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Abstract

This article argues that people who have a mental illness in addition to a developmental disability are usually served in programs which were not designed to meet the needs of individuals with psychiatric disability. It recommends that mental health consultants are used to provide community staff with the necessary education and information so that community programs are then able to serve people who have been dually diagnosed.

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"Caregivers in community programs often find themselves having to work with clients who have both developmental and psychiatric disabilities, even though they have not received specific training in mental health concepts and their agency did not plan to service psychiatrically disabled patients"

TRAINING STAFF TO INTEGRATE EDUCATIONAL AND THEREPEUTIC APPROACHES FOR THE CLIENT WITH DEVELOPMENTAL AND PSYCHIATRIC DISABILITIES

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The orientation of caregivers in the field of developmental disabilities is primarily educational: they focus on teaching their clients skills which will enhance their lives and promote self-determination. Typically this involves goals, writing curricula, and then motivating and training the clients using a variety of interventions based upon the principle of positive reinforcement. This is an active habilitative approach in which pressure is placed on the client to meet the predetermined goals and graduate to less restrictive environments and/or take on more normal activities, e.g., a paid job.[1]

This approach becomes problematic, however, when a client has a mental illness in addition to developmental disabilities. By mental illness we mean any behavioral, or cognitive, or affective disability related to a classic psychiatric illness (e.g., depression) or a central nervous system dysfunction (e.g., an organic mental syndrome secondary to tuberous sclerosis). Individuals with both a developmental disability and mental illness are not rare Not only do the developmentally disabled suffer from the full range of psychiatric disorders [2,3,4,7,] but the rates of mental illness in this population may actually be higher than in the general population.[8] Such individuals can become a source of frustration to careproviders if their client's psychiatric disabilities interfere with their ability to learn, or if they become "difficult" or " disruptive".

One solution to the problem of working with these "dually diagnosed" clients is to group them in special programs designed to meet their needs, but this strategy presents its own problems. First, the intermittent crises for one client after another can disrupt the program, create a chaotic atmosphere, and potentially increase maladaptive behaviour. Second, many psychiatrically disabled persons have acute or episodic illnesses, with periods of remission, so that they do not need such programs at all times. Finally, once a client is labelled as "dually diagnosed," other community programs may be reluctant to provide services after the specialized care is no longer needed.

In any case, specialized programs of this sort are not generally available, which means that these clients, by default, are usually served in programs which were not designed to meet the needs of individuals with psychiatric disabilities. If, however, these community residential and vocational programs provide a proper programatic structure and staff orientation, they can deliver high quality habilitative mental healthcare services.

The Role of the Mental Health Consultant and Consultation Meetings

A mental health consultant, knowledgeable about the diagnosis and treatment of psychiatric illness and able to work collaboratively with agency staff,[6] plays a critical role in helping community programs serve dually diagnosed clients. (The community agency or the state Department of Mental Retardation often knows of consultants who can provide such consultant services.)

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The consultant's role is to manage the client's treatment in residential and vocational settings, and to work closely with the mental health clinicians treating the client. The consultant also plays a critical role in educating staff about mental health issues and helping them develop the skills necessary to work with clients who are both developmentally and psychiatrically disabled.

Without specific training, the staff will likely share the general public's lack of knowledge and many incorrect impressions of psychiatric disorders. It cannot be expected, for example, that staff will initially understand the treatment implications of an "anxiety disorder." Thus, the consultant must first provide information about the client's diagnosis, treatment options, and expected clinical course. As staff become more familiar with mental health concepts and terminology, other questions and concerns will arise.

Consultation meetings, which must be mutually agreed upon by the consultant and program staff, provide a vehicle for this staff education and supervision. These meetings should occur on a regular and predictable basis. (The consultant also needs to be available, if only by telephone, for emergencies.)

Once the client stabilizes and staff become comfortable with the mental health aspects of care, the consultation meetings can be scheduled less frequently, but it is a mistake to abandon them completely. Staff may require continued support and treatment plan supervision for particularly difficult clients such as those with borderline personality disorder.

General Consultation Principles

1. Help staff accept the client's psychiatric disability.

The first step in responding to the needs of a psychiatrically disabled client is to accept the idea that the individual has a mental illness. Although some clients are referred to a community program with a mental health diagnosis and treatment plan already in place, it is not uncommon to find instances in which the psychiatric nature of the problem was not recognized for months and even years. In many such cases, by the time the psychiatric diagnosis is made the client has already acquired a "reputation" and staff are frustrated and angry.

Once the psychiatric diagnosis has been established the first intervention should be to deal directly with any such attitudinal baggage. Staff meetings should be scheduled to allow caregivers to ventilate the frustration engendered by the client's behaviour. Staff will often challenge the idea that the client has a mental illness and argue that he is "just acting out". They may believe that the diagnosis is irrelevant to habilitative programming. They may be afraid that once the client is "labeled" as being mentally ill, he or she will immediately be sedated with antipsychotic drugs.

Over the course of several meetings the consultant can facilitate attitudinal change and help staff accept that the client has a psychiatric disability, i.e., that he or she is "different" from the other clients and, at least temporarily, must be treated "differently".

2. Change staff expectations about how the client should behave.

Accepting the idea that a client has a mental illness means accepting the idea that some of the individual's behaviour is not under his or her control, and that this situation will persist for the indefinite future. This means that expectations, requirements, and rules which have been developed with an educational program in mind, may have to be modified.

Modifying the program rules and expectations may generate comments from staff such as, "It's not fair - everyone should be treated equally," or "You're just spoiling him by rewarding acting-out behaviour." Despite such initial reservations, staff must accept the idea that everyone will be treated as an individual in the program, and that individualized treatment aimed at meeting individual needs will create an overall atmosphere which is both healthier and more conducive to growth.

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It is important that staff be helped to understand that an individualized approach is appropriate because allowances must be made for the presence of a mental illness. In-service educational programs should deal with the issues of fairness in service delivery and the question of how a client's specific mental illness can and should affect the program. A manic client, for example, may need less sleep and be unwilling to go to bed at 10:30 pm when everyone else does.

3. Teach staff to respond to disruptive or bizarre behaviour in accordance with a treatment plan.

Staff who lack experience in dealing with highly disruptive or bizarre behaviour may over-react to specific incidents. For example, when a volatile and irritable client begins to yell, the natural tendency is to take charge, set limits, and tell the client to "calm down." In some situations, however, this may exacerbate the problem and result in the staff member's being assaulted.

The treatment plan for disruptive clients should specify how staff should deal with the problem behaviours. Staff need to learn to under-react, i.e., first to assess the situation, then think about what intervention the treatment plan calls for, lastly react according to the plan.

Because under-reacting is not a natural response for many people, supervision can be very helpful in helping staff members to react appropriately. This supervision should provide as much information as possible about the client's treatment plan and the rationale for it. Role playing can be quite helpful in ensuring that all staff members understand what is expected of them in specific situations.

4. Help staff to engage other clients in the treatment plan.

A major objection to a psychiatrically disabled client's receiving "special treatment" is that the other clients will have a negative reaction and perceive the different approaches as unfair. Such responses can best be dealt with by telling the other clients that the psychiatrically disabled person has a "problem which we are helping him/her overcome" and that "everyone in our program is treated as an individual." When manipulative clients ask "If so-and-so can do it, why can't I?" it is helpful to respond with statements such as, "So-and-so has a problem, but you are very competent and can handle more responsibility."

5. Assist staff in recognizing the limitations of mental health interventions.

Educationally-oriented staff often become frustrated when a client does not meet his or her specific learning objectives. The fact that the client has not lost skills and has been maintained in a community program, rather than being admitted to an institution, may not seem to be a positive result of all the agency's work, and may, in fact, be viewed as a programatic failure. On the other hand, staff with a habilitative mental health orientation, understand that maintaining the status quo can be a great achievement when working with a client who has a serious mental illness.

Another issue which must be dealt with is that mental health interventions may take weeks or months to be effective, while in the meantime staff have to manage a disruptive individual. Drug therapy, for example, may not work for several weeks until a stable therapeutic drug blood level has been achieved. Staff must therefore develop adequate containment and management programs and must learn to accept not seeing any results of the mental health intervention in the immediate future.

In general, then, staff must be helped to reframe their expectations of what the psychiatrically disabled client and the mental health treatment can accomplish. By supporting and praising staff for maintaining a highly disruptive client, the clinical consultation can facilitate this very important goal.

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6. Validate staff concerns regarding the appropriateness of the client's placement.

As meetings are held to educate and support program staff, responses such as "He doesn't belong here," and "We aren't doing her any good" should be expected. It is, important that this issue of appropriate placement be dealt with directly.

If the clinical consultation believes that the placement is appropriate, then a support program must be developed to help staff develop the skills and strategies to cope with the difficulties in dealing with the particular client. If, on the other hand, the placement is inappropriate, staff concerns should be validated, and the consultant should share information on a regular basis about what steps are being taken to find an alternative program. This prevents staff demoralization and the feeling among direct care provides that the supervisor and the agency care little about them or what happens to the client.

Often the supervisor or consultant is frustrated by having to deal with an unresponsive agency or state bureaucracy. These frustrations should not be directly shared with staff, because they tend to have a demoralizing effect and ultimately undermine treatment. In such cases the consultant needs to seek support from his or her supervisor or peers (who are not directly involved in this situation).

7. Teach staff how to collaborate with mental health professionals.

The information used by mental health clinicians in making treatment decisions is often different from that which caregivers use in educational programs. In establishing a specific psychiatric diagnosis, changes in mood, sleep, and concentration, for example, may be more important than how many specific habilitative goals have been achieved in the past six months. The consultant can help staff integrate the "mental health" approach into the client's habilitation plan by helping them "speak the same language" as mental health clinicians. Teaching staff the terminology and concepts utilized in psychiatric treatment programs will also decrease the frustration often felt by staff who have to deal with a mental health clinician or agency.

Conclusion

Caregivers in community programs often find themselves having to work with clients who have both developmental and psychiatric disabilities, even though they have not received specific training in mental health concepts and their agency did not plan to service psychiatrically disabled clients. Nonetheless, the developmentally and psychiatrically disabled client can receive highly effective services, if a mental health consultant provides staff with positive feedback and the necessary information and education to become therapeutic caregivers.

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