This webinar is presented by AUCD’s Mental Health Aspects of I/DD Special Interest Group

Supporting Individuals with I/DD and Mental Health Needs

Presented by:
Dr. Beth Bryant-Claxton received Dr. Leslie Gene Smith

January 12, 2016
Webinar Overview

- Introductions
- Presentation
- Q & A after presentation
  - You can ask a question by pressing the * then # key to request the floor. Questions will be answered in the order they are received.
  - You can also submit any questions throughout the webinar via the ‘Chat’ box below the slides.
  - The moderator will read the questions after the presentations.
- Survey
  - Please complete our short survey to give us feedback for the next webinar!
Dr. Beth Bryant-Claxton received her Ph.D. in Clinical Psychology from the University of Florida. She completed pre-doctoral and postdoctoral fellowships at the A.I. DuPont Hospital for Children in Wilmington, DE, and a postdoctoral LEND (Leadership Education in Neurodevelopmental Disabilities) fellowship at the Westchester Institute for Human Development, a University Center for Excellence on Developmental Disabilities (UCEDD), where she also served as faculty at the New York Medical College. She previously was the Director of the Positive Behavior Support (PBS) Training Project at Partners for Inclusive Communities, Arkansas' UCEDD, an Arkansas-licensed Clinical Psychologist, providing the statewide training and certification for Positive Behavior Support Specialists and developing PBS plans for United Cerebral Palsy of Arkansas. Most recently, Dr. Bryant-Claxton served as the Clinical Director for Arkansas START (Systemic, Therapeutic Assessment, Resources and Treatment), a crisis prevention and intervention program for individuals with Intellectual/Developmental Disabilities and complex behavioral health needs. She joined the Institute for Disability Studies, the UCEDD at the University of Southern Mississippi, as Executive Director in October of 2014.

Leslie Gene Smith, M.D. is double boarded in Psychiatry and Addictions. Dr. Smith earned his medical degree at the University of Arkansas for Medical Sciences in Little Rock, Arkansas. He is currently the Medical Director of the GAIN program, an assertive community treatment program with 3 teams: SMI population, Dual Diagnosis population, and Forensic population. He also owns a private practice psychiatric clinic that includes 3 physicians and the private practice focuses on hospice care, geriatrics, substance abuse treatment, and dual diagnosis patients (SA/MI and or DD/MI). Dr. Smith is the medical director of the CET/ArkSTART program for Arkansas.
Supporting Individuals with I/DD and Mental Health Needs

Using the Biopsychosocial approach and case presentation learning forums

Beth Bryant-Claxton, Ph.D.
Executive Director, Institute for Disability Studies
University of Southern Mississippi
Former Clinical Director, ArkSTART
Beth.Bryant@usm.edu

Leslie Smith, M.D.
Psychiatrist, Medical Director
ArkSTART, GAIN

Adapted from National Center for START Services
www.centerforstartservices.org
and Arkansas START
www.arkansasstart.org
“If all you have is a hammer, everything looks like a nail.”

Abraham Maslow
Biopsychosocial Model

- Has dominated medical care since the 1980’s because it takes into account issues missed by the simplistic disease model.
- Opens or expands therapeutic interventions at several points on the cause/effect chain of a disease-impairment-disability model
- Bioscience reduces outcomes to a monofocus and tends to be paternalistic
Biopsychosocial Model

- Biological focus puts the focus on the disease and not the person or the system where the individual may interact.
- New science with tailored care is important because it can improve outcomes but at what cost to the individual seeking to be heard.
- The biopsychosocial model seeks to incorporate pharmacology, dynamic stressors, and social support system into a complex interpersonal intervention of care.
Biopsychosocial Model

• Failure tends to evolve from “evidence-based” practices that focus on pharmacology over psychosocial interventions
• This BPS approach distills down an individualized treatment that is expressed as an experiment of “1” and this approach can mean it is difficult to duplicate or show evidence based outcomes
• The model promotes a participatory clinician-client relationship yet this model can be hard to create in the “real world” due to available resources
Biopsychosocial Practice

• Self awareness of both clinician and client
• Active cultivation of trust
• Empathic curiosity
• Self-calibration as a way to reduce bias (critical treatment team self examination)
• Understanding emotions that assist with diagnosis and forming therapeutic relationships
• Use of informed intuition
• Communicating clinical evidence to foster “dialogue” and not dogma of applied protocol.
• Guides rather than defines application of interventions
The point...

- Challenging behaviors are puzzling, baffling, annoying, scary! Successful intervention relies on the identification and understanding of behavior in the context in which it occurs, and its meaning/function/communication.
- When conditions to promote wellness (e.g., meaningful life experiences, social connectedness, stimulation) are undermined, problem behaviors may occur.
- Must look at the whole person and their systems.
CETs: What are those?

• Clinical Education Teams (CETs) are a forum designed to improve the capacity of the local community to provide supports to individuals with intellectual/developmental disabilities (I/DD) and complex behavioral health needs through clinical teaching.

• The presenting team consists of the START Coordinator, and consultants such as Psychologist, Psychiatrist, Systems Expert
Goal and Structure of the CET

• The goal of the CET is to help service system providers/stakeholders learn how to best support people while improving the capacity of the system as a whole through information sharing, learning, and collaboration among team members.

• We learn through case presentation, systemic analysis, brainstorming.

• Because this is an educational event, each individual presented has his or her identity hidden to protect confidentiality.
Goal and Structure of the CET

• The training is not so much about the person presented, but rather descriptions of the problems faced, strengths and resources, as well as diagnosis and treatment information. The individual serves as an example for discussion and further examination.

• However, it is expected that the discussion will generate ideas about possible remedies to improve services and clinical outcomes to explore for the individual presented.
CET Presentation Preparation

• "Mine" the record and obtain all background information: educational, psychological, behavioral, medical, psychiatric
• Think of this as an archeological dig
• We must get original information because of so many beliefs, reputations, and hypotheses that are incorrect
CET components

• Personal description (skills and interests, strengths, person “at their best”)
• Reason for Presenting, Goals
• Recent history of problem
• Life story
Psychiatric history & ID

• The history of the presenting complaint is very important in the “differential diagnosis”

• Histories may be:
  • Complex
  • Confusing
  • Lacking in information
  • Contain ? diagnoses & interpretations due to problems of IDD and MH care
Medical history

• Many medical conditions can be a cause of the CC/Reason or may influence its presentation and treatment options

• Examples of medical sources of MH are:
  • hypothyroidism > depression
  • medication side-effects > psychosis

• Question all diagnoses

• Question all medications

• Include Family/genetic history
Family & community supports

• Family involvement
• Friends in the community
• Natural supports, e.g., belonging to a church or club
Mental health providers & treatment

• List type of provider and current services, e.g.,
  • Sees local psychiatrist in mental health center quarterly
  • Has private psychotherapist
  • Behavior specialist is following person
Ecomaps are a TOOL to inform systemic analysis and consultation

Support the team with the development of a common understanding and goal in order to support the person as effectively as possible.

We use ecomaps to:

- identify the client's connectedness to his/her system as well as the larger environment (relationships, resources)
- express strength/effect of relationships
- aid in the development of a working hypothesis that explains how and why the system works as it does
- be a starting point when addressing a person's needs

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<thead>
<tr>
<th>Symbol</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>______</td>
<td>Strong/+</td>
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<tr>
<td>_______</td>
<td>Very strong</td>
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<td>~~~~~~</td>
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<td>Weak/-</td>
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<td>←→ ←→</td>
<td>Influence</td>
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Some lessons learned…

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<tr>
<th>Bio</th>
<th>Psych</th>
<th>Soc</th>
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<tbody>
<tr>
<td>Multiple medication changes</td>
<td>Expressive language&gt;Receptive</td>
<td>Staff turnover; double standards</td>
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<tr>
<td>More meds&gt;more side effects</td>
<td>Role of multiple losses and trauma</td>
<td>Let write notes for “distance”</td>
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<td>Monthly injectables</td>
<td>Sensory concerns</td>
<td>Comfort objects</td>
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<td>Thyroid function</td>
<td>Using too many words</td>
<td>Social skills and safety training</td>
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<td>UTI infections, other</td>
<td>Diagnoses added, not removed</td>
<td>Away from family; paid supports</td>
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<td>Lack of communication between providers</td>
<td>Lack of records, documentation</td>
<td>How to be a leader</td>
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<tr>
<td>How info is communicated back to the system (all 3 areas)</td>
<td>Need a common language</td>
<td>Where’s the FUN?</td>
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Q & A

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THANK YOU!

Please take a few minutes to complete our survey!