# Psychosocial Diagnosis and Treatment Services in Inpatient Psychiatric Facilities for Persons With Mental Retardation: Practice Guides

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Placement of persons with mental retardation in inpatient psychiatric hospital settings may occur when psychiatric and behavioral symptoms cannot be treated or managed successfully by available community resources. It is suggested that the prevailing mental illness diagnostic and treatment paradigm used in psychiatric hospitals may be inappropriate for persons with mental retardation. An alternative Habilitative Mental Health Treatment approach is offered to guide the diagnostic-treatment case formulation process. A set of practice standards addressing critical elements of this process is offered.

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Persons with mental retardation (MR) who also present significant behavioral and psychiatric challenges require a range of community services designed to provide supports during periods of crises. These include such services as crisis interventions in the community place of residence, short-term community respite care, and crisis hospitalization in psychiatric units of public or private community or regional hospitals.[14,23] When these resources are unavailable or unsuccessful in resolving the crisis, and the person's symptoms persist at a level of severity and potential dangerousness that precludes continued residence in the community until the problem symptoms are resolved, placement in an inpatient psychiatric facility may be undertaken. In these instances, at the time of admission:

(a) The person's behavioral symptoms are judged to represent a significant danger to self or others or, if currently under environmental or medication control, are deemed highly likely to recur if returned to a less supervised setting without additional treatment, or

(b) The person is deemed to be at high risk for future significant and unmanageable property destruction, or

(c) The person has threatened to create harm to self or others and/or threatened to engage in significant property destruction and thus is judged to represent a significant danger to self or others or likely to engage in significant and unmanageable property destruction.

(d) Additionally, and a central criterion for admission to an inpatient psychiatric facility, it is assumed that specific aberrant psychiatric, neurological, or psychological conditions, unless reduced or stabilized with appropriate interventions, will continue to place the person at significant risk for hospitalization due to recurrence of the dangerous behavioral symptoms.

(e) Further, it is assumed that these aberrant conditions can best be diagnosed and treated by a structured therapeutic environment provided in an inpatient psychiatric facility. Closely related is the assumption that professional staff members of the inpatient psychiatric facility are skillful in diagnosis and treatment of persons with developmental disabilities (DD) who present with behavioral symptoms that at a minimum reflect a partial influence of aberrant psychiatric and psychological conditions ("disease or defect").

(f) Even in cases with forensic implications, the assumption is made that the alleged illegal actions reflect at least a partial effect of psychiatric or psychological conditions ("disease or defect"). Because of these conditions, the person continues to pose a

risk for recurrence of these alleged illegal actions and requires the protection and controls offered by an inpatient facility. This placement decision is based on the assumption that these psychiatric and psychological pathologies are best diagnosed, managed, and treated in a psychiatric facility rather than through use of other community or residential services associated with the criminal justice system.

Psychiatric hospital placements that are not forensic in nature may be used for two major purposes, viz., (a) to produce stabilization of psychiatric and related dangerous behavioral symptoms and rapid return to the community place of residence once this is accomplished or (b) to provide specialized diagnoses and intensive treatments of the aberrant personal psychiatric and psychological conditions presumed to influence occurrence and severity of the behavioral acts that precipitated hospitalization. The initial group typically consists of those patients who had not been provided adequate community supports sufficient to resolve the situational crisis or to manage an acute psychiatric crisis relating to medication failure. The latter group typically consists of persons with previous psychiatric hospitalizations whose behavioral symptoms have increased in dangerousness and whose previous hospitalizations had not provided appropriately specialized and intensive psychiatric and psychological treatments.

In sum, persons admitted to psychiatric hospital settings present with behavioral and psychiatric symptoms that have not been responsive to community interventions including partial and short-term acute psychiatric hospitalization. Thus, since hospitals have an obligation to meet the specific treatment needs of persons admitted, it is reasonable to expect that inpatient hospital treatment programs will be designed to meet the specific mental health (MH) treatment needs of those patients with DD.

This paper describes minimal practice standards as guides for evaluation of the psychological and related psychosocial diagnostic and treatment services provided in inpatient psychiatric settings and the manner in which these are interfaced with psychiatric, including psychopharmacological, and other medical interventions to promote desired therapeutic outcome. As background for this discussion, a brief description of the specialized MH treatment needs of persons with DD is provided.

## Needed: A Specialized Mental Health Treatment Focus

A specialized MH treatment paradigm is needed to meet the unique MH treatment needs of patients with MR who also present mental illness and/or psychological and behavior disorders. Patients with MR admitted to psychiatric hospital settings present a range of medical, neurological, psychiatric, behavioral, emotional, cognitive, perceptual, impulse control, personality trait, and motivational symptoms, but frequently not in clusters that are clearly diagnostic of specific mental disorders. Even when a psychiatric disorder is diagnosed, in most instances the person also presents with a range of psychological difficulties that contribute in a significant manner to the behavioral symptoms necessitating initial and continued hospitalization. A recurring feature of these psychological difficulties is that of impulsivity and loss of self-control related to such aberrant personal characteristics as hyperarousal, confusion, cognitive and perceptual deficits, and restricted coping repertoires.

Although drug intervention may be of significant therapeutic value in addressing primary acute psychiatric symptoms, most hospitalized patients with DD continue to present recurring psychological and related behavioral challenges. These patients thus remain at continued risk for highly disruptive acts such as physical and verbal aggression, property destruction, arson, self-destructive behaviors, and unacceptable sexual activities that represent the basis for hospitalization. The patient's aberrant psychological features and associated behavioral symptoms most typically are ongoing in nature. As noted, the majority of patients with DD have experienced either lengthy or previous and recurring hospitalizations for emotional and cognitive dyscontrol and related behaviors that represent a danger to the safety, privacy, and well being of self and others. Moreover, many have experienced years of multiple psychiatric drug regimens, both in community and hospital settings without substantial benefit with regard to the behavioral dysfunctions that place the person at risk for hospitalization.

In the primary author's recent experiences involving review of over 300 hospital admissions to ten mid-western, western, and west coast psychiatric facilities, over 95% had experienced from 2 to 16 previous admissions. Although a variety of DSM-IV psychiatric diagnoses were present, the most common ones were those of Impulse Control Disorder, NOS and Intermittent Explosive Disorder.[1] These diagnoses highlight the central feature of impulsivity and self-control deficits under conditions of excessive emotional arousal.[2,4,15]

### Differential Diagnosis Issues

From a differential diagnostic perspective, the behavioral symptoms (e.g., fire setting, self-injury, property destruction, assaultive behaviors, sexual violence, exposing oneself to dangerous conditions) resulting in hospitalization may be described as nonspecific in nature. That is, the factors influencing occurrence, severity, and chronic recurrence of these behavioral symptoms do not reflect any single or predetermined or limited number of psychiatric, neuropsychiatric, or psychological conditions.[5,7] Seldom is there support for a state-dependent relationship in which occurrence of behavioral symptoms reflect a 1-1 relationship with presence of primary psychiatric symptoms.[6] Nor does the co-occurrence of symptoms diagnostic of a specific mental disorder necessarily indicate a major contributing cause-effect relationship with the disruptive behavioral acts. Rather, impulsive behavioral acts involving violence toward self, others, or property most typically reflect the effects of a diverse array of environmental, psychological, medical, and in some instances, psychiatric and neuropsychiatric abnormalities. Even when primary psychiatric symptoms are present, the particular role and magnitude of influence of these symptoms on occurrence, severity, and chronic recurrence of those and related dangerous behaviors can be determined only through complete multimodal diagnostic studies.

To emphasize this point further, as behavioral symptoms precipitating hospitalization rarely arise solely from any single cause such as a specific psychiatric disorder (such as Major Depression, Bipolar Disorder, or Schizophrenia), effective treatment requires complete and individualized diagnostic studies to identify the particular unique complex of causes influencing both those behavioral symptoms present at admission as well as those that may have emerged during hospital placement. Only after appropriate diagnostic studies have identified the patient-specific complex of causes is the hospital staff in a position to designed individualized treatment

programs to address these vulnerabilities and related pathologies.

As a specific illustration, as behavioral symptoms resulting in initial and continued hospital placement frequently reflect a "loss of impulse control," the diagnostic questions used to gather information as a basis for treatment planning, selection, and implementation would include the following:

(a) Under what conditions has or does the person show loss of impulse control (e.g., the specific instigating stimulus complex, central processing psychological features)?

(b) What functions or purposes are served by the resulting impulsive acts reflecting loss of control?

(c) What specific impulses or emotional states are involved in a person's loss of impulse control (e.g., anger, fear, frustration, jealousy, loneliness, greed, sexual arousal, sadness, irritability related to denial of requests or loss of hospital privileges, desires for possessions that person does not have)?

(d) Is the person's loss of control influenced by cognitive/perceptual deficits[5] or cognitive disintegration?[30] As examples, is the person able to accurately read facial features or other feedback cues? Is the person overly sensitive to expressed emotions, overwhelmed by complex or rapidly changing environmental stimulus conditions, or unable to understand what is being said or expected in a particular context or situation?

(e) Does the person's loss of control represent skill deficits, performance deficits, or a combination of the two? That is, does the person have the cognitive and emotional skills to actually inhibit his/her impulses and to select from his/her social, problem solving, and coping repertoires a socially suitable alternative way of responding to the conditions that provoked the impulsive actions? Does the person actually have the alternative functionally related coping skills in his/her repertoire? If not, how can these best be taught to the person with limited cognitive and emotional resources? If individual assessment indicates that the skills are in fact present but not being used, why does the person respond impulsively rather than selecting an alternative coping behavior available to him/her? Is this performance deficit due to absence of motivation or to excessive emotional arousal such as anger, irritability, mania, anxiety?[8]

### Diagnostically-Based Interventions

All components of the resulting treatment plan thus should be diagnostically based, that is, related to the various psychiatric, medical, psychological, and social-environmental diagnostic hypotheses derived from assessments specific to each modality (viz., bio-psycho-social) of influence. Further, all treatment program components should be designed to treat or manage the conditions identified as contributors to (causes of) the target behavioral symptoms, e.g., fire setting, assault, property destruction, self-injury, exposure to dangerous conditions such as walking into traffic, removing one's clothing in public, or excessively intruding into the privacy of others.

As illustration of the diagnostic-intervention formulation process, a psychiatric evaluation of a person presenting with behavioral challenges involving aggression may inquire about the presence of irritability, dysphoric mood, or anxiety based on the assumption that these emotional states contribute to the occurrence, severity, and variability of aggressive responding when the person is confronted with social demands. These emotional states, when experienced as distressful by the person, would be presumed to represent risk influences for aggressive responding. Psychiatric diagnosis of an anxiety disorder may result in selection of psychopharmacologic agents to reduce the aberrant anxiety level. If treatment is successful in reducing the level of distress-producing anxiety and a controlling relationship does in fact exist between anxiety levels, social demands, and aggressive actions, relevant features of the person's aggressive acts should be influenced. That is, with reduced levels of distressful anxiety, the person will be better able to tolerate and respond appropriately to social demands that previously had produced aggressive actions.

Examination of a young adult with severe cognitive impairment provides illustration of a similar diagnostic-intervention formulation process involving psychological features. Observations of the person in a community placement prior to hospitalization may reveal that whenever an intrusive peer violated his personal space, the adult typically responded immediately with a sudden surge in emotional and motor

agitation followed by impulsive acts of severe physical aggression. Further examination may reveal that, under these conditions of instigation, the adult displayed a number of personal characteristics that placed him at high risk for aggressive and related disruptive responding. These may include such features as an inclination to become hyperaroused under minor conditions of instigation, limited effective socially appropriate communicative means of expressing his distress, an impaired emotional modulation system, a strong habit of aggressive responding under conditions of distress, and limited cognitive and affective skills to inhibit these aggressive acts and to select an alternative coping skill. These diagnostic insights would offer a basis both for selection of a number of interrelated psychiatric, psychological, and socio-environmental therapeutic procedures to address the multiple conditions influencing occurrence of the behavioral challenges and for speculating about the nature of changes expected and the time frame within which these may be expected to occur.

## Inadequacies of Prevailing Case Formulation Paradigm

The prevailing case formulation (diagnostic and treatment) framework typically used in a psychiatric hospital setting is the mental illness multiaxial DSM-IV system, with the primary diagnoses being psychiatric and related medical ones.[1] The Axis I and Axis II Mental Disorder diagnoses, reflecting a unitary mental illness paradigm, provide major direction to the treatment experiences provided. All other assessment information and related interventions are secondary to this psychiatric diagnosis and related pharmacological interventions.

It is infrequent, however, that persons with MR are admitted primarily for acute symptoms of a major psychiatric disorder that were unmanageable in the community, i.e., major thought (e.g., delusions), perceptual (e.g., hallucinations), or mood dysregulation. Rather, as noted, reasons for admission reflect a range of behavioral symptoms that represented a threat of harm or damage to self, others, or property. It thus would be reasonable to expect that the array of potential multiple factors (including possible mood, perceptual, or cognitive symptoms of a mental illness if present) presumed to influence occurrence, severity, and persistent recurrence of these critical behavioral symptoms would receive equal attention in the diagnostic and treatment planning process. A number of medical, psychiatric (including those associated with the DSM-IV diagnostic and classification scheme), psychological (including behavioral), and social and physical environmental diagnostic hypotheses, thus would be provided equal attention initially in evolving the diagnostic bases for devising the patient's multimodal treatment plan.

This rarely is the case in clinical practice. Over the past 20 years many public and private providers of inpatient psychiatric services have reduced the availability and sophistication of psychological, including behavioral, interventions while the concentration of persons with comorbid psychiatric and behavior disturbances has increased.[16,18] There has been a move away from providing specific treatment of the array of conditions that produce behavior dysfunction and an increase in the use of psychoactive medications, leading in many instances to unnecessary chemical and mechanical restraints and seclusion.[16,17,18] Outcomes for people in psychiatric hospital settings with serious behavior dysfunction have suffered as comprehensive service arrays have been reduced to what may be described as "drugs and TV therapy" models of care.[16,17,18] As noted, adequate services require attention to treatment of both the acute and recurring symptoms of a psychiatric disorder (usually through medication) and the additional personal vulnerabilities (through use of psychological, including behavioral, assessment and intervention strategies) that underlie behavioral dysfunction. The psychosocial interventions strategies would include habilitation in the areas of social, community survival, and vocational functioning to build personal coping immunities.[17,18] A review by the second author of hundreds of cases of people with inadequate inpatient treatment outcomes using a record review protocol revealed insufficient attention to the treatment of problem behaviors, lack of teaching of functionally equivalent replacement skills, lack of functional assessments of the environmental antecedents and consequences and the personal contexts of the behaviors of concern, and an over use of medications and controlling interventions such as restraints and seclusion.[17,18]

## Recommended: A Habilitative Mental Health Treatment Paradigm

To meet the unique psychiatric and psychological treatment challenges of patients with DD, a case formulation diagnostic and treatment model is recommended that combines both habilitative and MH components into an integrated treatment focus in order to maximize the unique therapeutic features of both. The habilitative focus of developing and supporting a wide range of personal cognitive, emotional, motivational, and behavioral skills and competencies is based on the recognition that the recurring behavioral problems and personality pathologies present in patients with DD reflect an absence of functional social, vocational, community survival skills as well as such personal skills and features as impulse control difficulties under conditions of negative emotional arousal, delay of gratification, rejection, intense feelings of inadequacy and the like, skills of coping with interpersonal conflict, and skills of self-regulation. The MH focus involves psychiatric and psychological treatment and management of such symptoms of mental illnesses as depression, hypomania, hyperarousal, delusions, and hallucinations. These interventions are combined with those designed to promote prosocial and personal emotional and motivational competencies and well being associated with positive self-image.[5,10,13]

Thus, the recommended Habilitative Mental Health Treatment Program model consists of the two intertwined and interactive treatment components of (a) psychiatric (predominately psychopharmacological) and related medical interventions and (b) psychosocial interventions with a habilitative MH focus designed to treat the psychological features and social- and physical environmental conditions that influence occurrence, severity, variability, and persistent recurrence of behavioral challenges. In this program model, specific attention is given to assessment and treatment of behavioral dysfunctions that may co-occur with Axis I and Axis II disorders.[17,18] These latter interventions, including skills training and other psychological therapies adapted for persons with cognitive limitations, promote intra-and inter-personal social and emotional competencies. The overriding objective of all interventions is to increase the personal resources and coping competencies of each person treated and as such to reduce or eliminate recidivism, i.e., recurrence of symptoms that increase risk of psychiatric hospital placement.

### Psychiatric Interventions

Psychiatric interventions are selected to address acute symptoms (e.g., hallucinations, delusions, other psychotic reactions) of the current psychiatric disorder(s) and related neuropsychiatric features such as debilitating levels of irritability, hyperarousal, and emotional lability. Each of these psychiatric features may represent one of a number of other features of a psychological or social-environmental nature that interact to produce a person's impulsive and related acts that in turn pose a threat to the safety of self or others to the degree that hospitalization is required. It is counter-therapeutic to assume, except in rare instances, that psychopharmaceutical interventions provide adequate treatment for behavioral challenges. While treatment of acute symptoms of a mental disorder is most valuable, unacceptable outcomes result when psychopharmaceutical interventions are used as the primary or major intervention for behavioral challenges.[24,25] Such practices often lead to unwarranted and excessive chemical or mechanical restraints and seclusion.[17,18] Again, while not selected to treat dangerous impulsive behavior difficulties directly, psychiatric interventions do address the presumed biochemical basis of various psychiatric symptoms such as delusions, hallucinations, irritability, emotional lability or hypomania that may in turn serve to influence occurrence, severity, variability, or recurrence of the behavioral challenges.[5]

To summarize, rather than treating behavior symptoms such as aggression or property destruction, psychiatric and related medical interventions may address symptom categories reflecting cognitive (e.g., delusional thought patterns, flights of ideas), perceptual (e.g., visual and auditory hallucinations), mood or affective (e.g., anxiety, anger, dysphoria, irritability, hyperarousal), affective dysregulation (e.g., rage, emotional lability), motoric (e.g., hyperactivity, aimless pacing) and somatic (e.g., headaches, sleep disorders) abnormalities that may contribute as antecedent instigating or central processing conditions to occurrence, severity level, and variability of behavioral symptoms. Rarely,

however, do these psychiatric symptoms represent sufficient conditions independent of psychosocial influences to produce behaviors that place a person at risk for hospitalization.[5]

### Psychological and Socio-Environmental Interventions

Psychological and related interventions, based on the empirical and clinical literatures and related theoretical systems having specific relevance to persons with cognitive limitations and MH issues, address the following areas of personal functioning.[5,23,27,28] These areas represent major personal vulnerabilities that (a) place the person at heightened risk for aberrant behavioral acts that result in psychiatric hospital placement and (b) represent barriers to a more independent and personally competent level of personal and social functioning. These include two major classes of psychological risk factors.

The initial class consists of psychological features of a cognitive, emotional, motivational, and behavioral nature that by their presence or excessive nature represent vulnerabilities for aberrant actions.[5] These include, as examples:

(a) High habit strength for impulsive aggressive and related disruptive responding as a frequently used coping style when needs or desires are frustrated and stress level increases,

(b) A cognitive set or hostile attributional bias to inappropriately and persistently interpret hostile intent in the non-hostile actions of others, and a related cognitive expectation that acts of violence such as aggression, property destruction, or creating distress in others represent effective solutions to intra- and interpersonal conflict, and

(c) A number of emotional and motivational features such as an inclination to enjoy producing pain or distress in others, the idiosyncratic nature of conditions having motivational properties, the type, number, and range of events having aversive properties that produce excessive negative emotional arousal, the emotional level of arousal and lability when needs are thwarted or when the actions of others are viewed as hostile, and a motivational inclination to engage in sexual contact with children or other unwilling and non-consenting partners.

The second class of psychological risk factors include those that by their functional absence or low strength place a person with DD and MH issues at risk for those aberrant behaviors that necessitated inpatient placement.[5] These psychological features increase the risk of aberrant coping behaviors (e.g., fire setting, self-initiated exposure to conditions such as walking on busy roadways or entering private homes or property without permission and at unacceptable times, elopement from supervised settings, physical aggression, property destruction, threats of violence, sexual assault, and self-injury) whenever the person is exposed to provocative or exciting conditions that require alternative socially appropriate actions that are not present in the person's functional repertoires. These psychological vulnerabilities or risk factors for repeated occurrence of the aberrant behavioral symptoms that necessitate inpatient psychiatric placement include deficits (functional absence or low strength) in a range of behavioral, cognitive, perceptual, communicative, emotional, motivational, and impulse inhibition skills areas. Specific groupings of these personal vulnerability features include:

(a) Deficits in skills of self-monitoring and self-modulation of heightened arousal such as anger, irritability, or inappropriate sexual arousal,

(b) Deficits in skills to self-regulate (monitor and inhibit) impulsive acts, i.e., impulse control skills,

(c) Deficits in skills of communication, problem solving and interpersonal conflict resolution skills, and deficits in prosocial skill and social competencies as alternatives to interpersonal and personal conflict,

(d) Deficits in skills of self-selecting and initiating alternative prosocial coping strategies,

(e) Deficits in a socialized motivational system that values prosocial alternatives. Deficits in the following have been implicated by various sources[5,12,26,29]: empathic skills to cognitively and emotionally anticipate the effects that impulsive acts such as physical or sexual aggression, property destruction, or threats of violence have on others, and social motivation to please others, to assist others, to contribute to others, and to adhere to socially appropriate standards of conduct,

(f) Deficits in social motivation involving concern over creating distress in others,

(g) Deficits in social motivation to develop positive affective attachments with others, and

(h) Deficits in the motivational basis for assuming personal responsibility for one's behavior. This includes deficits in the cognitive and emotional internalization of socially appropriate standards of conduct. The person thus is without effective internalized standards against which to judge the appropriateness of his or her behaviors or to be motivated to self-regulate them.

To emphasize, a Habilitative Mental Health Treatment Program approach for patients with DD is designed primarily to promote personal competencies, increase choices, and promote mental wellness rather than to manage illness or control or suppress aberrant behavioral tendencies. To maximize the value of treatment strategies and to minimize the length of inpatient stay, treatment programs are required 24 hours daily, 7 days each week for the entire length of hospital stay. These treatment program experiences for each patient are individually designed to address the array of psychological, social and physical environmental, medical, and psychiatric or neuropsychiatric conditions identified through appropriate diagnostic assessments as contributing to each patient's behavioral and related psychiatric symptoms that resulted in hospital placement. Thus, individualized treatment experiences are required. Successful treatment of these individually unique clusters of causes would eliminate or significantly decrease the person's risk of repeating the same or similar dangerous acts or other related symptoms on discharge from the hospital setting.

### Treatment vs. Stabilization

It should be noted that effective treatment of the personal (medical, psychiatric, psychological, including behavioral) conditions resulting in the dangerous behavioral symptoms differs from a process of stabilization of these behavioral symptoms following hospital placement. To illustrate, a patient's dangerous behavioral symptoms may abate following hospitalization if the person is removed from the crisis producing conditions present in the patient's community placement. These stressors (e.g., chronic rage-producing interpersonal provocations, environmental constraints, supervisory characteristics) or environmental opportunities (e.g., to set fires or to molest children) may not be present in the hospital setting. As a result the patient's behavioral symptoms may reduce or disappear in this managed environment. Nonetheless, unless the patient's psychiatric and psychological pathologies have been identified and successfully treated while hospitalized, he or she will remain vulnerable to recurrence of the behavioral symptoms on being exposed to the symptom-producing conditions when returned to the community.

### Habilitation vs. Rehabilitation

A final distinction is offered. The habilitative nature of the treatment needs of the patient with DD are not adequately addressed within the prevailing unitary mental illness treatment paradigm that defines the predominate case formulation paradigm that guides diagnostic and treatment activities for psychiatric patients who do not have the dual diagnosis of a developmental disability. A mental illness paradigm designed to remove or manage acute symptoms of a mental illness via psychiatric treatment (mostly psychopharmacology) and ancillary therapies is inadequate for people with cognitive limitations and co-occurring behavioral challenges. The objective of the mental illness paradigm is one of (re)habilitation, that is, that of restoring the patient to the level of personal and social competencies present prior to occurrence to the current mental illness episode that required hospitalization. As noted, the specialized Habilitative Mental Health case formulation paradigm for persons with DD, in contrast, is designed to understand and facilitate development and functional use of a range of personal psychological and related functional competencies that either are nonfunctional or had never been acquired by the patient. With successful habilitative MH treatment, these newly gained emotional, cognitive, and behavioral competencies will replace each person's cluster of psychological pathologies and thus reduce the likelihood of recurrence of the symptoms that place the person at risk for hospitalization.

## Methods of Providing Psychosocial Interventions

A Habilitative Mental Health Therapy approach provides a desirable therapeutic match between psychosocial therapy and training procedures, and the cognitive, emotional, and

motivational characteristics of patients with impaired intellectual and adaptive behavior features.[11] A careful reading of the clinical and empirical literatures reporting the effects of psychological therapies with persons with MR suggests that attainment, as well as generalization and durability, of treatment effects may be enhanced by using concrete action-based rather than abstract cognitive-based therapy procedures. This treatment theme is an essential when working with persons with limited cognitive and language skills. A Habilitative Mental Health Therapy approach utilizes a concrete and direct therapy and teaching approach designed to facilitate change in interrelated triads of behaviors, emotions, and cognitions. Verbal or "talk therapy" represents only one element of a range of action-based skills teaching and behavioral rehearsal therapies. When "talk therapy" is offered, the approaches used are modified to meet the cognitive and language characteristics of persons with impaired cognitive skills.[19,20,21,22] Rather than attempting to change pathological cognitions or pathological behaviors or pathological emotions and motivations, all three components are viewed as intimately interrelated. Thus, these interrelated elements comprise the "triads" that become the central focus of treatment. Specific adaptive skills (selected on the basis of patient-specific diagnostic formulations) that could be useful for each individual in coping with specific problem situations are taught initially. Concrete (rather than abstract cognitive) representations of skill deficits are used to facilitate learning.[11]

Such action based program components as role modeling, role playing, emotional retraining, behavior rehearsal, specific performance feedback, self-monitoring, self-evaluation, self-consequation, and self-instruction paired with graduated exposure to conditions of provocation and leading to eventual practice of skills in situ all represent major therapy and teaching tactics. Incentives are a critical treatment component in therapy and identified through an individualized motivational analysis.[5] The contingent relationship between behavior and positive consequences is represented (e.g., visually, pictorially, graphically) in a concrete manner and reviewed routinely. Positive reinforcers are provided frequently and represented concretely. Progress toward goal attainment is concretely represented (e.g., visually, pictorially, graphically) and reviewed frequently. Situations in which problem behaviors occur are progressively reconstructed during training to insure functional utility for the patient as these situations are faced in the future. Additionally, following success in specific situations of provocation, the patient is then taught more general problem solving skills for use in other similar situations. Specific procedures, including cognitive labeling, self-talk, and problem solving skills, are used to train for generalization of these skills to future situations. (Note the sequence: initially train specific coping skills with suitable motivational supports, then teach the person to self-management these when confronted with problem situations.) The patient is systematically provided increased independence in decision making relative to behavior-consequence outcomes.

Therapeutic outcome is maximized when various "core conditions" are present. Buetler[3] has emphasized that "therapeutic change is greatest when the therapist is skillful and provides trust, acceptance, acknowledgment, collaboration and respect." (p. 1005) Additionally, as illustrated, the therapist with a major objective of increasing triads of cognitive-emotional-behavioral competencies is in an ideal position to contribute to the patient's concept of independence, competency, empowerment, and self-esteem.

In summary, the end goals entail increasing the person's triads of interrelated behavioral-emotional-cognitive competencies. These competencies serve as functional replacements for both the pathological personal features that place the person at risk for hospital placement and for those personal features identified as being so dangerous or disruptive that continued hospital placement is needed.

This Habilitative Mental Health Therapy Model is ideally suited for persons with DD who present impaired cognitive skills as the person is taught specific skills and provided the motivational supports to use these rather than assuming that cognitive representations learned during verbal exchanges will automatically be translated into action in future situations. In the context of the Habilitative Mental Health Therapy Model, the functional significance of any program component and its objective(s) can be evaluated relative to the discharge criteria established for each person.

## Suggested Standards of Practice

**Standard 1.** Multimodal Diagnostic Assessments

1. (a) At the time of admission or within a reasonable time thereafter, hospital staff will complete diagnostic assessments of each patient. These assessments are undertaken to identify possible biopsychosocial modalities of influence (i.e., medical, psychiatric, neuropsychiatric, psychological, and social and physical environmental features) that have contributed to and continue to represent risk factors for repetition of the dangerous behavioral incidents that resulted in inpatient placement. Professionally trained members of the multidisciplinary staff will complete those diagnostic assessments relevant to each of the modalities of influence.

   (b) The results of these modality diagnostic assessments (i.e., medical, psychiatric, psychological, social and physical environmental) will be integrated into a comprehensive matrix of diagnosed pathological risk conditions presumed to produce or contribute to the occurrence, severity, and recurrence of the dangerous behavioral symptoms precipitating hospitalization.

   (c) A comprehensive multimodal case formulation compatible with this integration is required to represent the separate and possible interactive effects of each set of influences. Gardner and colleagues[5,6,9,10] offer one such model. This Multimodal Contextual Case Formulation paradigm offers guidance to the treatment team in speculating about the separate and interactive roles served by each of the diagnosed conditions presumed to influence each patient's aberrant behavioral and psychiatric symptoms. In this multimodal paradigm, the DSM-IV diagnosis(es) may represent only one of a number of other possible biomedical, psychological, and socio-environmental diagnostic hypotheses relating to vulnerability or risk factors involved in a patient's problem areas.

**STANDARD 2.** DIAGNOSTICALLY-BASED TREATMENTS

2. (a) All biomedical and psychosocial interventions will be integrated into a comprehensive Treatment Plan. This Treatment Plan will specify the interrelationships between and among all components of the Plan. Specifically, the results of the diagnostic assessments are used to guide selection of specific treatments to address each component of the matrix of medical, psychiatric, psychological, and social and physical environmental risk conditions diagnosed as contributing to occurrence and severity of the behavioral and related psychiatric symptoms that result in and continue to place the person at risk for hospital placement. To repeat, all interventions are based on diagnostic hypotheses derived from results of individual assessments of possible causative influences. Additionally, for each treatment target (e.g., psychotic symptoms such as hallucinations or delusions, anger management skill deficits, conflict resolution skill deficits, self-monitoring skill deficits), the specific role and presumed magnitude of effect of these on the dangerous behavioral symptoms are specified. Finally, an estimate of the time frame is provided within which treatment effects can be expected to occur prior to modification of the treatment approach. In sum, diagnostic-treatment formulations shall be provided for the following: what is being treated, how do the various interventions interrelate, what results are expected, within what time frame are these expected to occur, and to what extent these treatments will reduce the risk of recurrence of the problem behavioral symptoms requiring psychiatric hospitalization.

   (b) The biomedical and psychosocial conditions identified during the diagnostic process as producing the behavioral and related psychiatric symptoms that resulted and continue to represent risk for hospital placement shall represent the central and continuing focus of each patient's treatment programs.

   (c) The habilitative treatment program objectives and associated therapies and training programs included in each patient's Treatment Plan shall be individualized; that is, selected specifically to treat the individually unique biomedical and psychosocial pathologies identified during the diagnostic assessment process as major contributors to the dangerous behaviors precipitating hospital placement.

(d) Each patient's Treatment Plan shall address in an individual manner the medical, psychiatric, psychological, and social and physical environmental conditions involved in any additional behavioral and psychiatric concerns that have developed since hospital placement. These interventions are diagnostically-based.

**STANDARD 3.** BEHAVIOR SUPPORTS INTEGRATED AS COMPONENTS OF TREATMENT PLAN

The Treatment Plan for a patient who presents recurring behavioral concerns in the hospital setting that result in use of time out, seclusion, restraints, and PRNs for behavior control:

3. (a) Shall include individualized behavioral support strategies and approaches based on comprehensive and integrative biomedical, psychological, and social and physical environmental assessments of factors influencing occurrence, severity, fluctuation, and durability of these current behavioral concerns.

   (b) Shall include strategies and approaches that shall be predominately proactive and preventative and specifically designed to avoid undue restraint on the patient's freedom of movement.

   (c) These behavior support strategies and approaches shall be designed to encourage each patient to use prosocial coping skills as alternatives to disruptive actions under the specific antecedent conditions that influence occurrence, severity, and recurrence of these behavioral concerns.

   (d) The behavior support strategies and approaches shall be integrated into the patient's Treatment Plan rather than being a separate and independently developed Behavior Support Plan document. The strategies and approaches shall be designed to reduce or eliminate the conditions producing these behavioral concerns, including the development of coping skills to serve as prosocial functional alternatives, rather than merely to manage problem behavioral symptoms.

**STANDARD 4.** APPROPRIATENESS OF PSYCHOLOGICAL AND RELATED THERAPIES

The psychological and related therapy and teaching methods used in the patient's program approaches shall be appropriate for persons with limited cognitive skills and persisting problems of impulse control and related difficulties involving negative states of emotional arousal and over-arousal. Determination of appropriateness is guided by the empirical and related conceptual literatures that support or suggest possible efficacy with persons with MR who present with psychiatric and behavioral disorders.[5,8,27,28]

**STANDARD 5.** ASSESSMENT OF PROGRAM EFFECTIVENESS: PRESENCE OF AN OBJECTIVE DATA OBSERVATION, RECORDING, AND TREATMENT EVALUATION SYSTEM

An objective data observation, recording, and evaluation system shall be present to monitor the progress and outcome effectiveness of the separate and combined treatment program components. Both individualized and program-wide objective data evaluation systems are present. These procedures may involve standardized scales and inventories as well as individually developed procedures. These systems support the clinical decision making process, facilitate a hypothesis-testing approach to case formulation, and provide measures of the impact of interventions. These monitoring systems shall be used by the Treatment Team to assess effectiveness of each biomedical and psychosocial intervention and to make timely changes in the treatment approaches when data results dictate.

**STANDARD 6.** SPECIFICATION OF RESPONSIBILITIES FOR TREATMENT PLAN

Each Treatment Plan, including the behavior support components, will include specification of staff responsibilities for each component of the plan, i.e., who will do what, when and where will it be done, how will implementation be monitored, how and when will program effectiveness be assessed, and who will supervise each component?

**STANDARD 7.** NATURE OF DISCHARGE CRITERIA AND PLANS

7. (a) All discharge planning shall involve the patient, family, guardians as appropriate, and community service and residential providers. A comprehensive matrix of community supports needed for each patient to insure successful transition and adjustment to community living will be developed and modified as need to reflect the patient's current status. Specification of responsibilities

for delivery and ongoing monitoring of each of the identified community supports will be included in the Discharge Plan.

(b) Discharge criteria will be objectively defined and reflect consistency with treatment plan objectives and treatment experiences provided in the hospital setting. These criteria will be considered in selection of short and long-term treatment program objectives.

(c) These discharge criteria shall be communicated to each patient in such a manner that, in view of the impaired level of cognitive understanding present in persons with DD, insures that each patient is aware of his or her current status and progress toward attaining these criteria.

**STANDARD 8.** TREATMENTS DESIGNED TO ENHANCE COMMUNITY ADAPTATION

Treatment experiences provided each patient will best represent those required for more responsible and independent functioning in less restrictive community environments.

**STANDARD 9.** PROTECTION FROM HARM

The hospital treatment experiences, living arrangements, and staffing patterns will provide for adequate protection from physical and psychological harm and freedom from time out, seclusion, physical or chemical restraints or other movement restrictions. A review process will be present that evaluates in a timely manner each incident of use of restrictive procedures. Written results of this evaluation will be provided for use by the Treatment Team to insure progressive reduction and elimination of these procedures.

**STANDARD 10.** SPECIALIZED TRAINING OF STAFF

10. (a) All staff members shall be specifically trained to provide a Habilitative Mental Health Treatment Program and care for persons with DD and significant MH concerns. Only staff specifically trained in their use will implement specific therapies, including behavioral therapies.

    (b) There will be an active program of staff development training designed to insure that all staff are trained in the most current and effective interventions for persons with MR and significant MH issues.

## SUMMARY

Placement of individuals with MR in inpatient psychiatric hospital settings may occur when behavioral and psychiatric symptoms cannot be treated or managed by available community resources. It is suggested that the prevailing mental illness diagnostic and treatment paradigm used in psychiatric hospitals may be inappropriate for persons with MR. An alternative Habilitative Mental Health Treatment paradigm is offered to guide the diagnostic-treatment case formulation process. A set of practice standards addressing critical elements of this process is provided.

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