to prevent head-injury, Phil's team had put him in multiple types of "equipment." It was all part of an effort to keep a helmet on his yet, yet it appeared that the helmet was the most distressing part of all to Phil.

The team discussions had turned to how we should fund the purchase and repair of these various mechanical restraints. I advocated that we pause, and re-frame the conversation: what does Phil want, and what does Phil need? His need, we all agreed, was to keep his head safe. What did he want? Well, one thing we could all agree upon: Phil doesn't want to wear the helmet. How else could we meet the need without using the helmet? He loves hugs, we all knew. And even though Phil did bite his caretakers on occasion, it was usually while they were attempting to put his helmet on him, not during an embrace.

Phil's staff were the among most dedicated direct support professionals in the agency — people were attracted to working with Phil because of his personality, and because his needs were so great, and his love was so powerful. His staff were people who valued deep challenges

and deep rewards. The question became: how can we equip Phil's DSP's with the training, materials, and support they needed in order to keep themselves and Phil safe without using the helmet? Over time, we boiled the question down to "Can we replace helmets with hugs?" The answer: not all of the time, but most of the time.

When Phil was injuring his head, we trained staff to rub his back, approach him with their arm around him, and try to put their shoulder and upper arm between his head and solid objects. If they could get him to calm in the embrace, that was wonderful. If not, perhaps they could get him to hit his forehead against their shoulder rather than against a solid object. We made sure that smocks and other personal protective equipment were available, that all of the staff in the area were coached to help each other take breaks, and to make sure that the person assigned to Phil was always able to call for help, and made sure that the supervisors who assigned staff to their daily duties understood that helping Phil's staff to switch off and take breaks was a high priority. We did not tell staff that they *had* to use their body to block Phil's head-banging, but we trained them in using the option safely and skillfully if they were willing. In addition, we talked with staff about Phil's feelings about the helmet (they were the first to offer that Phil hated his helmet - but the idea that he might be able to live without it, with the agency's support, was revelatory), and we empowered staff to decide whether to use their body or the helmet to keep Phil safe in each unique situation.

Here is what I see as the most important discovery of Phil's journey — Phil's staff loved him. They always had. They always would, whether the agency, county, or state surveyor approved or not. In the past, Phil's staff had understood that being a "good DSP" meant putting on his helmet at the right time, putting on his arm splints at the right time, knowing when to use which restraint, how to address each behavior. In our embrace of a relationship-based model, and

our attempts to "replace helmets with hugs," we told Phil's staff that their relationship with Phil was the most important part of their job. We gave our staff permission to do what they had already been doing — love him — and helped them to skillfully use that relationship to support Phil's quality of life and safety.

Two years after we were told by consultants to discharge Phil, he is now settled into his new waiver home, a cozy ranch house with a large yard in a residential suburb. He has had a few outbursts of self-injury, but they were all short, isolated incidents, and all had antecedents which became clear after the fact. His team knows that he still might have an unexplained downturn, but can look back at the recent past to reassure Phil and each other that he will eventually turn the corner.

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Sample Work Sample

Behavior Specialist

Marie T. Dubé, PhD

Abstract

This presentation reviews the history of a young woman who is classified with mild intellectual disability, diagnosed with numerous mental health issues to include Bipolar, Schizoaffective, Disorder, Impulse Control Disorder, Post Traumatic Stress Disorder and Oppositional Defiant Disorder. Medical complications such as Morbid Obesity, and Sleep Apnea. It is a case study based upon observations, staff interviews, and interactions with said individual over a period of five years. It will provide a comprehensive description of the individual's emotional dysregulation and challenging behaviors. It will review issues within the medical and mental health fields as they relate to medication management specifically how the medical field can be viewed as being reluctant, or opposed to treating someone with IDD. It will also suggest the need for person centered treatment approaches.

Society as a whole has come to accept the fact that persons with intellectual and developmental disabilities are often subjected to additional challenges such as comorbid psychiatric disorders, and medical disorders (Brown, Brown, & Dibiasio, 2013). Such individuals must rely on the care and support of others and a majority of these individuals live in residential care facilities. The individual under review known as Mary (alias) resided in numerous foster care homes, group homes throughout her life and a Developmental Center located in New Jersey. She was required to move out of the group home system after starting fires in the homes. She stayed in the Developmental center for several years until 2010 when she was discharged into the care of a new group home residential agency. It was in 2011 that this writer first began to work with Mary as her Behavioral Analyst. Mary at the time was twenty eight years old. Records indicated that Mary was diagnosed in the mild range of her intellectual disability. Mary's intellectual level defines her having an IQ between 50 and 70. She has the ability to achieve academic success, and can be self-sufficient with some supports, however, she has some difficulty with conception, social norms, and practical life skills. Records also indicated that she was diagnosed with Bipolar Disorder (characterized by episodes of increased/elevated mood, arousal, and/or increased energy levels, and can contrast with episodes of low mood and depression), Schizoaffective Disorder (characterized as an uninterrupted period of illness where at some time a Major Depressive episode, a Manic episode, or a Mixed episode of symptoms that meet the criteria for Schizophrenia occur), Oppositional Defiant disorder (a pattern of negative, hostile, and defiant behavior lasting more than 6 months), Post Traumatic Stress Disorder (the individual was exposed to some type of traumatic event and continues to suffer with flashbacks of the event and feelings of reliving the event), and Impulse Control

Disorder (failure to resist aggressive impulses that result in assaultive acts of destruction), as is cited in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*).

Initially, Mary presented very personable, and friendly, yet shy. She enjoyed the same activities as any other young girl her age would enjoy such as shopping, music, dressing up, parties, and other social events. However, Mary also displayed challenging behaviors characteristic of her intellectual disability and mental health classifications. Mary would become aggressive and destructive whereby she would hit, scratch, kick and spit on others. She would also throw objects, rip pictures off walls, overturn furniture, urinate on the floor and break office equipment. She would also elope often running into the street in the middle of traffic where she would lie down and bang her head on the street. Other times she would disrobe in the middle of the street and sit down where she would not respond to redirection requests from staff. Additionally, she would make frequent 911 calls and claim she had a knife and was going to hurt herself.

The antecedents to Mary's behavior included her inability, despite her being able to use language, to be unable to effectively communicate her desires or needs, to use self-injury as a means to communicate frustration or to get attention from staff, or the hearing the word "no" as a result of asking for something whether it be a food item, an outing, or similar event. It was also noted that Mary's feelings of frustration or anger would trigger her behaviors especially if she thought she was being treated unfairly, was having overwhelming feelings of frustration, and/or overwhelming sexual desires.

The frequency and severity of Mary's behavioral episodes warranted several crisis interventions per month over a twelve month period initiated by Mary herself, or staff reactions to her presentation. Often times, Mary would be released to staff's care a few hours after crisis

being contacted due to her ability for calming down and presenting stable. Medications were never adjusted and hospital personnel would state that her needs were of a behavioral nature as opposed to a medication need. Often times the crisis center would rely on staff's interpretation of the episode and not keep Mary overnight for observation. Due to the frequency of crisis visits, Mary became known by the crisis personnel, and assumptions regarding her needs were made. As is cited in (Erickson, Salgado, & Tan, 2016), ineffective communication between a care provider and hospital personnel can lead to inaccurate assessments of the patients presentation whereby resulting in poor medication management.

As a result of the crisis centers reluctance and opposition to consider the fact that Mary may have been experiencing a psychotic episode and prescribe her additional, or adjust her current medications, her outpatient attending psychiatrist questioned the severity of her episodes and was hesitate to explore additional medications himself. Additional concerns were based upon the fact that Mary was already prescribed a variety of psychotropic medications. Due to all of the aforementioned hesitations, Mary was scheduled appointments with her PCP to detect, or rule out any medical conditions that may be the cause for her increased behaviors, behavioral contracts were developed to assist Mary to make improved decisions, and reward systems were implemented to also assist Mary with making appropriate choices and selecting alternative methods for communicating her needs. Additional trainings for staff were increased and included specific mental health disorder trainings to educate staff on specific disorders and symptoms to assist staff with interacting with Mary in an increased positive and supportive fashion. Additionally, the number of house visits made by the behavioral analyst were increased as a means to both support staff and Mary. Despite the increased efforts by Mary's team, she continued to struggle and spiral in a negative way.

During a routine visit with her PCP and being supervised and escorted by her staff, Mary became physical and disruptive in the waiting room. Staff contacted her behavioral analyst, the house manager, the program director, and the program coordinator to report the event. Upon arriving at the site, this writer (BA) observed the staff attempting to redirect Mary and get her to go onto the agency van so she could be escorted back to her residence. Additional observations noted were that Mary was naked, lying face down half way in the parking lot and the sidewalk outside of the Doctor's office, and staff (3 total) attempting to lift her together as she was on top of a blanket staff were using as a means to lift her off of the pavement. Three staff were called upon to assist due to Mary's morbid obesity status. The team felt this was the best approach for assisting Mary because it was believed she was having a behavior as opposed to a psychotic episode. This writer believed the later and instructed the program coordinator to call 911 for assistance. As is cited in Glicksman, Goldberg, Hamel, Shore, Wein, Wood, & Zummo, 2017, people with an intellectual disability have the right to be treated "like everyone else," this includes with dignity and respect. An individual reacts best when treated with genuine and sincere respect regardless of the individual's intellectual level. Person centered, or person first approach to treatment is a proven method of treatment and has identified the uniqueness of the individual, not the population (Glicksman, et al., 2017).

When the EMT's arrived on site, the BA was able to provide a specific and thorough account regarding Mary's case and recent history of events. The EMT's were asked to rely the same to the attending crisis staff to include the staff psychiatrist. Recommendations were made by the BA to keep Mary overnight for observation, and phone numbers were provided for medical staff to contact the BA for further information and/or additional questions. Mary was kept overnight and this writer went to the hospital the following day to consult with the medical

team. There was a continued reluctance to adjust Mary's medications, despite Mary's state of mind and need for restraints based upon her levels of aggression. The crisis center bound both Mary's arms and legs as a means of control. When the restraints appeared ineffective, the attending nurse attempted to inject Mary with a relaxing component, but due to her lashing about and spiting on everyone, additional staff were called to assist. This behavioral demonstration, and the BA's report regarding Mary's period of cycling out of control for the past six months, and not receiving the necessary reactions from the medical team, the BA's request to consult with the staff psychiatrist was granted. It was this consultation that proved effective whereby transferring Mary to the psych unit and the eventual transfer to a psych hospital for further evaluation and treatment.

In the Spring of 2013, Mary was admitted to Island Psychiatric hospital located in Anytown, New Jersey for additional assessments and evaluation. She remained there for a period of two weeks. During her stay, she was engaged in both individual and group therapy whereby learning new coping skills to assist her with maintaining control in times when she feels most vulnerable for having a behavior. Additionally, while a patient there she received an adjustment to her medications to include a new psychotropic medication called Latuda. The staff psychiatrist prescribed an initial dosage of 200mg, however this dosage was decreased over a period of time to 80mg once Mary was discharged and returned home to her group home. Since being discharged (4 years ago), Mary has been happy, stable, and compliant.

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Sample Work Sample

Care Coordination

Ginger Yarbrough

My work sample is a combination of work done over the last 10 years of my career. This includes work as a Care Coordinator on the Complex Integrated Care Team at Alliance Behavioral Health. This team was formed as a response to the increase in the population of individuals with dual diagnoses served by Alliance and the reported success of the Home Health Model (Fueyo, M., Caldwell, T., Mattern, S. B., Zahid, J., & Foley, T., 2015).

Case #1 Background: Peter S

Peter S is an 18 year old white male who currently lives in an Agency Name Home. He is diagnosed with Autism Spectrum Disorder and Klinefelter, 48XXYY. He receives Innovations Waiver Services daily in addition to Testosterone gel and psychotropic medications to address behavioral concerns.

Family/Support System: Peter is from a large family. He lived with his mother, adoptive father, 5 younger half-siblings ranging in age from 4 years old to 15 years old until he was about 16 years old. His family is active in their church, frequently participating in events 5 days/week, which Peter reports . Peter has no interaction with his biological father, who was reportedly diagnosed with schizophrenia and described as a "violent person."

Approximately 3 years ago, Peter began experiencing altercations with authority figures (parents, teachers, staff). Altercations can vary from verbal threats to punching with a closed fist. He has pushed his younger siblings as well.

Education/Services: Peter participates in the Occupational Course of Study. His school day is spent in the mainstream setting 50% of the day, work study 25% of the day, and self-contained 25% of the day. Peter reports enjoying school and liking his teachers and classmates. Teachers report that Peter is always eager to offer his assistance and is liked by his peers.

At home, Peter receives Residential Supports (a service that include habilitative services, supervision, and monitoring) daily. Staff provide structure and routine in the home and community consistent with principals of TEACCH.

Trauma History: Peter was kidnapped at age 5 by his biological father. He was missing for 7 days. Peter was non-verbal at the time and presently reports not remembering this event.

Current Situation: Peter has had at least 4 events in the last 5 months resulting in emergency services transporting him to Crisis and Assessment Services. At least 2 of these events resulted in admission to an In-Patient Unit for psychiatric stabilization. Peter's physical appearance has changed. He now appears disheveled (hair unbrushed, clothes wrinkled, etc) and he is making statements to his parents that are unusual for him. For example, he reports that he heard a deer in his backyard telling him to kill his father. Since Peter moved out of his family's home a year ago, he has lived in 4 AFLs. There are concerns related to sustainability of current AFL staff, which would result in another move. AFL provider reports being fearful due to Peter "posturing in a threatening manner" when asked to participate in his goals.

Problem Addressed: What are the causes of the behaviors? What supports does Peter need to be safe and stable in his home?

Work Sample:

Core team of supports included Peter, his mother, and AFL provider. The team agreed upon next steps were to schedule an appointment with the Endocrinologist. I provided a follow up email to entire team regarding who needed to schedule and attend appointments, as well as the responsibility of the AFL staff to track information. AFL staff were to track hours slept at night to share with the doctor. Mother scheduled appointment for two weeks out. AFL staff and mother both attended appointment. Information was shared with Endocrinologist re: sleep

habits. Blood work was done to check testosterone levels. It was discovered that Peter was taking his T-gel to his room for application daily, but not using it. He would save about 5-7 days-worth of the gel to use for masturbation at a later date, thus resulting in fluctuation in testosterone levels. Peter and his guardian had an established rapport regarding sex and masturbation, however, Peter had not been comfortable asking for lubricants from his AFL provider as they did not have an established relationship yet. I communicated with the AFL provider to add lubricant to personal hygiene list that Peter used as a checklist for shopping. This allowed Peter to add this to the shopping list. Once Peter had access to address his basic need, Peter started using his t-gel as prescribed and testosterone leveled out and Peter reported increased energy. However, there continued to be reports of "bizarre" comments from Peter.

Peter has had his psychotropic medications managed by his primary care physician. With guardian permission, I scheduled a psychiatric evaluation with Raleigh Neuropsychiatry due to continued concerns regarding command hallucinations to harm others. Upon completion of testing, a diagnosis of schizoaffective disorder was received, and medications were adjusted. Based on a Comprehensive Clinical Assessment completed, Peter was linked to Assertive Community Treatment (ACT). The barrier we ran into with requesting ACT was that it is approved in 3-6 month increments. This expected "length of stay" does not account for the adjusted progression that occurs with individuals with developmental disabilities. By working with the ACT team, we were able to include sufficient information into the request to inform the reviewing body of the affects autism may have on the progress towards resilience.

Case #2 Background: Evan

Evan is a 16 year old Caucasian Male with autism, ADHD, and anxiety. Evan also has been linked to the Critical Response Team following an admission of sexual attraction to children under 12 years old. The Critical Response Team is a Care Team Model involving Care

Coordination and a Clinician in the same spirit as the Health Home Model (Fueyo, M., Caldwell, T., Mattern, S. B., Zahid, J., & Foley, T., 2015) to address the complex needs of individuals with dual diagnoses. Upon referral, Evan was receiving Community Guide services to assist with linkage to community and peer activities. He was also receiving School Based Care Coordination to assist with transportation issues to/from school.

Family/Support System: Evan currently lives with his adoptive mother and younger foster brother. His adoptive mother is in a wheelchair and suffers from migraines and back pain. Evan is responsible for much of the activities of daily living. There are no other natural supports in Evan's life. There is no known information about his biological parents.

Education/Services: Evan attends his local high school and pursuing a standard diploma. He is mainstreamed throughout his day with minimal supports.

Trauma History: Trauma history is unknown. Evan and his mother report no trauma.

Current Situation: Evan has voiced concerns that he is attracted to children under 12 years old. He is afraid of acting on those impulses and is seeking assistance. Evan's School Based Care Coordinator referred Evan to the Critical Response Team due to concerns related to Evan's seeking assistance and adoptive mother's lack of acknowledgement.

Problem Addressed: Access to services appropriate to address needs presented by autism, psychosexual assessment, potential need for targeted therapy based on assessment results, service limitations

Work Sample: Given his level of anxiety, Evan was referred for a Comprehensive Clinical Assessment, which lead to the recommendation for Community Supports Team. Evan's CST was familiar with autism and felt they could support needs related to his autism, but did not feel comfortable addressing the possible risks associated to his attraction to children. Evan was

referred for a psychosexual assessment with a local clinician specializing in this area. He was given a diagnosis of pedophilic disorder. Evan's CST considered discharging as they felt Out-Patient Therapy should be provided by a CST that was more familiar with this diagnosis. CST noted they would consider remaining involved if he was seeing an additional OPT provider that specializes is pedophilic disorder. This raised concerns related to service limitations. OPT is typically unable to be provided concurrently with CST. However, I noted that due to Evan's age, it would be appropriate to request both services under the EPSDT review process. Through this process, Evan was approved to receive specialized OPT in addition to his CST to provide for treatment of his whole self.

Until the psychosexual assessment was completed, Evan's mother denied his attractions to children and even suggested he work with children. Once the assessment was completed, Evan's mother acknowledged his diagnosis and supported his involvement in treatment and moving out of the family home to protect the other children in the home.

Case #3 Background: Cantor

Cantor is a 16 year old male of Middle-Eastern descent. Cantor came to the US with his family on a work visa when he was 7 years old. He has had limited services in his home. Cantor has been diagnosed with autism, major depressive disorder with psychotic features, and encopresis. According to a study in Sweden, 70% of individuals with autism report symptoms of depression (Murphy, C., Wilson, C. E., Robertson, D. M., Ecker, C., Daly, E. M., Hammond, N., . . . Mcalonan, G. M., 2016).

Family/Support System: Cantor's behaviors appear to have increased when his family split up for work purposes. His father was working in California, while Cantor and his mother and siblings moved to NC. His mother has linked herself to the Autism Society of North Carolina and been very involved in Cantor's school.

Education/Services: Cantor voiced that he would like to quit school and did so on his 16th birthday. Cantor displays a great deal of stress related to school. If he does not get a perfect score, he considers the grade to be failure.

Trauma History: History of domestic violence – police have been to the home several times in response to Cantor's aggression towards his mother.

Current Situation: Cantor and his mother have a strained relationship and have had the police called due to Cantor becoming aggressive with his mother. Cantor has quit school and will defecate on himself while playing video games. Cantor's mother has attempted to prevent social isolation by setting up dates with friends, but this is not always successful. Cantor appears to get into a cycle of becoming socially isolated and in turn, refusing to be social.

Problem Addressed: Access to services

Work Sample: CIC became involved with Cantor following a hospitalization due to an aggressive episode. Cantor's mother reached out to Alliance to locate resources to address Cantor's depression and autism. Family was interested in accessing Intensive In Home Services and/or ABA. Accessing ABA in the home would allow for Cantor to practice these skills in the natural setting (Dixon, Dennis R., et al. 2016) which is a benefit of community based ABA programs. This being said, it was difficult to initiate services due to the kind of Medicaid Cantor has. Because Cantor is not a citizen of the US, his Medicaid is not managed through our local Managed Care Organization. This required much coordinating between providers and our own Department of Medical Assistance in the state of North Carolina to ensure the chosen ABA provider knew how to get prior approval and utilize EPSDT review process. This was the same coordination required for the Intensive In Home provider and a respite provider to allow for Cantor's mother to have intermittent breaks to maintain her own wellbeing.

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Sample Work Sample

Training and Care Coordination

Uzama Price

Background Information

The member is an African American female who is 32 years of age. She was diagnosed with Intellectual Disability Mild and Schizoaffective disorder, bipolar type. She is five feet two inches and her weight per the hospital records was 342 pounds. Outpatient therapy (CBT) had been tried in the past with minimal success as the member attended weekly sessions for two months and this was interrupted due to a group home change to another county. Current medications include Trazadone 50mg for sleep, Quetiapine 200mg twice daily for psychosis, Propranolol 10mg three times daily for anxiety, Chlorpromazine 100mg twice daily, Cetirizine 10mg for seasonal allergies, Vitamin D3 100units 2 tablets daily, Ortho Novum birth control 1mg daily, Victoza 1.2mg daily for blood glucose management. Records indicate six inpatient stays in the past year with an average of 7-10 days on each admission for aggression and suicidal/homicidal ideation with and without a plan. Also noted in the records are five trips to the emergency department for aggression and suicidal/homicidal ideations with a plan. The length of stay for the visits to the emergency department averaged 24-48 hours on each trip. Behaviors of concern include property destruction, verbal and physical aggression towards staff, elopement, self-injurious behavior, non-compliance with medication, hygiene, and programming. The team reports that hospital admissions resulted in numerous medication changes but did little to address the behaviors of concern. The member is easily angered when she is over prompted by staff, when staff are punitive, when she feels that she is being forced to perform a task that is not of interest to her or when she is tired.

Format for Addressing the Issues

Five onsite observations were made at various times across multiple settings. There were several telephone calls with various members of the treatment team to collect additional information. The third activity was a review of the records. This writer applied a multi modal bio psycho social approach to identifying the issues and placing them in a format, so the entire team can work efficiently to address each problem.

Service Delivery Characteristics

A team meeting was scheduled. The baseline data was discussed, this writer encouraged the member to share a list of issues she had with her services and reminded her that she was in the "driver's seat" and that my role was to support her. This writer shared the concerns from the review of all the records. An urgent request was made by this trainer for a nutrition consult, the creation of a food & beverage log, sleep log, daily activity and medication log. The logs were being requested so that staff would have them available to share with the psychiatrist, endocrinologist, and the primary care. This writer explained in detail why the multimodal biopsychosocial approach is necessary to address all the concerns and the importance of ruling out medical issues first. This writer educated the treatment team on understanding that there is over lay with meeting the needs of the dually diagnosed person as nothing stands alone. Weekly meetings were scheduled until all issues were resolved.

Issues That Arose

There was a lack of knowledge and understanding about intellectual disability and co-occurring mental illness and how trauma affects this group of people. The guardian felt that this innovative approach with the use of technical assistance placed the "power" in the hands of the member and she was not pleased with this. Group home staff were upset that the member was being encouraged to create her own schedule and that she was now empowered to refuse

activities that they felt were in her best interest. The member stated she wanted a new guardian and information on the guardianship process and this writer made a referral to an advocacy agency to assist the member. The issues were resolved with this writer making a referral to the College of Direct Supports for training on dual diagnosis for the entire team. This writer will also discuss trainings that were scheduled with the team to address trauma, positive behavior and person centeredness.

Description of the Outcome

A sleep study was ordered for the member and it was found that she suffered from sleep apnea, the nutrition consults have been beneficial to the team as they are managing the blood glucose levels carefully and per the endocrinologist they are within a healthy range. She is losing an average of eight pounds per month. The member attends therapy weekly(CBT) and she is learning how to use her coping strategies. She is also utilizing other mental health support services such as mobile crisis and peer supports as opposed to the police. She is engaging more in the community and she remains in the current placement.

Ability to Communicate Effectively

This writer used role play and role modeling to share information with the group on effective communication strategies. This writer engaged the trainees in the role play and highlighted non- verbal body language such as facial expression, posture, eye contact, as well gestures and how communication can be impacted both positively and negatively. This trainer employed intentional listening skills and paraphrasing of pertinent information to ensure optimum communication was in place. I applied the “stop look and listen approach” in order to read the verbal and non -verbal cues by the audience members. The content of the trainings had to be altered to meet the needs of this group, so this writer used lots of visuals, hands on

activities, as well as broke down strategies into smaller pieces and confirmed verbally before moving on to the next session. This writer also used open ended questions and true and false questions to ensure knowledge attainment.

Understanding of Programmatic Issues

This writer trained several staff members from the Utilization Management department on the service array for people with waiver services and Medicaid and why it was critical that members have access to peer support professionals as hope, recovery and resilience is crucial in their journey to improve their quality of life. Research data was shared on the effectiveness of working with peer support professionals and the positive impact on recovery. This writer quoted the literature as it relates to serving the needs of the dual diagnosed and avoiding "diagnostic overshadowing". For the member mentioned in this work sample it proved to be of benefit after her plan was updated to include this service. The peer support staff was available to her when the member most needed help which was nights, weekends, and holidays.

Inter-systems Issues & Resolutions

One of the issues that was identified by this writer was the fact that the member did not have control of her life because her services were not person centered. The Quality of Life survey tool was introduced to the team. A recent study showed participants with an intellectual disability and cooccurring mental illness mentioned aspects of all eight domains (personal development, self-determination, interpersonal relations, social inclusion, rights, emotional well-being, physical well-being, and material well-being) as a response to questions on the Quality of Life Survey (Morisse, F., Vandemaele, E., Claes, C., Claes, L. & Vandevelde, S. 2013). This tool was well received as it was rooted in science and had valid data to support its efficacy.

The second training that was conducted by this writer was on Trauma and Intellectual Disability. The above-mentioned member has been in social services custody for more than a decade. It is critical that treatment teams understand trauma histories, professionals can shape clinical care to best support people with dual diagnosis by understanding the meaning of their behavioral problems and minimizing environmental cues and complexities that may lead to stress (Gardiner, Iarocci, & Moretti 2017). The Trauma & ID training I facilitated explained how past trauma is stored in the brain, as well as how present-day triggers such as over prompting, and a threatening tone of voice can trigger a trauma response such as flight or fight.

The third training for this treatment team was on positive behavior strategies. A preference assessment was completed by the member. Her schedule was created based on the information collected on the Preference Assessment. The member completed both of these tasks and verbalized her reinforcers, dreams for the future, and things she wanted to explore such as finding her family, losing weight, getting a job and moving into an apartment. This writer modeled a great deal for the group how to use positive strength-based language as well.

In the past 18 months I have trained more than one hundred employees of various provider agencies who are supporting members who are dual diagnosed. Data has been collected by the MCO and for the people who have received Technical Assistance we have dramatically reduced hospital visits and law enforcement involvement. This decrease is socially significant as we monitor to ensure positive gains in program outcome measures for each person. These trainings have been shown to improve quality of life.

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Sample Work Sample

Training

Susan Morris

NADD Specialist Certification Work Sample Susan Morris

My career in the field of dual diagnosis has often had a focus on system impact, that is, to implement clinical services and supports that are sustainable and integrated within the developing continuum of care within the region that I have worked. I learned through the early work of the MATCH Project in Ontario, a system change initiative to build capacity among mental health and social services, that education and/or training must be built into that continuum. Based on having held positions in community and hospital settings, much of my efforts have been focused on building and supporting sustainable initiatives within the University and Community environments. This work sample will focus on one such community initiative that I have lead for more than 10 years.

The Training in Partnership Program (TIP) is a cross-sector classroom based 4 day training provided to managers primarily from intellectual/developmental disability and mental health agencies (community and hospital). Participants from the justice, addiction and shelter sectors have also attended. The purpose of TIP is to support managers with at least one year of experience in that role to guide front line staff in their work with people with dual diagnosis using biopsychosocial and interprofessional (interdisciplinary) approaches. The first 2 days are a review of the clinical issues associated with developmental disabilities, mental illness and approaches to biopsychosocial assessment and diagnosis as well as examination of the family experience and role. Tools are provided for application to case examples using a group work format as well as through homework assignments. One example is a Decision Tree (Bradley & Summers, 2009) that is used to identify medical, environmental, emotional or mental health concerns and next steps. Day 3 addresses the role of managers as leaders as well as clinical

supervisors, and how to use Appreciative Inquiry techniques to support individual and group supervision. The final day is focused on the policy and system context of front line work, the role of managers in supporting effective service partnerships, and information exchange between participants regarding service pathways within each training locale.

The 4 days are spread across 4 months, with pre-reading of articles from peer reviewed journals and short homework assignments using small group facilitated email exchanges. The program is delivered by a team of 4 faculty - representing different sectors who have experience in various aspects of the content. The curriculum is delivered with a minimum of didactic time, encouraging shared learning, knowledge exchange and application through large group discussion, paired and small group exercises, as well as role play.

TIP is jointly administered by an Academic Health Science Centre (where I worked), a Community College that provides a certificate for successful completion (Dean of General Education and Access) and a Coordinator from the regional Specialized Network who has responsibility for day to day administration of the program.

My role in the development and implementation of TIP was to Chair the original community group that oversaw the needs assessment, then advised on the curriculum that was originally written by a consultant. I provided the initial faculty training with a team of clinicians/college professors and subsequently have been responsible for annual updating of the curriculum and mentoring of faculty. I have re-written most sections of the curriculum based on new research and evidence informed practices, as well as feedback from faculty and participants.

1. **Effective Communication: If you are a trainer, provide an example of how you have changed training content to meet the receptive communication needs of trainees**

Faculty recruited for the program are first interviewed by myself or the Network Coordinator to determine their suitability based on clinical experience and experience with teams, as a manager and/or trainer. The faculty meet as a team for orientation and between each of the 4 days of training as well as for a debriefing session at the end. The orientation session is intended to model the teaching approach with an opening exercise/ice breaker to introduce one another. The teaching approach is also reviewed based on the following tip sheet:

- **o** The role of the faculty in TIP is intended to be more as facilitator with content expertise - not the 'sage on the stage' approach > GUIDE ON THE SIDE
- **o** The content expertise comes from your own experience, backed up by the lesson plans
- **o** Draw upon the experience in the room - there is a lot of it
- **o** In preparation for your section - review the material as a whole and understand the objective of each section. Use your own experience to highlight main points, and draw out the experience of the participants - the differences of opinion and perspectives.
- **o** You are not expected to 'teach to the slides'. The content on the slides is provided as a touchstone for the basic information. They can be used to ask questions, as reference or to facilitate discussion. For example - there are some sections where we review definitions such

  as levels of disability - seek this info from participants or examples that explain the terminology - we do not want to read the definitions.
- **o** The lesson plans provide the content behind each slide, exercises and faculty notes where

more context is provided. This is for your reference - if you feel an exercise needs adjustment or you want to augment or emphasize a particular area - go ahead.

In addition to the orientation, the Network Coordinator attends each of the training days, providing support and feedback to faculty based on the above. I also attend 1 training day to observe the team and provide feedback. The faculty team, Network Coordinator and Community College (Dean of Liberal Arts) meet to debrief after each day, reviewing the feedback questionnaire responses from participants and to review the curriculum sections for the next training day.

Building upon the training approach outlined above and recognizing the adult education context, each section of the curriculum begins with identification of learning outcomes, followed by a section of faculty activities that includes suggestions for presentation of content and facilitated group discussion. Various teaching resources are provided in addition to slides, e.g., participants receive a handbook with the slides, exercises and writing space for a personal learning journal. Video clips, flip charts, handouts of tools, discussions based on the pre-readings and group exercises to apply the tools also facilitate engagement with the material.

2. **Understanding of programmatic issues: If you are a trainer, provide an example of a programmatic issue about which you have trained people so that the lives of service recipients are enhanced**

Part of Day 2 examines the clinical issues associated with accurate assessments, the role of behaviour as a communication, understanding trauma and trauma informed practice. Concepts such as baseline exaggeration, diagnostic overshadowing, cloak of competence and splinter skills are discussed using case examples provided by faculty and participants. Emerson's definition of challenging behavior definition (Emerson et al, 1988) is discussed in light of the recent Ontario

Social Inclusion Act for Persons' with Developmental Disabilities (2010) that provides an 'administrative' definition. Based on this review of diagnostic issues and challenging behaviour participants engage in a 30 minute group discussion of the following quote from a pre-reading article:

> "Mental health symptoms have been found to be largely unrelated to environmental factors. Conversely, challenging behaviors, tend to be independent of psychopathology and largely caused by environmental variables." (Matson & Shoemaker, 2011).

Participants are asked to discuss their agreement or disagreement with these statements as well as the clues that they look for in day to day practice to assess when something is a behaviour characteristic of the individual, a response to the environment, or a possible psychiatric symptom.

The next section summarizes the data related to trauma and PTSD in children, adults and women with developmental disabilities (Razza, Tomasulo, Sobsey, 2011). Participants then consider implications within their services in terms of what it might mean if many of their clients have experienced neglect or abuse as children but have not necessarily revealed it. Another area for consideration is the implication of staff witnessing violence but not reporting it. This is discussed in the context of Ontario's Social Inclusion Act that now requires mandatory reporting of abuse in community developmental services settings. This section is completed with a discussion of how participant agencies have adapted trauma- informed practices, based on a pre-reading article by Palucka & Lunsky (2012).

3. **Understanding of intersystem issues: If you are a trainer, please provide an example of at least three training sessions you have conducted, and how those improved services and supports for people with IDD/MI.**

The TIP training is specifically designed to address intersystem issues using a variety of approaches:

a) Each TIP offering must be comprised of a minimum of 30% of participants from sectors other than developmental services, e.g., health, mental health, justice, addiction

b) At least 1 facilitator must be from a sector other than developmental services

c) At least 1 facilitator is experienced in dual diagnosis

d) At least 1 facilitator has management experience

e) Participants are arranged each day at round tables, with pre-assigned seating to facilitate cross sector discussions during group exercises and informal exchanges

f) Day 4 is designed specifically to building intra and inter-agency capacity and understanding of the system context. For example, there is a group exercise on building a partnership to respond to justice issues, and a conflict resolution role play demonstrates how to facilitate successful resolution between hospital, community and family representatives. The day concludes with an exercise where participants explain to one another how to access the care pathways within their respective sectors.

At the end of each TIP training day and at the end of the full program participants are asked to complete a feedback questionnaire regarding how well the objectives of the day were met, overall satisfaction and comments regarding likes and improvements. Over the 7 years and

approximately 20 deliveries (average 18 participants per session) responses on a 4 point scale consistently fall in the 'agree and strongly agree' categories. Comments from participants are also quite consistent as noted in the sample below:

I liked:

- Group discussion, diversity of groups, case studies, presenters were great
- The homework groups, case studies and videos, group discussions, everyone has so much experience

- Tools to use with my team I learned:
  - The difficulties faced by mental health agencies are similar to those faced by developmental agencies
  - More about biopsychosocial model and 1st episode psychosis through group discussion of case assignment
  - A lot about trauma and PTSD as well as tools to use to prevent crisis

I would change:

- Shorten the course
- More mental health participants

Given the success of TIP in Toronto, the program is now being offered through the Networks of Specialized Care to 4 other regions in the province capturing South East, South West and Central Ontario and based on a similar administrative structure.

Trainings that I have conducted:

I have provided sections of the TIP training on Days 1 and 4 as well as variations of the 4 day content to many audiences in 1 hour, A day or full day formats. The TIP content basically represents a compilation of my own learning and development over my career in the field. As a result of a five day training in interprofessional education and care, my training approach in the last few years has been informed by Appreciative Inquiry (AI) concepts and techniques. Contrasted to a problem-based approach, AI is a more affirmative based approach, possibility oriented (appreciating the best of what is, envisioning what might be and co-creating approaches to address problems). This has been added to the TIP training and is well received.