The NADD Accreditation and Certification Programs:
Standards for Quality Services

THE NADD

COMPETENCY-BASED

CLINICAL 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 (IDD/MI). These individuals have complex needs and present clinical challenges to professionals, programs, and systems. Clinicians face the challenge of diagnosing mental illness and providing appropriate mental health treatment for persons who have IDD/MI.

NADD Competency-Based Clinical Certification Program

NADD, an association for persons with developmental disabilities and mental health needs, developed the NADD Competency-Based Clinical 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.

Clinical certification . . . validates and provides assurance to people receiving services, professional colleagues, employers, and third-party payers that a clinician has met the standards established by NADD for providing services to individuals with ID/MI.

Advantages of Clinical Certification by NADD

Clinical certification through the NADD Competency-Based Certification Program validates and provides assurance to people receiving services, professional colleagues, employers, and third-party payers that a clinician has met the standards established by NADD for providing services to individuals with ID/MI. Certification attests to the clinician's competency in providing these

> ***"My ability to provide clinical supports to individuals supported both by medical assistance and private insurances has been expanded by allowing me to gain access to closed insurance networks."***
>
> ***Alyse Kerr, MS, NCC, LPC, NADD-CC***

services. In addition to the prestige this Certification provides, it may benefit the clinician through greater employment opportunities, job security, and promotions. The certification is portable; clinicians 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.

One NADD Certified Clinician, Alyse Kerr, MS, NCC, LPC, NADD-CC says, "The NADD competency-based clinical certification has provided me with an avenue to verify a dual diagnosis specialty. My ability to provide clinical supports to individuals supported both by medical assistance and private insurances has been expanded by allowing me to gain access to closed insurance networks. These networks had been closed to me prior to receiving this certification, allowing this population to remain largely unserved outside of community mental health centers."

Competency Areas

The clinician seeking certification will be required to demonstrate mastery of the following five competency areas:

- Positive Behavior Supports and Effective Environment
- Psychotherapy
- Psychopharmacology
- Assessment of Medical Conditions
- Assessment

Qualifications for a NADD-Clinical Certification (NADD-CC)

One (1) of the following is required:

- Licensure as an RN or a Master's degree in a field providing services to individuals with Intellectual & Developmental Disabilities and co-occurring behavioral health disorders with at least seven years of experience delivering clinical supports for persons with

Intellectual & Developmental Disabilities (IDD) and co-occurring Behavioral Health disorders.

- Five years of experience delivering clinical supports for persons with Intellectual & Developmental Disabilities (IDD) and co-occurring Behavioral Health disorders and licensure or certification in at least one of the following areas of practice:

Psychologist, Physician, Medical Doctors (M.D.), Doctor of Osteopathic Medicine (D.O.) Bachelor of Medicine /Bachelor of Surgery (MBBS), Mental Health Counselor, Marriage & Family Counselor, Addictions Counselor, Licensed Clinical Social Worker; Physician's Assistant, Registered Nurses, Nurse Practitioner; Occupational Therapists (OT), Physical Therapist (PT), or other similar USA or Canadian equivalent clinical licensure or credentialing. Final determination of clinical equivalence and experience relevance resides with the NADD Competency-Based Certification Program.

- Five years' experience and licensure or certification as a Licensed Behavior Consultant, Board Certified Behavior Analyst, (BCBA), a Board Certified Assistant Behavior Analyst (BCaBA), or recognition by your State/Province as able to provide behavioral assessment and training (e.g., Behavior Analyst). Final determination of clinical equivalence and experience relevance resides with the NADD Competency-Based Certification Program

- Primary teaching, training, or clinical supervision responsibilities in a post-secondary education or clinical supervision related to training toward the disciplines listed above with five years of directly related experience. (Please provide an explanation of relevant activities and experience.) Final determination of clinical equivalence and experience relevance resides with the NADD Competency-Based Certification Program.

In combination with:

The applicant must be able to thoroughly explain and demonstrate advanced expertise in at least one competency area and a general knowledge in the remaining competency as follows:

- Positive Behavior Supports and Effective Environment
- Psychotherapy
- Psychopharmacology
- Assessment of Medical Conditions
- Assessment

References

In addition to providing copies of the applicant's curriculum vitae and professional license, the applicant must submit reference letters from three people able to provide a reference about the applicant's clinical 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 describing the assessment, diagnoses and treatment of a single person who has a dual diagnosis (IDD/MI). See Appendix C: Work Sample Guidelines. The work sample submitted should be between 5 and 7 pages in length and should concisely address these five competency areas:

- Assessment of Medical Conditions
- Clinical /Behavioral Assessment
- Positive Behavior Supports and Effective Environment
- Psychotherapy
- Psychopharmacology

The following components should be included in the submitted work sample:

1. Formulation/conceptualization of clinical problem(s)
2. Format for intervention
    a. What were the goals/expected outcomes for treatment or intervention?
    b. Other interventions that were considered and rejected, if applicable.
    c. Why the selected intervention was chosen and why the rejected treatments were rejected, if applicable
    d. Were there modifications or adaptations of standard treatment protocol to meet the unique needs of this

individual? If so, briefly describe these modifications/adaptations.

3. Landmark events or salient issues that arose during the course of treatment and how these were addressed within treatment or intervention
4. Reflection on issues that arise within the clinical approach and/or ethical concerns and/or issues relevant to cultural competency
5. How the clinical approach was informed by an understanding of intellectual disability or co-occurring mental illness

Prior to submission of the work sample, the applicant should review it to verify that the submitted content includes consideration of each of above listed competencies and work sample components.

NADD will assign two examiners to review to work sample to determine whether the candidate demonstrates competency in the five areas. 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 shall be presented with a case vignette approximately 24-48 hours before the interview, about which he or she shall be asked to verbally offer their thoughts and reflections (i.e., provide a case formulation and treatment plan). The interview shall also include resolution of any questions raised during other parts of the application process.

Clinicians who receive NADD clinical certification will be entitled to use "NADD-CC" as a credential.

Credential

Clinicians who receive NADD clinical certification will be entitled to use "NADD-CC" as a credential.

Cost

The cost of the NADD Competency-Based Certification is $375.00. A non-refundable application/exam fee of $375.00 must accompany the application package. The NADD Competency-Based Certification is good for two years. The renewal cost is $100.00. 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.

Support for Applicants

NADD is pleased to introduce a Mentoring Program for clinicians interested in NADD Clinical Certification. Mentors are available to clinicians who have begun the certification process or are interested in applying who would like the support of a NADD certified clinician.

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CLINICAL CERTIFICATION WORK GROUP

The NADD Clinical Certification Program was developed using an expert-consensus model. This work group of experts has been meeting for the past four years to identify appropriate competency areas and to design a fair and comprehensive program for evaluating the competency of a clinician to properly serve individuals with intellectual and developmental disabilities who also have mental health needs.

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Clinical Certification

INTRODUCTION

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

Individuals who have both mental illness and intellectual disability (ID) are considered to have a dual diagnosis. More than a million people in the United States have both mental illness and intellectual disability.[1] It has been estimated that individuals with ID 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 Clinical Challenge

These individuals have complex needs and present clinical challenges to the professionals and systems providing treatment and support services. Clinicians face the difficulty of diagnosing mental illness with minimal verbal input of the individual.

Although psychiatric disorders in persons with IDD are common, they are frequently not appropriately identified. Clinicians often attribute maladaptive behavior or behavioral problems to the condition of an intellectual disability rather than assessing these behaviors in relationship

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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.

to the manifestation of a psychiatric disorder. This phenomenon is known as diagnostic overshadowing. Clinicians need to have an understanding of the manifestation of signs and symptoms of mental illness in persons with IDD. In order to provide adequate services for this group of people, clinicians need an understanding of how to modify existing treatment and support approaches in order to meet the clinical needs of persons with a dual diagnosis. This includes an adaptation in areas such as positive behavioral supports, medication treatment, and psychotherapy, as well as assessment and mental health diagnosis.

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 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 intellectual disability and has been an international leading force advocating on behalf of individuals who have mental illness and intellectual disability.

The NADD Accreditation and Certification Programs [are] part of its continuing efforts to improve the lives of individuals with intellectual disability and mental illness

In furtherance of its mission to advance mental wellness for persons with intellectual disabilities, NADD has spent significant time and effort identifying the service needs of individuals with intellectual 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 Clinical Competency-Based Certification Program is designed to review and assess the competence of professionals who provide clinical services to individuals who have co-occurring intellectual disability and mental illness.

Why Certification?

- To provide a clinical 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 provides 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 Clinician:

Clinical certification through the NADD Competency-Based Certification Program validates and provides assurance to people receiving services, professional colleagues, employers, and third-party payers that a clinician has met the standards established by NADD for providing services to individuals with ID/MI. Certification attests to your competency in providing these services. In addition to the prestige this certification

provides, it may benefit the clinician through greater employment opportunities, job security, and promotions. The certification is portable; clinicians 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 NADD competency-based clinical certification has provided me with an avenue to verify a dual diagnosis specialty. My ability to provide clinical supports to individuals supported both by medical assistance and private insurances has been expanded by allowing me to gain access to closed insurance networks. These networks had been closed to me prior to receiving this certification, allowing this population to remain largely unserved outside of community mental health centers."

Alyse Kerr, MS, NCC, LPC, NADD-CC

One NADD Certified Clinician, Alyse Kerr, MS, NCC, LPC, NADD-CC says, "The NADD competency-based clinical certification has provided me with an avenue to verify a dual diagnosis specialty. My ability to provide clinical supports to individuals supported both by medical assistance and private insurances has been expanded by allowing me to gain access to closed insurance networks. These networks had been closed to me prior to receiving this certification, allowing this population to remain largely unserved outside of community mental health centers."

The names and contact information of NADD certified clinicians will be posted on the NADD Accreditation and Certification Program website (unless they request that this information not be posted). This may provide referrals for the clinician from purchasers of services who are seeking a NADD-certified professional.

Benefits for the consumer or purchaser of services

Clinical certification through the NADD Competency-Based Certification Program will indicate that a clinician has met the standards established by NADD for providing services to individuals with ID/MI. People receiving services, parents, venders, regulators, and insurance companies can be assured clinicians who have earned the NADD certification have demonstrated clinical competence in the area of the provision of mental health therapy/supports for people with a dual diagnosis.

Benefits for the field

The goal of clinical 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 clinical services delivered for people who have a dual diagnosis. We believe that as a result of the NADD Competency-Based Certification Program, clinical services will be provided by clinicians who have a high level of competence. -We believe clinicians will strive to achieve this level of expertise in order to receive NADD certification. As more clinicians within North America become NADD certified, the quality of clinical service provided should be significantly improved.

Credential

Clinicians who receive NADD clinical certification will be entitled to use "NADD-CC" as a credential.

Development of Standards

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

COMPETENCY AREAS

The clinician seeking certification will be required to demonstrate mastery of the following five competency areas:

- Positive Behavior Supports and Effective Environment
- Psychotherapy
- Psychopharmacology
- Assessment of Medical Conditions
- Assessment

Positive Behavior Supports and Effective Environment. Individuals with dual diagnosis often have multiple factors effecting the presentation of their challenging behaviors (i.e., symptoms). While Positive Behavior Support (PBS) cannot cure underlying biological bases for mental illnesses, it has been shown that it can reduce the behaviors of concern for those who have mental health conditions. PBS does this by first identifying those factors that predict and trigger challenging behaviors (e.g., those environmental variables that cause heightened anxiety; the presentation of a request to engage in an activity that is considered aversive by the person). This process is called Functional Behavioral Assessment. First, PBS interventions are targeted to those identified variables to design positive environmental conditions that reduce, remove, or modify those variables known to trigger challenging behaviors. The Functional Behavioral Assessment also identifies the function, or purpose of the challenging behavior. Intervention also focuses on teaching the individual a more socially acceptable behavior that will serve the same purpose as the problem behavior (e.g., requesting to leave a situation that provokes high anxiety, rather than resorting to aggression to be allowed to escape that situation). PBS includes Applied Behavior Analytic perspectives and interventions.

The primary goal of PBS interventions is to improve the quality of life of the individual so that he or she can experience (a) positive relationships with others, (b) a sense of personal agency through experiencing sufficient choice and control in their life, (c) positive status for positive contributions, and (d) improving competence in managing their daily life. The PBS approach includes direct educational strategies to help teach individuals the skills needed to achieve these quality of life goals. Creating positive environments also includes arranging the social environment so that caregivers reinforce pro-social behaviors and eliminate reinforcement for the challenging behaviors. PBS always eschews the use of aversive procedures as punishment, but may include those restrictive procedures necessary to protect the individual or others in a crisis situation.

Psychotherapy is an intentional relationship between a trained professional (therapist) and client with the express purpose of improving the client's mental health or helping the client better cope with emotional problems or problems of living. This arrangement can be undertaken by an individual, a couple, a family or a group. It is a special relationship between client(s) and a professional, who is trained and credentialed within his/her own discipline to provide non-medical treatment of mental and emotional problems.

Psychopharmacology. Pharmacotherapy is most commonly thought of as a form of treatment that involves medications and other biologically active compounds. Psychopharmacology is the use of drugs that affect the central nervous system in the treatment of both challenging behaviors and psychiatric disorders. Psychotropic drugs are usually classified in terms of their mechanism of action (serotonin reuptake inhibitions) or condition specificity (antidepressants or mood stabilizers). In general the effectiveness of a drug can be assessed based on best practices or evidence-based criteria. Best practices are those that are judged by fellow prescribers, experts and clinical practice as effective. Some of these standards may not meet the level of well designed randomized controlled double blind studies required for evidence-based medical criteria. A second issue is whether a drug is approved by the Food and Drug Administration (FDA). This is a long process that requires demonstrating the safety and efficacy of a new drug. The manufacturer seeks approval or indication for a specific syndrome (depression) or function (irritability among individuals with autism). For persons with IDD, there are many drugs that are not approved for a specific indication by the FDA. Their use is based on community best practices or in some circumstances

randomized controlled trials demonstrating their efficacy for a particular indication.

Informed consent is required in order to prescribe a drug to an individual. For individuals who are legally competent to make medical decisions this requires a thorough discussion of what the drug is being used for, efficacy, and safety of use and a review of pertinent side effects. For a person adjudicated as incompetent, informed consent requires approval by the guardian or parent for a minor. Assent by the recipient of the drug is needed in research studies and when possible before the medication is given.

Assessment of Medical Conditions. The brain behavior relationships that underlie both challenging behaviors and mental disorders are intimately connected to physical health and well-being. Medical illness can have a profound effect on brain functioning. These effects include: delirium (brain failure); worsening of pre-existing mental status change; target symptoms; or psychiatric symptoms; and emergence of new patterns of behavior that mimic mental disorders. Medication side effects or iatrogenic causes can create similar problems. The differential diagnosis of these complications can require an extensive medical or neurological workup.

Clinical Assessment is an examination into a person's mental health and symptomatology conducted by a professional who is trained and credentialed within his/her own discipline with the purpose of arriving at a mental health diagnosis or arriving at a formulation of an individual's problems. The expected outcome of a clinical assessment is to recommend relevant treatment, intervention and supports consistent with the findings of the examination.

It is recognized that applicants will have the greatest degree of competency in their specific area of interest, but a working knowledge of all areas is required.

(See Appendix for listing of Competency Benchmarks and Performance Indicators.)

APPLICATION PROCEDURE

Qualifications for a NADD-Clinical Certification (NADD-CC)

One (1) of the following is required:

- Licensure as an RN or a Master's degree in a field providing services to individuals with Intellectual & Developmental Disabilities and co-occurring behavioral health disorders with at least seven years of experience delivering clinical supports for persons with Intellectual & Developmental disabilities (IDD) and co-occurring Behavioral Health disorders.

- Five years of experience delivering clinical supports for persons with Intellectual & Developmental disabilities (IDD) and co-occurring Behavioral Health disorders and licensure or certification in at least one of the following areas of practice:

Psychologist, Physician, Medical Doctors (M.D.), Doctor of Osteopathic Medicine (D.O.) Bachelor of Medicine /Bachelor of Surgery (MBBS), Mental Health Counselor, Marriage & Family Counselor, Addictions Counselor, Licensed Clinical Social Worker; Physician's Assistant, Registered Nurses, Nurse Practitioner; Occupational Therapists (OT), Physical Therapist (PT), or other similar USA or Canadian equivalent clinical licensure or credentialing. Final determination of clinical equivalence and experience relevance resides with the NADD Competency-Based Certification Program.

- Five years' experience and licensure or certification as a Licensed Behavior Consultant, Board Certified Behavior Analyst, (BCBA), a Board Certified Assistant Behavior Analyst (BCaBA), or recognition by your State/Province as able to provide behavioral assessment and training (e.g., Behavior Analyst). Final determination of clinical

equivalence and experience relevance resides with the NADD Competency-Based Certification Program

- Primary teaching, training, or clinical supervision responsibilities in a post-secondary education or clinical supervision related to training toward the disciplines listed above with five years of directly related experience. (Please provide an explanation of relevant activities and experience.) Final determination of clinical equivalence and experience relevance resides with the NADD Competency-Based Certification Program.

In combination with:

The applicant must be able to thoroughly explain and demonstrate advanced expertise in at least one competency area and a general knowledge in the remaining competency as follows:

- Positive Behavior Supports and Effective Environment
- Psychotherapy
- Psychopharmacology
- Assessment of Medical Conditions
- Assessment

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

Ethical Behavior

Most disciplines, through their professional disciplinary association or governing body, have a Code of Ethics to which members are committed to follow. All applicants shall attest to following the ethical standards of their profession association as well as state, province, or national ethics and regulations. The applicant's signatures in the Ethical Behavior section of the application form and in the Principles section of the application form are required and shall denote the candidate's commitment to ethical behavior. Professional associations as discussed above must be recognized as an established, respected, and legitimate organization. Questions related to their standing will be determined by the NADD Competency-Based Certification Program if necessary.

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 licensed 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 Clinicians," below.)

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

NADD Membership

Clinicians 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 clinical certification. A NADD organizational membership may satisfy this requirement if the clinician 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 clinician would need the benefits of a NADD membership.

A NADD organizational membership may satisfy this requirement if the clinician is an employee of the organization which has a NADD membership.

Application

The application and supporting materials should be mailed to:

NADD Competency-Based Clinical Certification Program
132 Fair Street
Kingston, NY 12401

Application Check List

The following should be included in the application package:

- Completed application form
    - Sign Ethical Behavior statement
    - Sign 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 professional license
- 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 one work sample of a case that demonstrates clinical work with an individual who has a dual diagnosis. See Appendix C: Work Sample Guidelines. The work sample should be no more than five pages in length and should include these five competency areas:

1. Formulation/conceptualization of clinical problem(s)
2. Format for therapy or intervention
    a. What were the goals/expected outcomes for treatment or intervention?
    b. Other treatments that were considered and rejected.

   c. Why the selected treatment was chosen and why the rejected treatments were rejected.
   d. Were there modifications or adaptations of standard treatment protocol in order to meet the unique treatment needs of this individual? If so, briefly describe these modifications/adaptations.
3. Landmark events or salient issues that arose during the course of treatment and how these were addressed within treatment.
4. Reflection on issues within therapy and/or ethical concerns and/or issues relevant to cultural competency.
5. How the clinical approach was informed by an understanding of intellectual disability or dual diagnosis.

Prior to submission of the work sample, the applicant should review the work sample to verify that the submitted content includes consideration of each of the targeted areas.

NADD will assign two examiners to review to work sample. The work sample will be reviewed to determine whether the candidate demonstrates competency in the five competency areas. 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 shall be presented with a case vignette approximately 24-48 hours before the interview, about which he or she shall be asked to verbally offer his or her thoughts and reflections (i.e. provide a case formulation and treatment plan – case formulation is discussed in Appendix E). The interview is limited to one hour, and the applicant should prepare a vignette response of about ten minutes. The applicant must bring a copy of the work sample submitted in support of the application for Certification and a copy of the

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

vignette provided by NADD for the interview to the interview. 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
2. Resolution of specific questions arising from application materials
3. Discussion of clinical case summary submitted with application. This discussion can include all the elements of the outline in Appendix C as well as:
    a. Diagnostic process including medical rule out
    b. Assessment approach and considerations
    c. Psychotherapy considerations, approach, complications, and response
    d. *Positive Environment.* Role of environment in clinical considerations and recommendations for changes
4. Discussion of case vignette presented just prior to interview
    a. Applicant will be asked to present a case formulation
    b. Applicant should be prepared to present a treatment plan
    c. Respond to questions about case formulation and treatment plan
        i. These questions can cover any of the items in the outline in Appendix C
5. 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, analog functional analysis of medication effects, etc.
6. Review expectations, procedure, and timetable for certification process

Scoring and Evaluation

For both the work sample and interview, the applicant's competence in each of the five competency areas (Positive Environments; Psychotherapy; Psychopharmacology; Ruling Out Medical Issues; and Assessment) will be evaluated using the following scale:

0 = No evidence of competence in this area of Best Practice
1 = Insufficient evidence of competence in this area of Best Practice
2 = Evidence of baseline competence in this area of Best Practice
3 = Evidence of a high level of competence in this area of Best Practice

Candidates are required to demonstrate at least a baseline level of knowledge (a score of at least 2) in all competency areas. In the event that the two examiners cannot agree upon whether the candidate achieved a passing score (2-3) or a failing score (0-1), 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 $100 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.

MENTORING PROGRAM

NADD is pleased to introduce a Mentoring Program now available for clinicians interested in NADD Clinical Certification. Mentors are available to clinicians who have begun the certification process or are interested in applying who would like the support of a NADD certified clinician.

The NADD Clinical Certification Committee recognizes certification may appear to be a rigorous and thorough process. Applicants must reflect upon their professional skills and experience in written and verbal formats, and demonstrate competency and expertise in dual diagnosis. Clinicians at a stage of experience and competency to undertake the certification process, however, will find that the steps are very manageable and the certification well worth the effort.

Mentorship by a certified clinician provides a collegial bridge to help potential applicants assess their experience and readiness for certification. Mentors are a resource for support and information to help candidates identify areas of strength or needed competencies and skills.

Mentors can answer questions about the certification process, preparation of the work sample and the interview/exam. In view of their supportive role, it will not be possible for mentors to directly review a candidate's work sample or preparation of the vignette formulation.

Working with a mentor is optional on the part of NADD-CC candidates. Mentorship can be done in person, by phone or e-mail.

Contact the NADD office to request a mentor.

Cost

The cost of the NADD Competency-Based Certification is $375.00. A non-refundable application/exam fee of $375.00 must accompany the application package.

The NADD Competency-Based Certification is good for two years. The renewal cost is $100.00.

CONTINUING CERTIFICATION

Requirements to Maintain Clinical Certification

Once a clinician has received NADD Competency-Based Certification, the clinician 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 Clinicians).

Renewing Certification

Once a clinician has received NADD Competency-Based Clinical Certification, the clinician must maintain the certification status by renewing certification every two years.

Approximately three months before the clinician's certification is scheduled to expire, NADD will send the clinician 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 certified clinicians shall obtain 10 hours of ongoing education and training every 2 years in areas related to Mental Wellness and Mental Health for persons with IDD. The competency areas listed previously are potential content areas for this ongoing education, but 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. Providing training on this topic to others or publishing on this topic is also acceptable for this purpose.

All certified clinicians shall obtain 10 hours of ongoing education and training every 2 years in areas related to Mental Wellness and Mental Health for persons with IDD.

One hour of ongoing education and training is equivalent to 60 minutes of instructional time, exclusive of breaks, lunches, or homework time. Providing training on appropriate topics will earn ongoing education and training hours for the purpose of continuing certification at a rate of twice the clock hours involved in presenting the training. For example, the clinician providing a 60 minute acceptable training would earn two hours of ongoing education and training credit. An article in a professional journal or a chapter in a published book that is on an appropriate topic may count as 10 hours of training. The article or chapter must have been published within the last two years (i.e., since either the applicant originally received or most recently renewed his or her NADD Competency-Based Clinical Certification).

It is the responsibility of the applicant to provide verifiable information of the training received, training provided, and publication to be considered for continuing education credit. For example, an applicant must provide the date, topic, sponsoring or training organization, trainer, and number of hours for each continuing education claimed. Information about the location, sponsor, topic of training, date, may be submitted as verification of training offered. Publication information such as publication date, book or journal name, article or chapter title, and page numbers may serve as verification of publication.

CONDITIONS THAT MAY RESULT IN CERTIFICATION REVOCATION

The NADD Clinical Competency Based Certification may be revoked for:

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

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

Once a certification has been revoked, a clinician 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 clinician whose certification is 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 CLINICIANS

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

Ethics Review – Clinical Certification
NADD
132 Fair Street
Kingston, NY 12401

When a complaint is received, the NADD-certified clinician will be immediately notified and asked to respond to the complaint in writing. The clinician 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 clinician'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, nor do any governmental or regulatory entities currently require certification. 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:
Positive Behavior Support and Effective Environments

OVERVIEW

Positive Environments is a term that reflects the emphasis of the field of Positive Behavior Support (PBS). Individuals with dual diagnosis often have multiple factors effecting the presentation of their challenging behaviors (i.e., symptoms). While PBS cannot cure underlying biological bases for mental illnesses, it has been shown that it can reduce the behaviors of concern for those who have mental health conditions. PBS does this by first identifying those factors that predict and trigger challenging behaviors (e.g., those environmental variables that cause heightened anxiety; the presentation of a request to engage in an activity that is considered aversive by the person). This process is called Functional Behavioral Assessment. First, PBS interventions are targeted to those identified variables to design positive environmental conditions that reduce, remove, or modify those variables known to trigger challenging behaviors. The Functional Behavioral Assessment also identifies the function, or purpose of the challenging behavior. Intervention also focuses on teaching the individual a more socially acceptable behavior that will serve the same purpose as the problem behavior (e.g., requesting to leave a situation that provokes high anxiety, rather than resorting to aggression to be allowed to escape that situation). PBS includes Applied Behavior Analytic perspectives and interventions.

The primary goal of PBS interventions is to improve the quality of life of the individual so that he or she can experience: (a) positive relationships with others, (b) a sense of personal agency through experiencing sufficient choice and control in their life, (c) positive status for positive contributions, and (d) improving competence in managing their daily life. The PBS approach includes direct educational strategies to help teach individuals the skills needed to achieve these quality of life goals. Creating positive environments also includes arranging the social environment so that caregivers reinforce pro-social behaviors and eliminate reinforcement for the challenging behaviors. PBS always eschews the use of aversive procedures as punishment, but may include those restrictive procedures necessary to protect the individual or others in a crisis situation.

AREAS OF KNOWLEDGE AND SKILL

The following areas of knowledge and skill have been identified as benchmarks for satisfying Competency Standard 1: Positive Behavior Support and Effective Environments.

Benchmark 1A: Performing a comprehensive functional behavioral assessment
Benchmark 1B: Understanding positive intervention practices

BENCHMARK 1A: Assessment Practices

The qualified clinician demonstrates knowledge about the factors involved in performing a comprehensive functional behavioral assessment that addresses all relevant aspects of the person's social environment and those aspects of their internal/ physiological (medical and mental health disorders and rule-out conditions) into an assessment of the predictors and reasons (functions) for problem behavior.

Benchmark 1A Performance Indicators

In the area of Assessment Practices, the qualified clinician:

- Demonstrates the ability to operationally define the problem behaviors and assess their frequency and intensity/severity.
- Demonstrates use of data and other data collection methods (informant interviews, record reviews, observation, etc.) in order to identify the setting and antecedent factors that appear to predict the problem behavior(s).
- Describes the potential multiple causes of challenging behaviors.
    - Demonstrates an understanding of medical or mental health disorders that may act as setting events and/or antecedents, and prescribes actions needed to rule out potential medical/mental health conditions, if relevant.
    - Understands and recognizes Behavioral Phenotypes (characteristic behaviors associated with genetic syndromes), when relevant.
    - Differentiates differentiate internal vs. external triggers to behavior (i.e., Respondent vs. Operant process; e.g., trauma

issues, anxiety disorders, etc. vs. task demands), when relevant.

- Communicates the results of the functional behavioral assessment clearly in written form (e.g., in a Summary Statement or similar form).
- Includes the person and all other relevant stakeholders in the assessment process and in the planning for behavior supports.

BENCHMARK 1B: Positive Intervention Practices

The qualified clinician demonstrates skill in planning and carrying out Positive Intervention Practices.

Benchmark 1B Performance Indicators

In the area of Positive Intervention Practices, the qualified clinician:

- Makes clear how the behavior support strategies are based on the results of the functional behavioral assessment.
- Creates a comprehensive (multi-component) treatment plan for the person.
    - Identifies needed social/emotional and other quality of life supports for a person and integrates them into a treatment plan.
    - First identifies strengths and works from a strength-based, individualized, and Person-Centered perspective.
    - Utilizes specific procedures that will prevent the challenging behavior, drawn from the antecedent events identified in the functional assessment.
    - Plans how identified triggers and setting event factors will be avoided, minimized or modified in order to reduce the likelihood of the challenging behavior(s).
    - Identifies environmental adaptations/ supports for the person.
    - Identifies needed medical and mental health evaluations and/or supports/ treatments for the person.
    - Understands the role of communication and communication disorders in supporting persons with ID/MI.

  - Identifies instructional/skill building supports for the person to address identified skill deficits and to teach functionally equivalent replacement behaviors.
  - Identifies specific consequence strategies to reinforce positive behaviors, including the replacement behavior and avoiding or minimizing the reinforcement of problem behavior.
  - Identifies crisis management procedures to use in case the person engages in problem behavior.
- Demonstrates an understanding of the developmental stage of the person and prescribes strategies that are developmentally appropriate for the person (i.e. not setting expectations too high or to low for the person's current abilities).
- Avoids relying on restrictive procedures**,** and if necessary for protection from harm, uses the least restrictive procedure necessary to insure protection.
- Eschews aversive (procedures that cause physical pain or emotional distress) and demeaning procedures (i.e., demeaning or dehumanizing —for a teen or adult, using techniques commonly used with children; being overly controlling, etc.
- Demonstrates knowledge of the professional literature on the use of Positive Behavior Supports (e.g., by the AAIDD, APBS, The Arc, or other state/province and local organizations).
- Demonstrates knowledge of lifespan and development as related to positive environments.

References:

Positive behavior support for people with developmental disabilities: A research synthesis. By Edward G. Carr, Robert H. Horner, et al., 1999 - The Research and Training Center on Positive Behavioral Support. Washington, D.C.: American Association on Mental Retardation Monographs.

APBS Standards of Practice, Association for Positive Behavior Support Website, at: http://www.apbs.org/standards_of_practice.html

COMPETENCY STANDARD 2:
Psychotherapy

OVERVIEW

Psychotherapy is an intentional relationship between a trained professional (therapist) and client with the express purpose of improving the client's mental health or helping the client better cope with emotional problems or problems of living. This arrangement can be undertaken by an individual, a couple, a family or a group. It is a special relationship between client(s) and a professional, who is trained and credentialed within his/her own discipline to provide non-medical treatment of mental and emotional problems.

AREAS OF KNOWLEDGE AND SKILL

The following areas of knowledge and skill have been identified as benchmarks for satisfying Competency Standard 2: Psychotherapy.

Benchmark 2A: Psychotherapy Assessment
Benchmark 2B: Plan for Psychotherapeutic Intervention

BENCHMARK 2A: Psychotherapy Assessment

The qualified clinician demonstrates a comprehensive assessment strategy that addresses the full array of factors that may be relevant to the individual's clinical presentation. In broad terms, the clinician gives thought to the following three key domains: (1) Bio/Medical; (2) Psychological; and (3) Social/Family.

Benchmark 2A Performance Indicators

In the area of Psychotherapy Assessment, the qualified clinician:

- Considers Bio/Medical factors
  - Suspected or Known Medication Side Effects
  - Suspected or Known Medical Illness
  - Suspected or Known Medical Conditions, including, but not limited to, the following conditions commonly associated with behavioral/psychiatric presentation: seizure disorders or

pre-seizure irritability, sleep apnea, otitis media, blocked shunt, migraine headaches, menstrual/premenstrual problems, dental problems, and thyroid problems.

- Considers Psychological factors
  - Premorbid Personality
  - History of Presenting Problem/Symptom
  - Communication Difficulties
  - Life Events/Stressors: phase-of-life change; loss of significant other; abuse; rejection; victimization; accidents, illness, disability.
- Considers Social/Family factors
  - Family Structure/System Dynamics
  - Bereavement/Loss
  - Change: some common examples include: a new boss, a new group home manager, new work assignment, a move, a sibling getting married.
- Communicates the results of the assessment in written form (e.g., in a Summary Statement or similar form)
- Includes the person and all other relevant stakeholders in the assessment process.

BENCHMARK 2B: Plan for Psychotherapeutic Intervention

The qualified clinician demonstrates skill in planning for psychotherapeutic intervention.

Benchmark 2B Performance Indicators

In the area of planning for psychotherapeutic intervention, the qualified clinician:

- Identifies what assessment tool(s) were used in the development of the plan.
- Provides a diagnosis or diagnoses, if appropriate, and indicates how they are supported by assessment findings.
- Makes clear how the proposed therapy relates to the assessment.
- Provides a rationale for his or her choice of therapeutic intervention that evidences awareness of the individual's needs as well as strengths.

- Notes the need for referral to other services, in addition to psychotherapy, that might be critical to the individual's maximal well-being (for example, social support through recreational services, or evaluation by a psychiatrist for medication issues).
- Notes the need for reporting of suspected abuse, where indicated.
- Recognizes the possible need for multi-modal intervention (for example, the use of a positive behavioral support plan including training for caregivers, along with individual or group psychotherapy).
- Notes possible suicide risks where relevant.
- Demonstrates knowledge of lifespan and development as related to psychotherapeutic intervention.

References:

Bradley, E. & Burke, L. (2002). The mental health needs of persons with developmental disabilities. In D.M. Griffiths, C. Stavrakaki, & J. Summers (Eds.), *Dual diagnosis: An introduction to the mental health needs of persons with developmental disabilities* (pp. 45-79). Ontario, Canada: Habilitative Mental Health Resource Network.

O'Hara, J. (2007). Inter-disciplinary multi-modal assessment for mental health problems in people with intellectual disabilities. In N. Bouras & G. Holt (Eds.) *Psychiatric and behavioral disorders in intellectual and developmental disabilities* (pp. 42-61). Cambridge, UK: Cambridge University Press.

Summers, J., Stavrakaki, C., Griffiths, D.M., & Cheetham, T. (2002). Comprehensive screening and assessment. In D.M. Griffiths, C. Stavrakaki, & J. Summers (Eds.), *Dual diagnosis: An introduction to the mental health needs of persons with developmental disabilities* (pp. 151-192). Ontario, Canada: Habilitative Mental Health Resource Network.

COMPETENCY STANDARD 3:
Psychopharmacology

OVERVIEW

Pharmacotherapy is most commonly thought of as a form of treatment that involves medications and other biologically active compounds. Psychopharmacology refers to the use of drugs that affect the central nervous system in the treatment of both challenging behaviors and psychiatric disorders. Psychotropic drugs are usually classified in terms of their mechanism of action (serotonin reuptake inhibitions) or condition specificity (antidepressants or mood stabilizers). In general the effectiveness of a drug can be assessed based on best practices or evidence-based criteria. Best practices are those that are judged by fellow prescribers, experts and clinical practice as effective. Some of these standards may not meet the level of well designed randomized controlled double blind studies required for evidence-based medical criteria. A second issue is whether a drug is approved by the Food and Drug Administration (FDA). This is a long process that requires demonstrating the safety and efficacy of a new drug. The manufacturer seeks approval or indication for a specific syndrome (depression) or function (irritability among individuals with autism). For persons with IDD, there are many drugs that are not approved for a specific indication by the FDA. Their use is based on community best practices or in some circumstances randomized controlled trials demonstrating their efficacy for a particular indication.

Informed consent is required in order to prescribe a drug to an individual. For individuals who are legally competent to make medical decisions this requires a thorough discussion of what the drug is being used for, efficacy, and safety of use and a review of pertinent side effects. For a person adjudicated as incompetent, informed consent requires approval by the guardian or parent for a minor. Assent by the recipient of the drug is needed in research studies and when possible before the medication is given.

AREA OF KNOWLEDGE AND SKILL

The following area of knowledge and skill has been identified as a benchmark for satisfying Competency Standard 3: Psychopharmacology.

BENCHMARK 3: The Use of Psychotropic Medication

Psycho-pharmacotherapy is adjunct to already established therapies. These include behavioral, family, and individual psychotherapy. When possible, medications should be used in a time limited basis and polypharmacy minimized. Drug selection should be based on the best available evidence (FDA approved indications), best practice standards for that drug, and a careful risk -benefit analysis.

Benchmark 3 Performance Indicators

The qualified clinician should demonstrate working knowledge of the following elements in their consideration of the use of psychopharmacological intervention.

- A thorough past and current medical history; medical, neurological, mental status examination, baseline laboratory studies, and neuro-diagnostic testing when appropriate. These studies should be repeated on at least a yearly basis if there are no adverse medication effects.

- Effective drug monitoring requires the integration of the psychiatric assessment, functional behavioral analysis, and information from family, caregivers, and other sources to monitor response. Decisions regarding efficacy should be based on a combination of rating scales, clinical assessment by the prescriber, and data-driven monitors of selected target symptoms.

- Side effects assessment by a trained clinician, considering appropriate serum drug levels, laboratory monitors of potential adverse drug effects (liver, cardiac, neurological and renal complications). Drug-drug interactions should be reviewed with team members and polypharmacy should be kept to a minimum. This includes non psychotropic medications by other physicians or health care providers.

- A mechanism for timely communication and action plan for dealing with adverse medication side effects. Life threatening side effects should be treated as a medical emergency or reviewed as soon as possible by the prescriber or team nurse.

Any side effects, additional assessment, and treatment plan should be recorded in the progress notes.

- Based on ICF-MR regulations, the treatment team is required to review all psychotropic medications at regular and emergency team meetings. The team should discontinue or replace ineffective medications, those with significant adverse events, and determine the risk-benefits of continued use of an effective medication. For persons with severe mental disorders such as bipolar disorders, recurrent depression, or schizophrenia this decision should be based on the severity of symptoms, outcome of past attempts, and understand the risk factors for relapse and loss of drug effects with more frequent episodes.

- Ineffective medications should be tapered under close supervision. Cross tapers include a protocol for replacing ineffective drugs. This process should also be data driven either through the behavioral plan or based on ongoing assessment and measures of efficacy. Because many medication side effects can mimic symptoms of a mental disorder or create an exaggeration in existing baseline rates of target behaviors the team should be vigilant to unexpected changes.

- Demonstrates knowledge of lifespan and development as related to use of psychopharmalogical intervention

References

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COMPETENCY STANDARD 4:
Assessment of Medical Issues

OVERVIEW

The brain behavior relationships that underlie both challenging behaviors and mental disorders are intimately connected to physical health and well-being. Medical illness can have a profound effect on brain functioning. These effects include: delirium (brain failure); worsening of pre-existing mental status change; target symptoms; or psychiatric symptoms; and emergence of new patterns of behavior that mimic mental disorders. Medication side effects or iatrogenic causes can create similar problems. The differential diagnosis of these complications can require an extensive medical or neurological workup.

Being aware of these conditions can improve the quality of life for many individuals with IDD. It can also be helpful in minimizing psychiatric misdiagnosis and inappropriate pharmacotherapies.

The candidate may be the first to encounter such changes and needs to be able to recognize common medical/neurological sources of mental status change. The medical provider in concert with the treatment team can use this information to begin the clinical assessment, refer to an outside specialist or in the case of an emergency refer for acute medical care.

AREAS OF KNOWLEDGE AND SKILL

The following areas of knowledge and skill have been identified as benchmarks for satisfying Competency Standard 4: Assessment of Medical Conditions

BENCHMARK 4: Assessment of Medical Issues

The qualified clinician demonstrates knowledge about the connection between physiological or neurological disorders and behavioral problems or psychiatric symptoms.

Benchmark 4 Performance Indicators

The qualified clinician:

- Understand that medical and neurological disorder can mimic any primary mental disorder

- Demonstrate knowledge of common causes of cognitive/behavioral changes or the intensification or emergence of symptoms similar to those seen in primary mental disorders, including:

    - Rapid changes in level of consciousness behavior can occur in association with a seizure, stroke or brain injury. It is important to be aware of a history of past seizures, current seizure medications, and side effects of these drugs. Abrupt changes can be related to stroke or intra-cerebral bleeding. A recent head injury, past history of stroke, paralysis, difficulty understanding or speaking, disorientation, and confusion are common symptoms. Brain tumors are rare but shunt failure in someone with hydrocephalus or degenerative disorders such as Parkinson's may present over an extended period of time

    - Elevated blood sugar and diabetic ketosis, electrolyte problems, acute oxygen deprivation and liver failure are suspected when an individual has a current history of diabetes, kidney problem, liver disease, and chronic lung disease.

    - Older individuals with Alzheimer's, vascular (stroke-related), and other types of dementia are at increased risk for agitation, aggression, and acute onset of psychosis. Vitamin B12 and folic acid deficiencies are associated with dementia, mood and anxiety disorders, and psychosis in some extreme cases.

    - Thyroid and other endocrine disorders can present with the gradual onset of mood and anxiety related symptoms. Lethargy, depressed mood, and loss of interest in activities due to hypothyroidism are common and may be exacerbated by some medications like lithium. Premenstrual changes in mood and behavior can be particularly vexing to sort out and the cyclical

changes in symptoms can be mistaken for bipolar disorder or recurring depression.

- Sleep apnea can contribute to chronic mood and cognitive disorders, high blood pressure, worsening diabetes, and heart disease. Obesity and anatomical changes seen in Down syndrome are risk factors. Children with enlarged adenoids and tonsils can also present with sleep apneas as well as worsening of hyperactivity, agitation, irritability, and in some situations increased self-injury and aggression.

The candidate is not expected to make diagnoses but to have an elevated index of suspicion for their presence. These observations and suspicions should be raised with the treatment team and appropriate work up put in motion. The most common medical complications are generally due to polypharmacy, medication side effects, or errors in dosing.

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COMPETENCY STANDARD 5:
Assessment

OVERVIEW

Clinical Assessment is an examination into a person's mental health conducted by a professional who is trained and credentialed within his/her own discipline with the purpose of arriving at a mental health diagnosis or arriving at a formulation of a person's problems. The expected outcome of a clinical assessment is to recommend relevant treatment, intervention and supports consistent with the findings of the examination.

AREAS OF KNOWLEDGE AND SKILL

The following areas of knowledge and skill have been identified as benchmarks for satisfying Competency Standard 5: Assessment.

Benchmark 5A: Recognizing the challenges of making an accurate assessment in individuals with co-occurring intellectual disability and mental illness.
Benchmark 5B: Knowledge of tools/instruments and strategies for making an accurate assessment in individuals with co-occurring intellectual disability and mental illness
Benchmark 5C: Understanding of the uses of assessment.

BENCHMARK 5A: Recognizing the Challenges of Making an Accurate Assessment

Benchmark 5A Performance Indicators

In the area of Challenges of Making an Accurate Assessment, the qualified clinician:

- Recognizes the special challenges in clinical assessment of individuals with intellectual disability and understands that limited communication and information processing problems will affect individuals' ability to self-report.

- Utilizes appropriate strategies to assess an individual who has limited verbal ability or who is non-verbal.

- Demonstrate an ability to include information from observation, direct assessment of the individual, and collateral sources of information into his/her assessment protocols.
- Demonstrate an appreciation of cultural factors impacting upon the assessment process.
- Demonstrate an appreciation of the multi-disciplinary nature of comprehensive clinical assessment.

BENCHMARK 5B: Knowledge of Tools/Instruments and Strategies

Benchmark 5B Performance Indicators

In the area of Tools/Instruments and Strategies, the qualified clinician:

- Demonstrate a working knowledge of the *DM-ID.*
- Demonstrate knowledge of specific tools/instruments and strategies that have been used in examination of individuals with intellectual disability.
- Understands the limitations in using tools/instruments and strategies that are used for the general population and have not included individuals with intellectual disability within the normative sample.
- Can identify an instrument or strategy to identify children (or adults) as being on the spectrum and is aware of the tools that are used for early identification of spectrum disorders.
- Can identify at least one test used to assess emotional functioning developed for individuals with intellectual disability and mental health needs.

- Can identify at least one adaptive behavior screening used to profile adaptive skills for our population of interest.
- Can identify at least one tool/instrument/strategy used to identify cognitive decline in individuals with intellectual disabilities suspected as having dementia.

BENCHMARK 5C: Understanding the Uses of Assessment

Benchmark 5C Performance Indicators

In the area of Uses of Assessment, the qualified clinician:

- Understands how guardianship status is assessed in persons with intellectual disability and mental health needs.
- Can identify other special instances in which clinical assessment of individuals with intellectual disability might be requested, including:
    - Forensic assessment
    - Eligibility for entitlements
    - Competency
    - Treatment recommendations
    - Recommendations for level of support

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Clinical Certification

Appendix B

The NADD Competency-Based Clinical 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. License or Credential to Practice

You must have (1) a state or provincial license as indicated below, or (2) a credential from a professional governing body entitling you to practice in your discipline, or (3) hold a Master's degree in a related field or be a Registered Nurse. Please select from the list below, and provide the requested information about which state, province or professional governing body issues the license or credential, the license or credential number, and its expiration date.

1. **License**. I hold the following state or provincial license *(Please attach a copy of your license or certification.)*:

    [ ] Doctoral level psychologist (Ph.D., Psy.D., Ed.D.)
    [ ] Physician
    [ ] Licensed Clinical Social Worker
    [ ] Master's level Mental Health Counselor
    [ ] Master's level Marriage & Family Counselor
    [ ] Master's level Addictions Counselor
    [ ] Physician's Assistant, Advanced Practice RN, or Nurse Practitioner (or clinical equivalent). Please specify: _____
    [ ] Other, please specify: _____

2. **Certification.** I hold the following certification (*Please attach a copy of your certification)*:

    [ ] Board Certified Behavioral Analyst (BCBA)
    [ ] Applied behavior Analyst
    [ ] Other, please specify
    _____

3. **Master's in Related Field or R.N.**.

    [ ] I hold a Master's degree in a related field*.
    Specify: _____
    [ ] I am an RN* (please provide license information above)

    (**On a separate page, please provide details of your work with individuals who have a dual diagnosis*.)

License/Credential Information:

State or Province: _____

License Number: _____

Professional Governing Body: _____

Credential/Number: _____

Expiration Date: _____

III. Experience

You must have 5 years of experience in support of persons with intellectual disabilities and mental health issues. This can include internships and externships. For applicants with a related Master's degree or an RN, 7 years is required.

How many years of experience do you have working with persons with intellectual 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

On a separate page, please provide the details of any past or pending lawsuits or disciplinary events.

Affirmation of Ethical Behavior

All candidates for the NADD Competency-Based Clinical Certification are required to affirm their commitment to ethical professional behavior.

Most disciplines, through their professional disciplinary association, have a Code of Ethics to which members are committed to follow. For example, social workers may be members of the National Association of Social Workers (NASW), and NASW has a clearly articulated Code of Ethics. Similarly, psychologists may be members of the American Psychological Association and psychiatrists may be members of the American Psychiatric Association, both of which have clearly articulated Codes of Ethics. Canadian professionals are similarly bound by their respective professional associations.

By my signature, I affirm that:

I uphold the Code of Ethics of my disciplinary association
.

Discipline: _____ Disciplinary Association_____

Signed: _____ Date: _____

Principles

All candidates for the NADD Competency-Based Clinical Certification commit themselves to the following principles:

- Clinicians discharge their responsibilities in accordance with standards of practice in their field.
- Clinicians recognize the collaborative nature and unique role of the interdisciplinary team in providing quality services for individuals with intellectual/developmental disabilities and mental illness
- Clinicians respect the inherent dignity and worth of the individual.
- Clinicians strive to ensure that services are culturally relevant to the individuals receiving services.
- Clinicians build on the strengths and capabilities of individuals.
- Clinical 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.
- Clinical services promote self-determination and empowerment.
- Clinicians uphold professional standards of conduct and accept appropriate responsibility for their behavior.
- Clinicians maintain their professional independence and avoid situations of conflict of interest that may affect or may affect the discharge of their clinical responsibilities towards the individuals who receive their services.
- Clinicians take measures to resolve real and apparent conflicts of interest.
- Clinicians 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.
- Clinicians 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.
- Clinicians 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
132 Fair Street
Kingston, NY 12401-4802

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

I. Introduction (.5 page)
II. Biopsychosocial approach (.5 page)
III. Formulation of problem(s) (.5 page)
IV. Assessment(s) used
V. Structure of clinical intervention (.75 page)
VI. Course of Treatment (1 page)
VII. Termination and treatment outcomes (.5 page)
VIII. Reflections on issues within clinical approach or ethical concerns (.5)
IX. How was clinical approach informed by an understanding of intellectual disability or co-occurring disorder? (.75 page)
X. Citation of at least two works (2 journal articles, 2 books, 1 article and 1 book) (.25 page)

The work sample should be no more than 5 – 7 pages double-spaced and should be 12-point font, Times New Roman. Work samples exceeding 7 pages may be returned to the applicant for revision. The citations/references do not count toward the page limitation.

The work sample should include the following elements:

- The initial portion of the sample should include:
  - Identifying information regarding the person that presents person's characteristics
  - Description of the practice setting (private practice, clinic, etc.)
  - Referral information: John Doe was referred for counseling by XXX to address signs and symptoms of depression; John Doe was self-referred to develop his coping with the recent death of his mother, etc.
  - A brief description of the clinician's theoretical orientation and how it is tied into the approach to treatment.
- Relevant background information including the nature of the person's intellectual and/or developmental disability as these might impact upon the treatment arrangement or format for work. Relevant biopsychosocial background should be noted. For instance, was the person previously diagnosed with a mental health disorder and on a therapeutic medication

regimen when therapy began? Has the person had previous experience with therapy? Has the person previously been hospitalized? If other team members were involved, please identify who they were and how the applicant worked with other team members/disciplines.

- Structure/format for intervention:
    - How is the applicant conceptualizing the presenting problem?
    - What were the goals/expected outcomes for treatment?
    - How was your specific intervention structured; including the length and type (e.g. weekly supportive psychotherapy or monthly behavior observations)?
    - What techniques were used? What was the rationale for choice of approach? What was the person's response?
    - Alternate interventions/clinical approaches that were considered and rejected, if applicable
    - Detail interventions which did not work, if applicable, with explanation.
    - What other resources were needed?
    - The justification for rejecting or adopting each intervention as applicable
- Characterize the course of the treatment; Landmark "events" or salient issues that arose during the course of treatment and how these were addressed. Was the person hospitalized or go into crisis during the course of treatment?
- Detail any ethical issues that arose and how they were addressed during treatment.
- What was the reason for termination of treatment/treatments (if the case is closed) and how was termination handled? Did the person reach the goals/expected outcomes? If not, why not? Were alternatives discussed upon termination, such as continuation with another clinician, another modality, or maintenance treatment?
- Any reflection regarding the unique challenges of the person, in terms of intellectual disability or other developmental disorder, that affected the course of clinical approach? In other words, were there any modifications/adaptations in approach, use of assignments, etc., that would characterize this as a specialty practice?
- Citation of at least two journal articles within the past 5 years regarding treatment of people with a dual diagnosis.

If the work sample reflects the efforts of a team, the candidate should clarify and highlight the role and contributions of each team member along with the candidate's specific contributions to the work sample.

Appendix D

NADD Competency Based Clinical 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 clinical skills, knowledge, values, and level of competency concerning the provision of clinical 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 Clinical 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 clinical 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 clinician working with individuals who have a dual diagnosis
5. Please indicate any potential concerns regarding professional certification of this individual

Appendix E

Vignette Response/Case Formulation

Twenty four to forty eight hours before the certification interview, the applicant will be presented with a case vignette. During the interview he or she will be asked to offer his or her thoughts and reflections about the case (i.e. provide a case formulation and treatment plan).

One definition of case formulation is *'Case formulation aims to describe a person's presenting problems and use theory to make explanatory inferences about causes and maintaining factors that can inform interventions'.* What this means is that it is essentially a story not just to describe, but *explain*, how a person's problem has developed, and how it is maintained so that treatments can be based on influencing those factors.

There are many different frameworks for case formulation, but several key elements are usually present:

1. a description of the presenting issues;
2. the factors that act to create vulnerability or precipitate the problems developing;
3. factors that may not have been involved in the initial problem developing, but are helping to maintain the problems; and finally,
4. factors that can help the person cope or act as resources.

To move beyond just *describing these factors,* a case formulation should **describe the relationships between these various factors and the problems that are present** – and should reflect not just the visible features of the problem (ie what we can see, or what the person reports that are unique to his or her situation), but also the underlying phenomena or stable, recognizable features that are present.

Since the interview is limited to one hour, applicant should prepare a vignette response of about ten minutes.

Sources

An introduction to case formulation. Retrieved from http://healthskills.wordpress.com/2008/09/25/an-introduction-to-case-formulation/ September, 2012

O'Brien W.H., Collins A., Kaplar M., (2003). Case formulation. In Fernandez-Ballesteros R. (Ed), *Encyclopaedia of psychological assessment,* 2, 1008-1011. London: Sage.

Persons, J. B., & Tompkins, M. A. (1997). Cognitive-behavioral case formulation. In T. D. Eells (Ed.). *Handbook of psychotherapy case formulation,* 290-316. New York: Guilford Press.

Appendix F

Examples of Work Samples

Work Sample 1

Introduction: ZZ is a 24 year old male with Autistic Spectrum Disorder and mild/moderate IDD. In 1999, he was referred to the Developmental Neuropharmacology Clinic by his primary care physician secondary to increasing bouts of moodiness and explosive aggressive behaviors. ZZ was diagnosed with autism and mild! moderate IDD at age 3 and entered a 2 year course of Discrete Trial Learning. He made and sustained considerable gains in language, adaptive behaviors and social relatedness. Residual symptoms include: persistent pronominal reversals, dysprosodic speech, cognitive and reduced behavioral flexibility and spontaneous, reciprocal social communications. There was no history of physical or sexual abuse.

Past Medical History: Transient periods of moodiness, irritability and periods of aggressive behavior began during early childhood. By the time of his referral, there was an intensification of symptoms consistent with bipolar depression. During these mood downswings ZZ became preoccupied with deceased relatives and there was a significant increase in his ritualistic and perseverative behaviors. By age 14 mood upswings emerged characterized by (1-2 days) episodes of decreased sleep time without fatigue, marked increases in irritability; explosive

temper outbursts; aggressive behaviors directly mainly at his mother; property destruction; but no self-injury. Initially loss of major life transitions seemed to trigger these upswings, but over a period of 5 years, mood changes occurred without obvious external triggers

Psychosocial History: ZZ was the product of an uncomplicated pregnancy, labor, delivery and early infancy. There were delays in early developmental motor milestones and social/emotional relatedness; verbal reciprocity; imaginative and social play; and restrictive/repetitive behaviors. At age 7, the family moved to NC. The transition was difficult initially but ZZ eventually adapted to his new environment and school placement. According to his parents noted that ZZ grew increasingly preoccupied with reciting birthdays and specific good experiences prior to their move from Pennsylvania. Interpreted as grief or stress mediated, these pre-occupations never interfered with daily activities or baseline mood, social relationships, or behavioral issue. ZZ attended public schools in a blended program, splitting time between classrooms for children with autism and mainstreaming for art, music and physical education. Throughout elementary and high school ZZ acquired a group of friends (mostly female) who "adopted him" (his mother's term).

His first major depressive episode began following the death of his maternal grandmother in 2004. ZZ withdrew socially, increased his ritualistic behaviors, apathy and near catatonic immobility, food refusals, persistent dysphoria and aggressive behaviors. These progressively worsened prompting a psychiatric hospitalization in March 2004. Within 3 days of his admission ZZ abruptly switched to a phase of severe aggression, irritability, hyperactivity, sleep phase delay and intense violent and destructive behavior towards unit staff and other young people. At that point his inpatient team started Vaiproic acid and risperidone. He stabilized on this combination and was discharged home.

Formulation: Illness, death, social transitions and seasonal changes are major triggers for mood changes. There is also a positive family history of mood disorders in both lineages (at least three generations), but none for IDD, or other genetic disorders linked to ASD. ZZ is at high risk for mood disorders. Early on complicated grief or stress-induced mood changes dominated his clinical picture. Graduating from high school was a major transition for ZZ, representing a loss of many structured activities, social contacts and a setting where he was a "celebrity". Shortly after graduation his obsessions increased (a stress marker) but he did not develop significant mood changes in large part due to mood stabilizers and an effective transition plan.

Family system issues impacted ZZ's transition to young adulthood. His parents (both parents are in their early 60's) struggled with long term planning and consideration of eventual out of home placement. It appeared that their attachment needs; genetic guilt over ZZ's autism and mood disorder and episodic depressions parents compound their ambivalence. Both parents are also anxious about my eventual retirement, raising interesting transference issues.

Structure of Therapy:

Currently I work with ZZ, his mother and father (when available) and his case worker/job coach. He is seen on a monthly basis for medication monitors and family/cognitive therapies.

Course of Treatment:

Working diagnoses are Autism, mild/moderate IDD and bipolar disorder (BD). BD is a relapsing-recurring condition that is intertwined with the developmental course of autism and mild/moderate IDD. Much of my work focuses on clarifying trigger factors (losses) and establishing a sequence of symptom progression to predict relapse. As a part of this strategy, we work on multiple relapse

prevention strategies and use his second generation antipsychotic episodically to avert symptoms progression and re-hospitalization. These monthly medication reviews, lab tests, physical exams became part of the psychotherapeutic regimen. These medical interventions serve as a focus for other therapeutic interventions.

His only psychiatric hospitalization at age 17 was traumatic for ZZ. On rare occasions his parents remind ZZ of the conditions that prompted that admission. This "aversive" intervention is followed by a reminder to run his relaxation programs. With a lot of support, they are fading this approach, creating ethical issues discussed below. Treatment and stabilization of his BD is critical. Valproic acid has been helpful in dampening his cycles but has not terminated them. He does have a prolonged interepisode interval (about 5 years between major bipolar mood cycles), raising questions about continuous medication use. I use short term risperidone during periodic, time limited mood upswings. Routine monitors include CBC/diff, liver function studies, basic lipid panels, Hgb Ale, thyroid profile and Vitamin D. Even though these levels are normal, long term risks remain. He is routinely monitored for EPS, akathesia and druginduced dyskinesia for 6 months surrounding each periods of antipsychotic use. ZZ is involved in multiple community activities. His case worker/job coach is quite

active in both ZZ's "job" (backing cookie for a college campus shop) and community activities. There is a nagging worry about the wisdom of an overweight young adult taking meds that stimulate appetite working in a bakery. Thus far weight stable and there is no evidence of metabolic syndrome or type II diabetes. His case manager/job coach is actively working to increase his nonfood related social activities and closely monitors dietary preferences. His job coach initiated an exercise program that ZZ seems willing to follow.

Ethical Issues:

Reminding ZZ of his hospitalization raises ethical concerns about using the "threat" of an aversive experience to enhance compliance and treatment motivation. We continue to provide other parenting skills to minimize this strategy: shifting the focus away from avoiding doing badly to positive experiences such his job, growing activities and ability to use his stress management skills.

Termination issues:

There are no imminent termination issues. My eventual retirement is a long term one. We planning alternatives operating under the assumption that a family with a history of reactive mood disorders.

Role of IDD in mental disorders:

The Presence of autism and IDD complicate his clinical presentation and vulnerability. Critical issues are limited adaptability, capacity to understand and describe affective distress, intolerance of changes and vulnerability to change. These limitations increase his vulnerability to overwhelming stressors, triggering mood cycles and episode sensitization.

Additionally autism and mild/moderate IDD increase the risk of diagnostic overshadowing and misattributing every baseline exaggerations in target behaviors to bipolar disorder. Recognizing the difference between these is critical to appropriate management.

ZZ's adaptability is affected by vulnerability to transitions; problem solving/executive functions and patterns of grieving-induced intensification of ritualistic behaviors. In spite of these deficits, ZZ has substantial strengths, including a sense of humor, a real joy for baking, and a capacity to elicit positive affective responses from others in spite of his behavioral rigidity and social communication issues. Once he adjusts to transitions, he is able to master

activities (growing resilience) that barring relapses in his mood disorder, ZZ can enjoy an expanding range of community activities.

Although psychotherapy in a traditional sense is limited, ZZ has improved his ability to apply relaxation strategies. His parents and case manager/job coach are adept at using cognitive strategies to help ZZ deal with unexpected events and other less dramatic transitions. It is encouraging that his family managed several BD breakthroughs and is increasingly comfortable recognizing and managing prodromal symptoms. We focus on differentiating day-to-day frustrations and target behaviors from BD and implementing their growing skills in functional behavioral analysis and positive supports.

References:

1. Harris JC. **Intellectual Disability: Understanding Its Development, Causes, Classification,** 2006. Oxford Press: New York ISBN- 13:978-0-517885-2.

2. Goodwin FK, Jamison KR. **Manic-Depressive Illness: Bipolar Disorders and Recurrent Depression,** 2007. New York: Oxford Press ISBN- 13:978-0-19-513579-4.

Clinical Certification

Work Sample 2

John Smith is a blind 40 year old Caucasian male who was referred to the Dual Diagnosis Treatment Team (DDTT), by the county administrator in his home county in early February 2012. John lives in a Community Living Arrangement (CLA) and attends a day program locally five days per week, which is funded through the consolidated waiver. John's biological parents are very involved in his care and have face to face contact at his home at least once per week. There is no history of trauma identified by John's parents or through records review. Though John has very limited use of verbal communication, those who know him well communicate with him relatively easily. John communicates in one or two word phrases and the use of non-verbal methods such as body language and self injurious behavior such as head slapping. John has refused all types of communication devices that have been trialed over a period of several years. John is accompanied by one-on-one staff during all awake hours.

Historically John has had very limited interactions with the majority of the individuals that he comes in contact with, his preference would be to lay on the couch with one of his microfiber blankets wrapped around his head. His past interactions have been marked with physical aggression, such as pinching, slapping, or flipping tables. John has been in and out of multiple local psychiatric

hospitals and his stays are usually marked with chemical and mechanical restraints. In both 2011 and 2012 John spent time at Western Psychiatric Institute and Clinic (WPIC) in Pittsburgh for diagnosis and treatment. John's significant time in local emergency rooms, inpatient psychiatric, restraints and limited interaction with his external world would indicate he has experienced a low quality of life. Since the involvement of the DDTT, members of his team including his parents, CLA staff, day program staff, supports coordinator, psychiatrist, primary care physician, and home county administrators have all indicated that his quality of life has improved significantly and that he has experienced much more meaningful interaction with the people and things around him. It was noted that yesterday (3/16/12) at a team meeting that John was smiling, shaking people's hands, talking, and hugging his parents, behavior that has not been observed in several years.

John's current diagnoses by his two collaborating psychiatrist are:

Axis I: Bipolar Disorder, Autism, Obsessive Compulsive Disorder, Impulse Control Disorder

Axis II: Severe Intellectual Developmental Disability (IDD)

Axis III: Legally blind, bilateral kerataconus, dense cataract, history of eye infections, tube in right ear, history of otitis, GERD, history of chronic constipation, history of pancreatitis, gall bladder removal, suspected stage III dysphasia, history of recurrent aspiration pneumonia, seasonal allergies, hyperlipidemia, prone to abscesses, enlarged prostate

Axis IV: Regression in the community, interruption in community residential supports

Axis V: 30

Some of the symptoms that have been noted with John over the last several years are extreme irritability, mood lability, and withdrawal from his environment, whether that is at the CLA or day program. His behaviors have historically been self injurious in nature, mostly commonly head slapping or punching and hitting himself in the abdomen. Though he has a history of several medical issues, the current medical focus for John is his enlarged prostate which has caused significant urine retention.

All services provided by the DDTT come from a holistic, person centered treatment model to promote positive approaches and recovery. This is primarily evidenced by the composition of the team which includes a licensed clinical director, a licensed clinical behavior specialist, a pharmacist consultant, a registered nurse, a psychiatrist, and two recovery coordinators. All members of the team have extensive face-to-face and collateral contact with John, his family, and his team every week. John's current paid support team is made up of approximately 30 professionals so communication on treatment becomes paramount, especially between the treating medical professionals and the direct care staff at both his CLA and day program. Again, the primary focus of John's treatment is on the enlarged prostate which is causing him to retain toxic levels of

urine. With that being the focus, the two treating psychiatrists and the nurse consult regularly with the pharmacist regarding medication that would be contraindicated for any of John's medical issues and to review all lab results.

Previous to John's admission into the DDTT his primary treatment was provided by the direct care staff at his home and day program, a behavior specialist, a psychiatrist, and local emergency rooms, with some support from the local Health Care Quality Unit (HCQU). The introduction of the DDTT provided access to all members of the team in addition to those who have been providing his supports in previous years. Upon admission data collection began in the form of a comprehensive assessment, functional behavior analysis, and sensory evaluation, along with interviews with those who know John best, consultation with his treating physicians and review of existing records. From this data collection a crisis plan, wellness plan, updated FBA, sensory plan, updated medical protocol, and updated behavior support plan (BSP) were developed to support John and his staff. Briefly some of the primary information that were listed in these updated plans were as follows:

Crisis Plan

The emergency room of choice by the family based on previous treatment was identified as well as an emergency room that the family would only like to use as a last resort. Protocol for the emergency room in the event that John has to go to the emergency room for a medical reason, including pharmacological

directives for the emergency room doctor as well as sensory suggestions for the nurses and emergency room aids.

Wellness Plan

What John looks like when he is feeling well is documented in addition to what he looks like when he does not. Who are the people and what are the things that make John feel better if he is not feeling well (parents, puzzles, quiet room) are listed here.

FBA

It was found that the primary function of John's behavior is medical which drove the development of an updated medical protocol. The information is used to drive other plans implemented for John.

Sensory

The DDTT completed a sensory evaluation on John and discovered that he has oversensitivity to noise and has proprioceptive under-sensitivity. These sensory issues were used to drive some of the interventions listed on the BSP. For example to address John's propioceptive needs it was indicated that John should be able to work around familiar environments with limited assistance as much as possible, with staff only keeping him safe from running into things that might cause him harm. To address his sensitivity to noise it was suggested that John should be provided with a quiet, calm environment when anxious and that John

should be offered one of his music cd's to listen to softly in the background. Both his home and day program should offer John a quiet option if the auditory stimulus becomes too loud around him.

Medical Protocol

John's vitals are taken every day, twice a day to establish baseline medical data (blood pressure and pulse). Protocol has been developed for blood pressure norms; outliers dictate evaluation at local ER. Urine retention protocols were also developed, if John does not void within a period of 24 hours he must go to the ER immediately for catheterization.

BSP

The behavior plan was written to include the crisis plan, wellness plan, information from the FBA, and both proactive and reactive strategies for use by John's family and staff. In addition to providing staff with interventions it also provides staff with known antecedents to target behaviors.

With approximately a maximum of ten to 16 months left in the DDTT goals will likely change significantly. The general desired outcomes for John are to reduce his emergency room presentations which will in turn reduce his inpatient psychiatric hospitalizations (no hospitalizations for a period six months that result in an admission to a hospital for psychiatric symptoms or behaviors) and to treat and resolve all medical conditions that have been identified. Once these goals are achieved the focus of the team will be to make sure that John

continues to engage his family, staff, and peers and to continue to develop his skills regarding relationship building. The team will also seek to expose John to new activities in hopes of identifying additional preferred activities which can be used to replace target behaviors and be integrated into his BSP, his wellness plan, and crisis plan.

As I have continuously reflected on this individual in the context of his ongoing treatment and achievement of goals, two significant concerns come to mind as they did on the first day with the DDTT. First is that John has no legal guardian, competency is a significant concern in the context of ability to consent, as that he is diagnosed with Severe IDD. To address this matter, the consent for treatment was signed by both his biological parents and treating staff. On a day-to-day basis when a service is provided by the DDTT John signs an encounter log as well as the staff that are present at the time of the service. The second issue is the limited ability of John to express himself verbally and his refusal to use any communication devices presented to him. This is resolved by the direct care team being very aware of John's needs, and for him to be supported and his treatment informed by those individuals that know him best and can communicate with him efficiently and effectively.

The primary driving force for the clinical approach to individuals with a dual diagnosis used to treat John was the holistic model. John is a very complex individual whose needs cannot be met by only addressing one competency area.

NADD suggests that there are several competency areas that should be considered when treating individuals who meet criteria for dual diagnosis (NADD, 2012). The areas suggested by NADD that are part of John's treatment would be basic healthcare (addressed by physicians, nurse , and pharmacist), medication evaluation and reconciliation (addressed by physicians, nurse, and pharmacist) , advocacy (all members of team, specifically Disabilities Rights Network advocate), evidence based practices (use of FBA), education of family and staff about complex needs (ongoing training of staff and family), outcomes (discharge criteria, treatment goals), interagency collaboration (ongoing face-to-face and collateral contact with team), long term living (maintaining current level of housing), and crisis management (providing protocol for avoiding/handling crisis situations).

As documented John's medical needs are quite extensive and are what is currently driving the treatment by his team, which has already show significant change in documented target behaviors. McFalls, Persons, Nemirow, and Philadelphia Coordinated Health Care (2006) noted the following:

> The clear identification of the target symptoms of mental illness is one of the pivotal points in evaluating the effectiveness of treatment for people with cognitive disabilities and mental illness. Without clear identification of the target symptoms, the treating physician cannot make an educated guess as to the diagnosis; without accurate identification of target symptoms the behavioral specialist cannot accurately devise a support plan, and without clear identification of the target symptoms, the direct support staff cannot collect data on frequency and report on progress toward

> healthy outcomes. In other words, without good team communication, psychiatric treatment becomes pure guesswork and outcomes are less than optimal.

Without keeping this treatment foundation the clear driving force for the model of service delivery, treatment will likely to continue to remain ineffective. Ongoing data collection, improved communication and collaboration, and data driven treatment planning have been an integral part of the development of a treatment plan that has allowed John to enjoy a significantly improved quality of life now and moving forward, to achieve desired outcomes, and to begin to develop new skills that will continue to allow him to live an "Everyday Life."

References

McFalls, Persons, Nemirow, et al. (2006). A Model of Treatment to Optimize Behavioral Health Outcomes for Individuals with Cognitive Disabilities. *NADD Bulletin, 9, 3.*

NADD. (2012) Competency Areas. Retrieved from https://www.thenadd.org

Work Sample 3

I am a Clinician working at SWITC. The Clinician is responsible for a variety of tasks including completion of comprehensive functional behavioral analyses, development of behavior support plans (BSP's) and corresponding training programs for replacement behaviors, staff training and participation as part of an interdisciplinary treatment team. Client needs vary from individuals with a significant cognitive impairment to those with co-occurring mental illness and corresponding behavioral issues. SWITC is a 24 hour residential Intermediate Care Facility for the Intellectually Disabled (ICF-ID) located in Idaho and provides specialized services for individuals who have no other placement options and have exhausted all community resources. SWITC also serves as a resource center for individuals in the community, providing training, assistance in locating alternative placements, and crisis prevention and intervention.

Sarah* is a 23-year old Caucasian female residing at SWITC. She was admitted at the age of 18 for significant self-injurious behavior, leaving the area without permission (LWOP), elopement, suicide ideation and attempts, destruction of property (DOP), assault and impulse behavior such as fire setting. Sarah continues to reside at SWITC as no alternative placement has been identified to provide for her mental health and maladaptive behavioral needs.

Records showed that Sarah was born at 36 weeks gestation and her mother reported being on bed rest the last few weeks of her pregnancy due to pregnancy-induced hypertension. During the delivery the umbilical cord was reportedly wrapped around Sarah's neck. There is little information about Sarah's development. Her family reported she was generally a "physically healthy" child, but was "delayed in all her developmental milestones" and "did not bond well with others". At two years of age she was admitted to a children's hospital where an Autism diagnosis was ruled out. Historical records showed a variety of intelligence tests were administered suggesting mild intellectual disability. The last psychometric evaluation using the Wechsler Adult Intelligence Scale-Third Edition in 2009 showed a full scale IQ of 62. Sarah attended a preschool for developmentally delayed children from ages 2-5 and continued her education up through junior high in a "self-contained classroom". She self-reports completing school up to the 10^{th} grade.

There is also very little information about Sarah's family history. Her parents divorced in 1992 when she was four years old and both have since remarried. She has two younger sisters and one step-sister and her father was appointed her legal guardian in June 2006. Sarah's records showed she has lived in several different placements including living with her parents, together and separately, as well as in several different community facilities including group homes and supported living.

Sarah has an extensive history of psychiatric hospitalizations as a young child, adolescent and adult. Her records showed she was hospitalized as a child numerous times for aggressive behaviors and then as an adolescent for high risk and aggressive behaviors towards her family. Some of these behaviors included attempting to set the family house on fire, assault and engaging in self-injurious behavior such as cutting herself and attempting overdose. Sarah's mother also reported a history of perseverative thoughts focusing on subjects like the devil, death and dying, dead babies and horror movies which intermittently persist today.

There is little documentation about Sarah's mental health diagnoses and treatment prior to her admission to SWITC though previous psychiatric impressions included Schizoaffective Disorder, Oppositional Defiant Disorder and Borderline Personality Disorder. Upon her admission to SWITC she was immediately scheduled and seen for a comprehensive psychiatric evaluation. At this time the psychiatrist's diagnostic impressions included Schizoaffective Disorder, Post Traumatic Stress Disorder and Borderline Personality Disorder. These diagnoses were supported by the following mental health illness symptoms documented in Sarah's history as well as her self-report: delusions, hallucinations, disorganized speech, disorganized behavior (unpredictable tempter outbursts, agitation), depressive episodes, anxiety, unstable interpersonal relationships, identity disturbance, impulsivity including self-damaging/mutilating behaviors,

recurrent suicidal ideation and gestures, affective instability and extreme mood changes including inappropriate and intense anger as well as difficulty controlling emotions.

Sarah continues to exhibit the above identified mental health illness symptoms as well as engage in maladaptive behaviors. She currently has a Behavior Support Plan (BSP) which provides guidelines to staff to keep her and others safe. Her current targeted maladaptive behaviors include: assault, injury to self including pica and suicide ideation and attempts, DOP, verbal threats and intimidation/antagonizing behaviors.

Because Sarah resides in an ICF-ID she has an active treatment schedule that includes participation in all aspects of her care focusing on maximizing her independence. Her active treatment has been developed by her Treatment Team using a Person-Centered Plan (PCP) approach which addresses all of Sarah's needs including medical and health as well as medication administration, dietary issues, oral motor and communication, activities of daily living, motor development, recreation/leisure, community living skills, social skill development, vocational skills and behavioral issues.

Sarah's course of treatment for her mental health illness symptoms and associated maladaptive behaviors have been addressed and treated in a variety of ways since her admission. She has been very difficult to treat which is likely correlated with her impulsivity and Borderline Personality Disorder. For example,

Sarah has been referred to and/or requested counseling multiple times with the goal of participating in Dialectical behavior therapy **(**DBT**).** She initially participated in on-campus counseling intermittently over the course of several years, but ultimately refused the service and discontinued her attendance and participation. In January 2012 Sarah was referred for outside counseling by her Treatment Team following her request. Initial treatment goals identified by Sarah and her counselor included developing and implementing coping skills, education related to her diagnoses and emotion regulation. Sarah's counselor reported no participation or progress after several sessions spanning three to four consecutive months and her services were terminated. Replacement behavior training programs for Sarah have focused on similar goals including anger management, emotion regulation, symptom education, coping skills, assertiveness, voluntary separation as well as reinforcement programs for the absence of maladaptive behaviors. She has also had service programs provided by staff including non-contingent attention and use of social stories. Sarah has demonstrated mastery over some of these skills, but the programs are maintained informally for generalization and practiced application. Her formal reinforcement program (differential reinforcement of other behaviors {DRO}) was discontinued as intermittent informal systems showed to be more effective.

It has been difficult to find new interventions as part of Sarah's course of treatment. The newest approach was the implementation of the level system in

October 2011. The level system was designed to provide Sarah with guidelines, structure and consistent boundaries for managing her maladaptive behaviors where she is given greater independence and privileges as she demonstrates increased behavior control. The level system is comprised of three levels and includes specific criterion such as participation and behavioral expectations as well as and consequences linked to those expectations in hopes of increasing Sarah to make positive choices, increase her self-management skills and development of personal responsibility for her maladaptive behaviors. Since the initiation of the level system Sarah has made considerable progress as demonstrated by overall decreased frequency of self-injury, assault and suicide ideation. During periods which she drops within her level system, her response time also has increased as evidenced by behavioral control and positive choices. For example, during the initial implementation of the system Sarah dropped to level one (the most restrictive level) due to a combination of assault, self-injury, suicide ideation and medication refusal. She remained on level one for approximately 10 days in which her Treatment Team was required to meet to establish alternative treatment options. Before alternative treatment options were needed, Sarah followed the expectations of her level system and was moved to the next level. As she has become accustomed to the level system she has demonstrated the ability to remain on level three (the least intrusive) for up to one month at a time. Her current goal is to remain on level three for three consecutive months with the anticipation of fading other restrictive components of

her BSP such as allowing her access to more personal items in her bedroom, consideration of fading times within her enhanced supervision or being given the opportunity to carry items like a water bottle.

In addition to her replacement training programs Sarah has had and continues to have a BSP that provides preventative measures and instructions for staff to keep her and others safe as well as a medication management plan. She has an extensive history of intrusive procedures as part of her BSP including use of physical restraint, chemical restraint, mechanical restraint using soft protective mitts and wrist cuffs with waist belt, body searches, mouth sweeps, room searches including limited items in her room, Enhanced Supervision (1:1 staffing), as well as the use of psychoactive medications for behavioral and/or psychiatric control. Several of these intrusive procedures have been discontinued over the years as most were ineffective and did not provide her any additional her safety and protection from harm. Sarah's current BSP continues to include Enhanced Supervision, room searches including limited items in her room and non-contingent removal of items, physical restraint, chemical restraint, a level system with specific criterion for interacting with Sarah at various levels and routine use of psychoactive medications for behavioral and/or psychiatric control.

While psychotherapy has been the recognized primary treatment for Borderline Personality Disorder (BPD), medications most often provide a necessary base for the effective treatment of BPD and are part of Sarah's course of

treatment. There is ample research suggesting that medication including anti-depressants, antipsychotics, mood stabilizers/anticonvulsants and anxiolytics have been shown to reduce some of the symptoms of BPD although there are currently no medications approved by the FDA specific to BPD[1,3]. Sarah's medication plan includes the routine use of Seroquel®, Haldol®, Prozac®, Topamax® and Naltrexone and these medications are primarily used to treat symptoms co-occuring with her BPD diagnosis.

Future programmatic and treatment options may include exploration of removing intrusive components of her BSP such as physical restraint. This is based on recent literature recognizing the psychological and cognitive effects of physical restraint. Research has suggested that physical restraint may be perceived as punitive and aversive and that individuals having histories of abuse have recalled the experience of being physically restrained as representing a reenactment of their original trauma. Additionally, there are reports that individuals who have been restrained reported nightmares, intrusive thoughts as well as painful memories and fearfulness[2]. This research would suggest that physical restraint may be contraindicated to Sarah's Post Traumatic Stress Disorder and would also blur symptoms associated with her BPD (e.g. intrusive thoughts, nightmares, avoidance behaviors, unstable relationships including mistrust, etc.). Sarah's Treatment Team will continue to explore various treatment options and alternatives to increase her success.

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