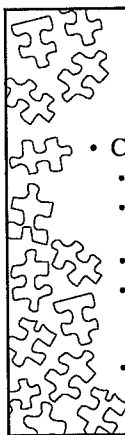


**Psychiatric/Behavioral Crises in
Persons with Dual Diagnoses**

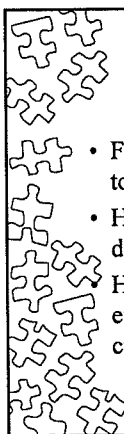
**Why they happen.
How do we minimize them?**

Deecil L. Moore, LCSW
Meridian Services



Info gathered from

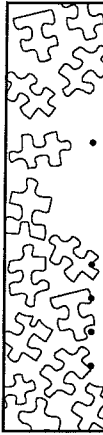
- Completing 2nd yr of Crisis
 - Available all ages, living situations—BDDS el
 - Cooperation with Indiana DDRS, AWS-cooperative agency
 - 577 persons in one way or another in crisis (20)
 - 24 hour hotline, in-home technical assistance, temporary out of home placements, follow along (*help in the thick*)
 - 308 at in-home or higher (in our 20 counties)



Today's Plan (*brief*)

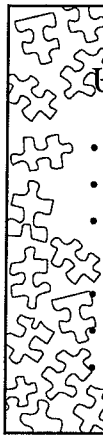
- Factors most commonly seen that contribute to Crises
- How to see commonalities that link; differences in need expression for each

How to develop Crisis Plans to enrich the environment—better meet needs/avoid crisis



Common Situation Which Lead to Crisis

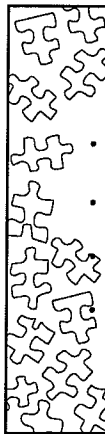
- Undetected/Misunderstood Needs
 - Notable medical needs
 - Poorly understood developmental level
 - Challenge seeing to social/emotional needs
- Complex Needs/Etiologies
- Defensive Caregivers/ Predetermined Plan
- Caregivers exhausted /angry
- Always starting from scratch



Undetected/Misunderstood Needs

- Medical
- Social/Emotional
- Developmental

Ted: head banging/biting
 Cheryl: no dating; no devices
 Diane: 4 hrs of appropriate behavior




**Tuning in to developmental level/
social emotional age**

- *DM ID quote*
- 50 something woman: focuses on eating, walking, showers, etc. Likes to touch others to connect
- 32 yo wants to date, curious about sex, worried about fitting in, resists direction
- 17 yo needs checks to see if wash hair well, has a girlfriend, has held her hand, hasn't thought of calling her outside of school

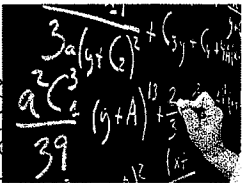
Complex Etiologies

- If only one etiology at work, Care Providers can often (not always) come up with appropriate interventions

Crises (whingle etiology) Come when the primary antecedent is not detected



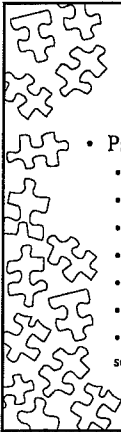
Escalating to Crisis



- Often, a combination of antecedents are at work
- When we address the issues in a “blanket” way, we can sometimes exacerbate needs

Complex Etiologies

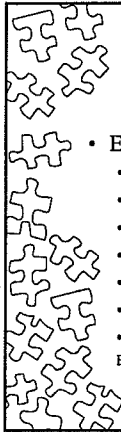
- **Medical/Dental/Neurological** (myriad of possibilities)
 - Physical pain
 - Neurological Events
 - Changes in blood sugar
 - Bad Teeth
 - Need for stimulation related to autism
- So may have an individual that has say... Labile blood sugars



Complex Etiologies

- **Psychiatric** (a few examples)
 - Active delusions
 - Mood disturbance
 - Anxiety
 - Post Trauma flashbacks
 - Hallucinations
 - ADHD
 - Personality Disorders/Self Perceptions

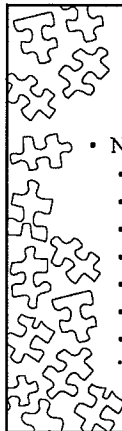
so ind w/ blood sugar, post traumatic responses



Complex Etiologies

- **Environmental**
 - Difficult to understand changes
 - Lack of control
 - Staff who interact in denigrating ways
 - Care givers who do not interact
 - Too much noise
 - Temperature not right
 - Too much/too little stimulation

Blood sugar, PTSD, developmentally resist structure,




Complex Etiologies


- **Need Management** (Behavioral/Developmental)
 - Communication of Emotion
 - Physical Needs: thirst, hunger, toileting, touch
 - Change in responsibility
 - Desire for connection
 - Desire for reassurance
 - Need for stimulation/relief from boredom
 - Need to individuate
 - Blood sugar, ptsd, adolescent resistance, difficulty expressing

Example. . . (help us get the mindset here)

- John's diabetes is increasingly a concern as he gains weight and has more drastic mood swings. His emotional/developmental age is approx. 15.
- Decision is made to ban all concentrated sweets



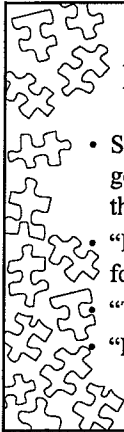
What Will Happen?



- How might he respond if we ban all sweets? (he may want only sweets)
- What will happen if we don't try to limit his sugar intake? (we become responsible for health plunge)
- How do we manage all needs and keep him healthy? (juggle all of those needs . . . Involve him)

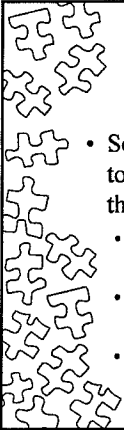
Dual Etiologies--ideas

- Certainly involve him—in everything, ask lots of questions, ask how he wants to be prompted
- Look to raise his awareness of what happens when his blood sugar is off (immediate and long term)
- Write expectations (mini culture)—how she people respond, prompt, limit, remind



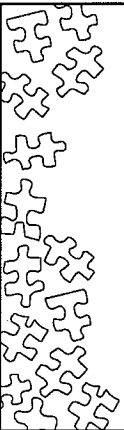
By the time a crisis comes. . .

- Sometimes caregivers are angry (often with good reason) and look for ways to make things unpleasant for the consumer
- "I'm gonna put you on a behavior program for that."
- "Then you can't have breakfast for dinner"
- "My eye is swollen up and I can't see."



State of Caregiver

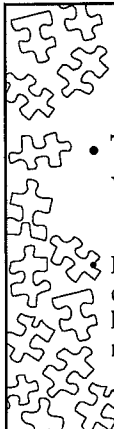
- Sometimes caregivers have some resistance to options because they want to believe that they have tried everything (this is natural)
 - *"We've tried that" . . . Sometimes, not always, it was for 45 mins back in 1979 (other factors)*
 - *"No. That won't work."* Sometimes no supportive evidence
 - *"Just need to go to the hospital"*



The Truth About Psychiatric Hospitalizations



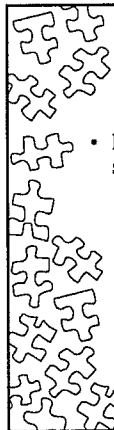
- No magic pixie dust
- Need to work together
- Could possibly look at medications (send home before sure of results)
- Give very brief respite
- Best case: begin to lay framework



Truth about hospitalizations


- **THEY WILL COME BACK WITH THE SAME ISSUES**

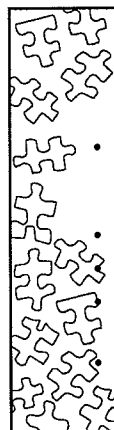
Essential that current care providers continue to work with the crisis team, hospital, individual, and each other to maximize the benefit



Starting From Scratch

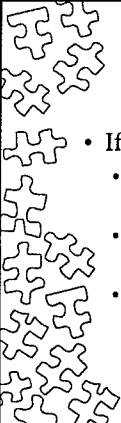
- Many times people start all other...
 - Searching for antecedents
 - Trying to find motivators
 - Trying to find consequences
 - Trying to find approaches






Another Example

- Jake is displaying: Verbal Aggression, Physical Aggression, Active Psychosis, Resistance to tasks
- 8 psychiatric hospitalizations in 5 months
- Goes through times of increased seizures
- Is angry at his parents for not understanding him better
- Environment Chaotic (parents depressed)




What Will Happen?

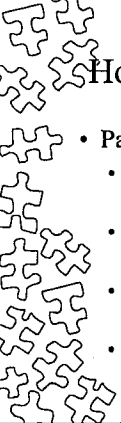
- If with Jake:
 - We take him to the psychiatrist and wait for a med change to take effect? (dec psychosis but incr seiz)
 - We take him to the neurologist and wait for guidance regarding neurological shifts. (inc in psyc)
 - We initiate a behavior plan that rewards for him for cooperating? (only addresses some—and inc env anger)



What If We Change All At Once?

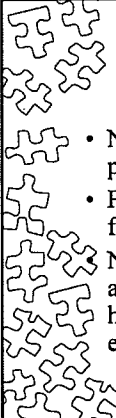


- Making all the reasonable changes at once can be dangerous: takes coordination but also confuses what's working
- Sometimes necessary



How Do We Address Them All?

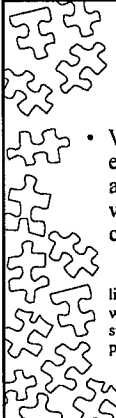
- Part of the answer. . . .
 - Understand subtle differences in communication/pattern
 - Understand and document differing preceding events
 - Look for common underlying needs and enrich the environment for all
 - Document!



For example. . . Jake

- Neurological: seizures increased when psychosis decreased
- Psychiatric: psychosis varied but kept him from staying focused on tasks

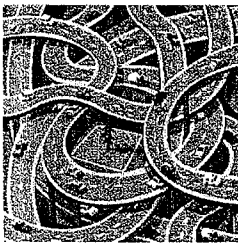
Need Management: got restless then angry at his parents for not helping him, this fed his agitation/resistance and sometimes evidence of psychosis

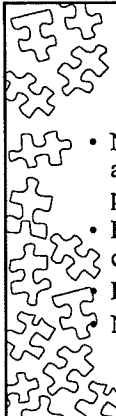


So, what hadn't work for Jake before?

- Wasn't a coordinated effort to understand and support his needs while coordinating changes. . . .

literally writing out a plan—what the progression is, ways to support needs, when to hit the panic button—helps



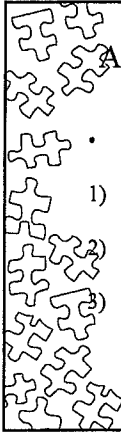


Jake

- Neurological: documented seizure pattern; asked neurologist to communicate with psychiatry
- Psychiatric: documented med history, coordinated communication w/neurologist

Environmental: gave parents some relief

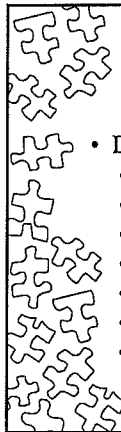
Need Management: “What do you want?”; “you seem mad”



Are there commonalities for helpful changes that we can make?

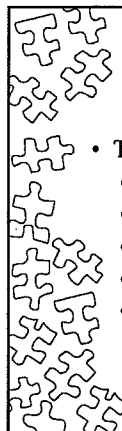
- Often there are basic changes that we can make that help meet all of his needs (coordinate a plan)

- 1) Tune in to him and changes in him (document and read)
- 2) Work to understand his needs and how he communicates
- 3) Structure opportunities to move his communication of needs to more universally understood methods write what we know down so every one can utilize, reflect and educate him so he can know/share



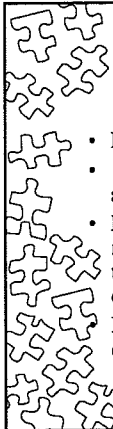
Crisis Plan for Jake

- Describe the basics—
 - where live
 - with who
 - how get along
 - medications
 - medical issues
 - learning style**
 - social/emotional developmental level**



Crisis Plan

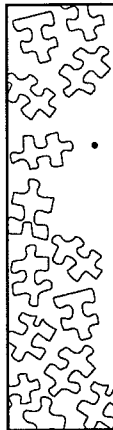
- The Basics Continued
 - Baseline frequency of behaviors
 - Strengths
 - Preferences
 - Supports
 - Stressors**



Crisis Plan

- **Behavior/Symptom:** Agitation/Resistance
- **Etiology/Hypothesis/Antecedent:** Often angry at the chaos and his parents
- **Proactive Interventions:** Get parents regular relief, Make sure that he has goals he can work toward, Give him things that he has complete control over

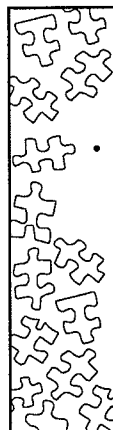
Reactive: Withdrawal, let him know consequences if tries to hurt someone



Progressive Behavior. . .

- **Seizures**
 - Agitation—pacing (looked a lot like <agitation)
 - Less responsive
 - One seizure then many

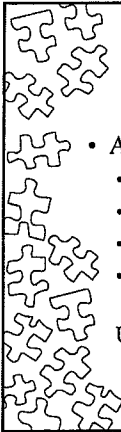
Identifying this sequence helped us understand when agitation meant seizure vs anger



Progressive Behavior

- **Resistance related to anger**
 - Would yell at parents about something small
 - Would become persistently verbally aggressive
 - Would become agitated and pace
 - Would become physically aggressive

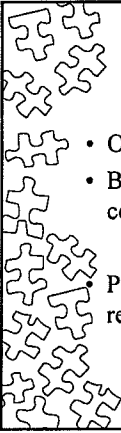
Understanding this progression helped us discern between anger, seizure, and psychosis agitation



Progressive Behavior

- Agitation related to Psychosis
 - Would pace and talk loud
 - When confronted, would talk of Jesus
 - Would resist showering
 - If agitation continued, he would become verbally and physically aggressive

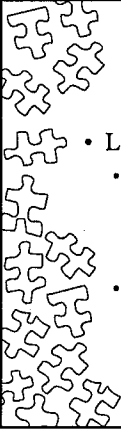
Understanding this progression, helped us respond to reassure him as opposed to previous



Agitations similar

- Often get labeled with one antecedent
- But they can mean different things—
certainly represent different needs

Progression helped us learn and then respond in positive ways



Crisis Plan

- Laid out. . . .
 - Overall preventative methods: allow him specific control areas, help him find goals, look for and document seizures and apparent hallucinations
 - Different response strategies depending on which kind of agitation was seen

Crisis Plan (preventative then. .)

- Agitation:
 - Pacing first: 1) "seem upset"
 - probably psychosis or seizures—w/anger pace comes later
 - talk about Jesus, when has he showered last??— psychosis (reassure)
 - Is he slowing down?—activate sz safety plan
 - Has he been yelling at parents about little things—anger (remind of goals)

Jake

- Now over one year without hospitalizations
- Living in group home
- At last report, visited parents happily at times


Q & A

Further Research Needed and Thanks

- Of course, still seeking to understand complex etiologies better

Thanks to organizations like Indiana DDRS, NADD as we seek to unravel the complexities of how crises occur in persons with Dual Diagnoses

Dual Diagnoses Heroes



- Randy Krieble
- Dortha Joyce
- Rob Fletcher

- Jim Wiltz, Tim Stultz
