
Chapter 10

The Interdisciplinary Mental Health Team

Jane Summers, Kerry Boyd, Julie Reid, Judith Adamson, Brenda Habjan, Valerie Gignac, and Charles Meister

Learning Objectives

Readers will be able to:

1. Describe the difference between an interdisciplinary and multidisciplinary team
2. Identify the roles and functions of health professionals on a dual diagnosis team
3. Define the role of the core team
4. Know how to get the most out of a consultation

Introduction

The purpose of this chapter is to describe the roles and functions of a number of health professionals who work with individuals with a dual diagnosis. While members of each discipline make specific contributions, their roles often overlap. We are using our interdisciplinary clinical service as the basis for the information that is presented in this chapter, but want to point out that dual diagnosis teams other than ours may look different (e.g., Ryan, Rodden & Sunada, 1991), depending on

a variety of factors such as the philosophy and mandate of the team, its model of service delivery, level of funding, proximity to medical and hospital-based services, and the availability of trained professionals.

We begin this chapter by offering some general comments about issues of importance to the field of dual diagnosis. These comments will be followed by a definition of *interdisciplinary* and *multidisciplinary* health care teams. Although many people use these terms interchangeably, they are in fact different. Afterward, we will describe the roles and functions of the health professionals on our own dual diagnosis team, and use a case example to illustrate our model of service.

General Comments

1. Currently, there is no commonly accepted definition of dual diagnosis. Essential elements of dual diagnosis appear to be a developmental disability and a mental health issue. Our own particular view of mental health issues is fairly broad and encompasses psychiatric, behavioural, emotional and/or communication problems. This perspective is not necessarily shared by everyone; some service providers use a more narrow definition of mental health problems (for example, mental illness or psychiatric disorders).
2. Although there are a few training opportunities in Ontario that prepare professionals to work specifically with clients with a dual diagnosis, the demand for their services far exceeds the supply of trained professionals. Key aspects of the job are often under-recognized or under-funded, such as the importance of ongoing education and research; the

need to allot ample time for assessment and consultation since they often take longer; and the availability of flexible funding arrangements that permit health professionals to be compensated for indirect clinical time. As a result, it is often difficult to recruit and retain trained staff.

3. Particularly for clients with numerous or complex problems (cognitive, medical, psychiatric, neurological, behavioural, communicative), an approach to care is required that draws on information from multiple disciplines and treatment modalities (AACAP, 1999; Fahs, 1988; Silka & Hauser, 1997).
4. Our role as consultants necessitates that we work very closely with a core group of people who know the client best, and who play an ongoing and important role in his/her life. This *core team* often consists of the client, family members, family physician, case manager and direct care staff, and may include the job coach, teacher, and other personnel. We depend on this core team to provide information during the assessment, and to play a key role in implementing our recommendations.

Definitions

Interdisciplinary Health Care Team

Members of two or more health professional disciplines, using a systematic and integrated approach based on their respective health disciplines' body of knowledge, work together to achieve common clinical goals. Decisions about the assessment, formulation and treatment of cases are made *collaboratively*. This type of approach is well-suited to clients with

complex or multiple disabilities (Dowrick, 1996).

Multidisciplinary Health Care Team

Members of two or more health professional disciplines, drawing on their own discipline's body of knowledge, work separately to achieve clinical goals. Decisions about the assessment, formulation and treatment of cases are made *independently*. This type of approach is well-suited to clients with few or less complicated disabilities (Dowrick, 1996).

Issues Affecting Interdisciplinary Team Functioning

Effective interdisciplinary team functioning does not occur merely because professionals are placed together who share responsibility for the same population, or who share the same physical workspace. Instead, what is most important is for team members to share a common framework and set of core values. Team members must often shift from a more hierarchical or "top down" organizational approach to one in which they have equal status, and view each other with mutual respect and understanding. A number of obstacles exist that impede effective interdisciplinary teamwork; these include preconceived notions of differential status among disciplines; the existence of professional rivalries; and differences in philosophy or theoretical perspectives (Hollins, 1985; Koskie & Freeze, 2000). The following factors and conditions may promote effective team functioning:

- At the outset, team members should devote sufficient time and attention to developing core group norms that promote and maintain interdependent functioning, including ways to resolve conflict within the team;

- Organizational and administrative supports may need to be engaged to assist with the process of team building, through the provision of mentors or facilitators to lead team building exercises and protected time in which to participate in these activities;
- A working environment that models and rewards interdisciplinary activities needs to be established (Sands, Stafford, & McClelland, 1990; Vinokur-Kaplan, 1995).

Roles and Functions of Mental Health Professionals on the Dual Diagnosis Team

Psychiatric Nursing

What is a Registered Nurse?

A Registered Nurse (RN) has obtained a nursing diploma or baccalaureate degree in nursing from an approved programme, has successfully passed a registration/licensure examination, and holds a certificate of registration with the College of Nurses of Ontario. After completing the basic training requirements, a nurse may choose an area of specialty (for example, psychiatry), and undergo additional training.

What is the role of the registered nurse in working with clients with a dual diagnosis?

1. Triage referrals and prioritize those who will be seen by the psychiatrist.
2. Coordinate the involvement of other mental health professionals on the interdisciplinary team.

3. Interview the client, family and caregivers (staff from the day and residential programme, support worker or case manager, teacher, advocate, as well as anyone who plays a significant role in the client's life).
4. Obtain background information from the family physician and other sources (previous assessments and involvement with other health professionals).
5. Prepare a summary of referral issues and clinical history.
6. Brief the psychiatrist prior to the psychiatric assessment via written summary and verbal report.
7. Coordinate the psychiatrist's schedule.
8. Provide follow-up and monitor the client's response to treatment.
9. Educate the client, family and caregivers about signs and symptoms of psychiatric disturbance, medication effects and side-effects, optimal use of a PRN (as-needed) medication, and a crisis response plan.

What is the role of the registered nurse on the interdisciplinary mental health team?

1. Provide the psychiatrist with background information that allows for the most efficient use of his/her time.
2. Contribute information regarding the cases that are seen by the psychiatrist, and assist other disciplines to identify clinical issues that may warrant a psychiatric assessment.

Psychiatry

What is a psychiatrist?

A psychiatrist is a medical doctor whose specialty is the study and treatment of mental disorders. After receiving an M.D. degree, the physician generally trains for four additional years at a university-based residency programme, and is required to pass written and oral examinations to be certified with the College of Physicians and Surgeons.

What is the role of the psychiatrist in working with clients with a dual diagnosis?

1. To identify psychiatric disorders and address mental health concerns. A further role of the developmental psychiatrist is to understand the communicative function of behaviours if the client cannot verbally report his/her inner experience. This requires a comprehensive assessment, and typically involves a review of the previous reports that have been gathered by the psychiatric nurse, information from other disciplines on the mental health team, and direct information that is obtained from interviewing the client (where this is possible), family members and caregivers. The clinical history can include the following:
 - Personal information (e.g., age, living/work circumstances, information regarding the developmental disability)
 - Identified problems:
 - Baseline information (e.g., functional capabilities, strengths, weaknesses, personality, interests, quality of social interactions) to appreciate whether there has been a change in functioning that may in-

- dicating a psychiatric disorder
- History of identified problems:
 - Past Psychiatric History
 - Developmental History
 - Medical History
 - Medication History
 - Social History
 - Educational History
2. Evaluate mental status. This involves direct observation/interview in appropriate settings, and the clinical impressions that are formed regarding the client's state of consciousness, mood and affect, thinking, speech, motor behaviour, memory, concentration, judgment, and insight.
 3. Work with the family physician and other health professionals to evaluate medical conditions that may give rise to or exacerbate mental health problems.
 4. Synthesize information from past records, other disciplines and the psychiatric assessment into a biopsychosocial formulation. This may include a psychiatric diagnosis.
 5. Formulate comprehensive management recommendations. Management often includes interventions offered by other disciplines (e.g., a behaviour plan, psychotherapy, communication aides) and/or pharmacological treatment.
 6. Contact the family physician and/or members of the core team with findings and treatment recommendations.
 7. Explain medication benefits/side-effects to the client or his/her substitute decision maker. Obtain informed con-

sent for proposed treatments.

8. Provide education regarding mental health issues to the client, his/her caregivers and other service providers.

What is the role of the psychiatrist on the interdisciplinary mental health team?

1. Contribute information about the client's mental functioning.
2. Consider and synthesize information from other disciplines.
3. Refer the client to other health professionals for further assessment and consultation as needed, and act as a liaison with the mental health team.

What types of questions can be answered by a psychiatric evaluation?

- Does the client have a diagnosable mental disorder?
- If so, what are the most appropriate form(s) of treatment?

Behaviour Therapy

What is a Behaviour Therapist?

A behaviour therapist assists people to change or modify their behaviour through the use of procedures that are based on scientific research. Behavioural therapies can be used to help people learn to behave in ways that are healthier from a physical and a mental health perspective. Common components of a behavioural approach include:

- selecting, defining and recording specific behaviours
- setting targets or goals for change
- breaking complex behaviours down into small steps
- using positive-based approaches to strengthen behaviour
- developing a system to monitor behaviour change

A behaviour therapist has usually obtained an undergraduate degree in psychology or another human service discipline, and has taken courses in the area of behaviour therapy or behaviour modification. Behaviour therapists work in a variety of settings, including hospitals and mental health centres, schools, correctional facilities, developmental service agencies, or private agencies. They are supervised by a registered psychologist in many places. Some Master's level behaviour therapists are registered with the College of Psychologists of Ontario, and have the title of Psychological Associate.

Behaviour therapists use behaviour analytic approaches to study the relationship between behaviour and the environmental context in which it occurs. Applied behaviour analysis, or ABA, is particularly well-suited to working with clients with cognitive and communication deficits who may display severe behaviour problems. Functional analysis is one of the most familiar aspects of applied behaviour analysis, and involves determining the function or purpose that a behaviour serves for a particular individual. Once the reason for the behaviour is understood, along with the conditions that serve to promote and maintain it, an intervention is developed that incorporates strategies for reducing the occurrence of the problem behaviour, and increasing the occurrence of a more "acceptable" behaviour (i.e., one that enhances the client's social and personal well-being).

What is the role of the behaviour therapist in working with clients with a dual diagnosis?

In collaboration with the client and/or caregivers, the behaviour therapist will:

1. Provide an *operational definition* of the target behaviour by describing it in a way that it can be observed and measured. For instance, anxiety may be defined as hand wringing, pacing, and crying.
2. Develop a recording system to track the behaviour, in terms of its *frequency* (how often it occurs), *duration* (how long it occurs for), and *intensity* (its severity), as well as its antecedents (what happens prior to the behaviour occurring), and consequences (what happens after the behaviour occurs). The behaviour therapist uses direct and indirect methods of observation.

Direct measures include:

- Frequency counts
- Antecedent-behaviour-consequence (ABC) data
- Interval recordings
- Scatterplots

Indirect measures include:

- Review of case history
 - Interviews of client and caregivers
 - Use of questionnaires
3. Set clear objectives or targets for behaviour change that can be evaluated -- for instance, John will use his relaxa-

tion strategies when he is becoming anxious in at least 8 of 10 anxiety-provoking situations.

4. Analyze and summarize the data.
5. Develop a multi-dimensional intervention plan to achieve the behavioural objectives that have been identified. The plan should be based on a least intrusive/least restrictive/non-aversive model, and should address issues such as durability of behaviour change, and generalization of new behaviour to different people, tasks and settings.

What is the role of the behaviour therapist on the interdisciplinary mental health team?

The behaviour therapist on the interdisciplinary team can serve several functions:

1. Translate psychiatric symptoms into observable behaviours that can be measured.
2. Help determine whether a behaviour has a biological or psychosocial basis. For instance, does the client's pacing and agitation occur across settings, tasks and people, or does it occur under specific circumstances (e.g., when a particular person is nearby?)
3. Set up a monitoring system to track and evaluate the effects of treatment (for instance, medication) on the target behaviour.
4. Contribute information regarding the environmental stimuli (such as crowds, changes in routines) that are associ-

ated with the occurrence of the behaviour, and the consequences that serve to maintain it (e.g., the client is permitted to leave a task whenever he/she strikes out).

5. Work with the speech-language pathologist to help caregivers understand the communicative function of a client's maladaptive behaviour, and develop more acceptable or conventional means for the client's needs to be met.

Psychology

What is a psychologist?

A psychologist is a regulated health professional. Requirements to practice as a psychologist in the Province of Ontario include a doctoral degree from a programme of study with a primary focus in psychology, completion of a period of post-doctoral supervised practice, and passing written and oral examinations, all of which lead to registration with the College of Psychologists of Ontario. Under the Regulated Health Professions Act, psychologists are permitted to diagnose neuropsychological disorders and dysfunctions.

What is the role of the psychologist in working with clients with a dual diagnosis?

1. Diagnose or confirm that the client has a developmental disability, and assess the level of disability that is present.
2. Profile the client's strengths and weaknesses to assist with diagnostic formulation, habilitative goal setting, and therapy. Clinical information may be gathered by a variety of means, including administration of psychological tests, ob-

servation, interview, and review of previous records. Assessments may cover the following areas or domains:

- cognitive functioning - intelligence, memory, attention, problem-solving skills
 - adaptive skills - e.g., self-care, social and play skills
 - expressive and receptive language
 - visual-perceptual skills
 - academic skills
 - vocational skills
 - behavioural and emotional functioning
 - personality style
 - coping responses
 - Psychopathology
 - environmental characteristics and demands
3. Determine the need for further assessments, and refer to the appropriate professional - e.g., assessment by a speech-language pathologist to determine the most appropriate form of augmentative communication for a client with minimal or absent verbal skills.
 4. Screen “at-risk” groups for indicators of psychopathology.
 5. Provide individual, group or family psychotherapy.

What is the role of the psychologist on the interdisciplinary mental health team?

1. Contribute information on the client’s psycho-social functioning in keeping with the biopsychosocial approach.

2. Integrate the findings from the psychological assessment with information that has been gathered by other disciplines.
3. Supervise the behaviour therapist.

What types of questions can be answered by a psychological assessment?

- How well does John perform on this test compared to his non-handicapped peers?
- How well does John perform on this test compared to his peers with developmental disabilities?
- At what age or grade level is John performing?
- Has John's performance on this test changed over time?

Speech-Language Pathology

What is a Speech-Language Pathologist?

A speech-language pathologist (SLP) is a regulated health professional. Requirements to practice as an SLP in Ontario include a Master's degree in speech-language pathology and completion of an initial practice period, both of which lead to registration with the College of Audiologists and Speech-Language Pathologists of Ontario.

What is the role of a speech-language pathologist in working with clients with a dual diagnosis?

1. Assess a client's strengths and weaknesses in the areas of communication and swallowing. Assessment includes a combination of the following procedures: review of previ-

ous records; interview with the client, caregivers or others involved in the client's life; observation in a variety of settings; and formal and informal testing. Specific areas of assessment include the following domains:

- Articulation/Phonology
 - Language (expressive, receptive and pragmatic)
 - Voice
 - Fluency
 - Augmentative and Alternative Communication (AAC)
 - Swallowing (oral and pharyngeal stages)
2. Diagnose or confirm that a client has a disorder in one of the above domains of communication or swallowing.
 3. Screen for potential disorders in the area of hearing.
 4. Provide management and intervention around a diagnosed communication or swallowing disorder. This may include working with the client, caregivers or others involved in the client's life, and may be in the form of individual or group sessions.
 5. Provide clinical and community education around issues related to communication and swallowing disorders.
 6. Determine the need for further assessment. For example: psychological, psychiatric, hearing.

What is the role of the speech-language pathologist on the interdisciplinary mental health team?

1. Contribute information on the client's communicative and/or swallowing function.
2. Integrate the findings from the communication assessment with the information that has been gathered by other disciplines on the team for the purpose of developing an approach to optimize the client's mental health through the provision of treatment and support.
3. Supervise the communication disorders assistant on the team.

When to make a referral to a speech-language pathologist:

Whenever a delay or disorder is suspected in any of the following areas:

- Articulation/phonology - e.g., client's speech is hard to understand; mispronounces words
- Expressive language - e.g., client is non-verbal or minimally verbal; uses behaviour as a means to communicate; echolalic (repeats back what he/she has heard); difficulty forming sentences
- Receptive language - e.g., difficulty following directions; difficulty answering questions; doesn't seem to understand what is said to him/her
- Pragmatic language - e.g., lacking in non-verbal skills; difficulty initiating, maintaining or ending a topic of conversation; interrupts others; difficulty with conversational turn-taking
- Voice - e.g., chronic hoarseness; voice too loud or too soft; monotone voice
- Fluency - e.g., sound or word repetitions; sound prolongations; tremors, struggle or tension when speaking; anxiety or frustration around speaking

- Hearing - e.g., doesn't seem to respond to sounds in his/her environment; doesn't respond to his/her name; difficulty following conversation; needs to watch the face of the speaker
- Auditory processing - e.g., significant delay before answering a question; difficulty remembering information; says "huh" or "what" frequently
- Feeding/swallowing - e.g., coughing or choking during or after eating/drinking; excessive drooling; minimal or excessive chewing; difficulty starting a swallow; pocketing of food; gurgly sounding voice after eating or drinking; food or liquid in the nose; history of recurrent chest infections or pneumonia; unexplainable weight loss

Communicative Disorders

What is a Communicative Disorders Assistant?

A communicative disorders assistant (CDA) has received a diploma from an approved programme of study. CDAs may perform tasks as prescribed, directed, and supervised by a speech-language pathologist, working in the areas of augmentative and alternative communication, articulation, phonology, language, fluency, and aural rehabilitation.

What is the role of the Communicative Disorders Assistant in working with clients with a dual diagnosis?

1. Assist the Speech-language pathologist with the intake process.
2. Prepare material for assessment and therapy as directed by the SLP.

3. Assist caregivers to implement individual or group therapy goals for speech, language and swallowing services under the supervision of the SLP.
4. Maintain and demonstrate equipment.

What is the role of the Communicative Disorders Assistant on the interdisciplinary mental health team?

1. Educate the other disciplines about augmentative and alternative communication approaches.
2. Assist the SLP and behaviour therapist to develop approaches to integrate communication and behavioural objectives - e.g., providing a picture communication symbol that a non-verbal client can use to request a break instead of hitting his/ her head to communicate the same message.
3. Provide sign language courses or community education workshops on topics relating to communication disorders in clients with developmental disabilities.

Other Health Professionals Who May Be Asked To Consult With The Dual Diagnosis Team:

- audiologist
- cardiologist
- dietician
- developmental pediatrician
- geneticist
- geriatrician
- gynecologist
- neurologist

- occupational therapist
- ophthalmologist
- orthopedist
- pharmacist
- physiotherapist

Helpful Tips to Consider When Requesting an Evaluation by Health Professionals

1. When making a referral, be clear. Avoid making vague requests such as: “I am looking for a psychiatric evaluation for Sally.”
2. Phrase your concerns in the form of a question that can be answered -- for example: “Can you tell me if Sally is depressed?”.
3. If you can’t come up with a question, state the issue or concern in clear, definable terms -- for instance: “Sally hasn’t been sleeping well, is crying a lot, and doesn’t want to go out anymore. I’d like to know what is wrong with her, and what I can do to help.”
4. In the case of multiple concerns, be sure to provide a clear description for each issue.

How to Prepare for an Evaluation

1. Write down your concerns and questions. Pay attention to when you first noticed the problem, how often it occurs, where it occurs, and with whom. Be prepared to talk about the client’s mood, appetite, sleep, energy, and ability to function in social, leisure and work-related activities.

2. Check with other people to see whether they share your concerns.
3. If the client is unable to provide informed consent, a substitute decision maker (usually a family member) will need to be identified.
4. Make sure the family physician is aware of the referral.
5. Gather background information. If this is not possible, try to find out if the client was seen by any professionals in the past, and when this happened. The following types of reports and records are helpful to obtain:
 - medical
 - psychiatric
 - psychological
 - speech and language
 - behavioural
 - academic
 - vocational
5. Make sure the person(s) who knows the client best is present for the assessment.
6. For a psychiatric assessment, record when a medication was started, by whom, the reason why, the client's response to medication (both positive and negative), the date the medication was discontinued, and by whom.

Our Interdisciplinary Mental Health Team: The Area Resource Team

At this point, we would like to describe our interdisciplinary mental health team, and use a fictionalized case example to illustrate how our team functions.

Overview of the Area Resource Team

The Area Resource Team (ART) was created in 1994 to respond to mental health issues in adults with developmental disabilities who live in the region encompassed by Hamilton, Niagara and Brant. The team is funded by the Ontario Ministry of Community and Social Services, and is mandated to provide clinical service, education and training. ART is a community-based consultation service. This means that we try to see clients and their caregivers in their natural environment (such as home, work or school), and to work collaboratively with the service providers in their local area. This model allows us to provide specific expertise when and where it is needed, and to use our resources as efficiently as possible.

We have established satellite offices in each of the three areas we serve, which has helped us develop and maintain working relationships with community service providers, and enhance our profile locally. ART operates out of the Chedoke Child and Family Centre at the Hamilton Health Sciences Corporation. In addition, we have ties to the Faculty of Health Sciences at McMaster University. These factors enable us to bridge the developmental and mental health systems.

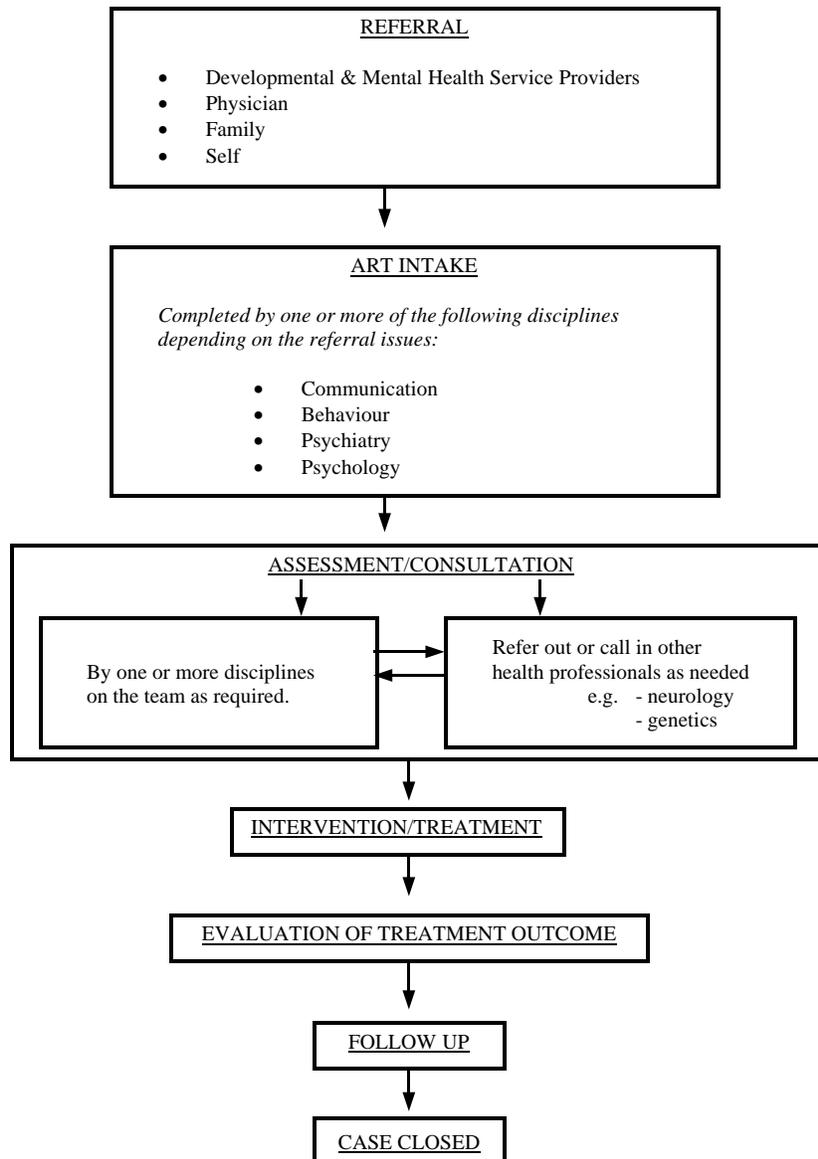
Consultation process

As we stated earlier, our conceptualization of mental health issues is fairly broad, and encompasses psychiatric, behavioural, emotional and/or communication problems. Referrals that are reflective of any or all of these issues can be made by anyone who is involved with the client, such as a family member, primary physician, case manager, direct care staff, inpatient or community psychiatrist, mental health worker, teacher, or probation officer, as well as the client him/herself. Referrals are screened to ensure that they meet the eligibility criteria for the service (i.e., the client is an adult, lives within the catchment area, is developmentally disabled, and has a primary physician). If the client is not eligible for the service, the person making the referral will be redirected to the appropriate resource.

Once the referral information is obtained, it is passed along to a member of the team. Discipline-specific referrals are handled by the appropriate health professional, whereas complex or ambiguous referrals are usually addressed by the psychiatric nurse who may request the involvement of other disciplines after clarifying the referral issues.

An intake meeting is held with the client and the members of his or her core team. The purpose of the meeting is to explain the process, obtain consent for consultation and release of information, gather clinical information, clarify expectations for the consultation, establish a tentative time-frame for the team's involvement, and sort out roles and responsibilities for the health professionals and core team members. The consultation proceeds with the interdisciplinary team members conducting their assessments simultaneously or in succession. During this process, the team members meet periodically to review the

Figure 1- Flowchart of The Area Resource Team Consultation Process



emerging information, and fine-tune the assessment plan.

Team members may make referrals to outside health professionals (e.g., cardiologist, neurologist, audiologist) for specialized or additional assessments to assist with their clinical formulation and treatment recommendations. Once the assessments have been completed, team members meet to integrate their findings into a bio-psycho-social formulation, and to outline a unified and comprehensive set of treatment recommendations. This information is presented at a case conference, and an intervention/treatment plan is developed. Staff training with regard to implementation of recommendations is provided as needed. Treatment is initiated and the client's response to treatment (as well as implementation of recommendations by the core team) is evaluated by way of systematic and objective data that are typically gathered by the behaviour therapist on the team. This process is repeated at follow-up meetings, and additional consultation may be provided on a short-term basis regarding specific clinical and systems issues. Once the goals for the consultation have been reached, the case is closed, but may be re-opened if the need arises.

The Case of Frank

Frank is a 40-year-old male who lives with his parents. His developmental disability is considered mild; however, he has significant difficulties in social situations, and in retaining employment. He had in the past, participated in anger management groups and individual behaviour therapy sessions because of long-standing problems with verbal and physical aggression. The behavioural interventions did not result in significant improvements in his social or occupational functioning.

Consequently, he was referred to the Area Resource Team by his case manager for an interdisciplinary assessment. Frank's family physician was contacted prior to the initial meeting, and was in support of the referral.

The presenting problems consisted of angry outbursts, anxiety, and lengthy cleaning rituals that interfered with Frank's performance on the job. Frank, along with his parents, case manager and vocational counselor, met with the psychiatric nurse, behaviour therapist and psychologist from the team. During the course of the meeting, it became clear that Frank had extreme difficulty responding to complex interpersonal dialogue. He tended to misread social cues, and was not able to integrate verbal and nonverbal information. Frank concurred with the recommendation to include the speech-language pathologist from the team.

The speech-language pathologist met with Frank and his caregivers to evaluate his communication style, as well as his strengths and weaknesses. The assessment revealed disabilities in the areas of expressive, receptive and pragmatic (i.e. language in social situations) language. These disabilities were a factor in relation to his tendency to misinterpret other people's verbal and non-verbal communications, and his striking difficulties in appreciating their perspectives. Moreover, he appeared to have difficulty maintaining a conversational topic, and giving appropriate non-verbal feedback to his communication partner. Too often, his interactions with others would lead to frustration and visible signs of anxiety or anger.

The behaviour therapist worked with Frank's family and vocational counselor to set up a data collection system to track his outbursts of verbal and physical aggression at home and on the job, providing information about what events and conditions preceded the outbursts (antecedents) as well as what followed them (consequences).

The psychological assessment revealed that Frank had deficits in basic academic skills (reading, spelling and arithmetic) that were more severe than would be predicted on the basis of his intellectual functioning. In terms of adaptive functioning, Frank displayed significant weakness (relative to other skill areas) in the area of social/communicative functioning. His emotional/behavioural profile revealed that he had difficulty organizing and completing tasks, had poor concentration and a short attention span. A personality inventory indicated that he had a tendency to argue with people, and to verbally challenge authority figures. He liked to do things his own way, and might react negatively to directions, suggestions and constructive criticism.

Frank identified that he had trouble understanding what people were trying to say, especially when he was in a group or when people used complex language. These difficulties were hypothesized to be related to a number of factors, such as attentional problems or difficulties responding to rapidly changing information, and could explain to some extent his tendency to misinterpret social situations, and to respond in an angry or defensive manner.

The team met prior to the psychiatric interview to share

their findings and treatment approaches. The psychiatric assessment supported his mother's theory that Frank had suffered from an undiagnosed obsessive-compulsive disorder since late childhood. In clinical terms, he had recurrent, unwanted, disturbing thoughts (obsessions) that dirt or invisible contaminants needed to be removed from his body or surroundings. He also had an intense need for symmetry and order in his environment. He was unable to suppress or distract himself from these thoughts, and engaged in repetitive behaviours (compulsions) to relieve the anxiety caused by the obsessions. Frank engaged in lengthy washing rituals for much of the day, straightening anything in the home that seemed "out of place", and vacuuming or wiping surfaces in the family home or vehicles whenever another person finished in the area. Although work placements were tailored to capitalize on his apparent interest in cleaning, he could not stop himself from performing cleaning rituals, nor could he tolerate directions or deadlines from supervisors. Apart from the diagnosis of obsessive-compulsive disorder, Frank did not have additional psychiatric, medical or neurological conditions, and was not on any medication. There was no family history of psychiatric or developmental problems.

The interdisciplinary formulation of Frank's long-standing problems with interpersonal conflict and retaining employment, highlighted biological and psychosocial factors that were informed by the speech-language, psychological, behavioural and psychiatric evaluations by the dual diagnosis team. This information was summarized in a written report that was presented at Frank's case conference, and a treatment plan

was developed.

Psychiatric treatment for Frank's obsessive-compulsive disorder was initiated through the family physician who prescribed a serotonin reuptake inhibitor, which was started at a low dose and gradually increased. Speech-language therapy targeted verbal and non-verbal communication and perspective-taking. Frank gained an understanding of the role of facial expression and body language in communicative interactions, and was able to apply that knowledge in his relationships. Perspective-taking was more difficult for him to grasp. Therapy sessions focused on the idea that people can "see" situations differently, and that in such situations it was important to attempt to "look" at the other person's point of view. He understood the concept, and could role play perspective-taking in a session; however, he had much more difficulty in real-life situations in which his typical emotional reactions and interactions prevailed.

The behaviour therapist and speech-language pathologist worked together, utilizing a variety of techniques (problem-solving, adaptive self-talk, social stories) to provide Frank with a means to better understand the triggers for his outbursts, and to teach him alternative means to resolve these situations before they escalated into conflict and aggression. Recommendations by the psychologist included allowing plenty of time for Frank to process information, and minimizing visual and auditory stimulation when possible; avoiding vague, imprecise language; and helping him to take personal ownership for his actions while recognizing his need for assis-

tance in the form of explicit teaching, reinforcement and practice in order to learn and apply new skills.

When Frank's response to medication was evaluated, there was an initial marked improvement noted in his overall mood, in that he was less anxious and "edgy". At follow-up three months later, he was better able to engage in a variety of work and leisure activities since his time was not taken up to the same extent with rituals and compulsions. Overall, Frank was pleased with the easing of his anxiety, and the fact that he was able to do new and different things. He also reported getting along better with his parents and his supervisor at work. Frank's family remarked on his improved mood, and mentioned that he was not as defensive and quick to anger.

Summary

In this chapter, we described the roles and functions of health professionals on a dual diagnosis team. We presented a rationale for using an interdisciplinary approach when working with clients with numerous or complex needs. We highlighted the necessity of working closely with a core group of people who are knowledgeable about the client's needs, and will be able to implement our treatment recommendations. We provided suggestions regarding what to consider when requesting an evaluation, and how best to prepare for it. Finally, we described our dual diagnosis service, and used a case example to link our points together.

Do You Know?

1. What is the difference between an interdisciplinary and multidisciplinary team, and which approach is better-suited to clients with multiple or complex needs?
2. What are the roles and functions of health professionals on a dual diagnosis team?
3. What is the role of the core team?
4. How do you get the most out of a consultation?

Resources

College of Audiologists and Speech-Language Pathologists of Ontario

Telephone: 416-327-0876

College of Nurses of Ontario

Telephone: 416-928-0900

Website: <http://www.cno.org>

College of Physicians and Surgeons of Ontario

Telephone: 1-800-268-7096

Website: <http://www.cpso.on.ca>

College of Psychologists of Ontario

Telephone: 416-961-8817

Website: <http://www.cpo.on.ca>

Communicative Disorders Assistant Association of Canada

Telephone: 416-544-3503

Ontario Association for Behaviour Analysis

Telephone: 416-410-6141

Website: <http://www.sl.on.ca/ontaba>

Ontario Association of Speech-Language Pathologists and Audiologists

Telephone: 416-920-3676
Website: <http://www.osla.on.ca>
Ontario Medical Association
Telephone: 416-599-2580
Website: <http://www.oma.org>
Ontario Nurses Association
Telephone: 1-800-387-5580
Website: <http://www.ona.org>
Ontario Psychological Association
Telephone: 416-961-5552
Website: <http://www.psych.on.ca>

References

- AACAP (1999). Practice parameters for the assessment and treatment of children, adolescents and adults with mental retardation and comorbid mental disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38 Supplement, 5S-31S.
- Dowrick, P.W. (1996). Principles of interdisciplinary team collaboration. In L.A. Kurtz, P.W. Dowrick, S.E. Levy, & M.L. Batshaw (Eds.), *Handbook of developmental disabilities: Resources for interdisciplinary care*. Gaithersburg, MD: Aspen Publishers.
- Fahs, J.J. (1988). Multidisciplinary psychiatric consultation in mental retardation. *NADD Newsletter*, 5, 1-4.
- Hollins, S. (1985). The dynamics of teamwork. In M. Craft, J. Bicknell, & S. Hollins (Eds.), *Mental handicap: A multidisciplinary approach* (pp. 281-287). Toronto: W.B. Saunders.
- Koskie, J. & Freeze, R. (2000). A critique of multidisciplinary teaming: Problems and possibilities. *Developmental Disabilities Bulletin*, 28, 1-17.

- Ryan, R., Rodden, P., & Sunada, K. (1991). A model for interdisciplinary on-site evaluation of people who have "dual diagnosis". *NADD Newsletter*, 8, 2-4.
- Sands, R.G., Stafford, J., & McClelland, M. (1990). "I beg to differ": Conflict in the interdisciplinary team. *Social Work in Health Care*, 14, 55-71.
- Silka, V.R., & Hauser, M.J. (1997). Psychiatric assessment of the person with mental retardation. *Psychiatric Annals*, 27, 162-169.
- Vinokur-Kaplan, D. (1995). Enhancing the effectiveness of interdisciplinary mental health treatment teams. *Administration and Policy in Mental Health*, 22, 521-530.

Acknowledgements

We would like to thank Dr. Elspeth Bradley and Carolyn Houlding for their feedback, as well as Julia Ollinger for her expert computer assistance.