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Please stand by for real time captions.

Good afternoon everyone. Thank you for your patience. We had technical difficulties. We will not see Dr. Trigoboff. Thank you for joining today's webinar. This webinar is presented in conjunction with the social worker's, healthcare professionals, nurses and MMCO to ensure that beneficiaries are enrolled in Medicare and Medicaid. And have a full range of coverages and programs. To learn more, please visit our website for more detail at [www.resourcesforintegratedcare.com](http://www.resourcesforintegratedcare.com) . Your microphones will be muted. There will be a question and answer session at the end. Please use the raised hand icon to ask a question. We will also have polling questions throughout today's presentation. At the conclusion of the webinar, you will be prompted to complete a survey. It is required to receive contact credits. If you are unable to complete the survey, you will receive an e-mail tomorrow with a link to complete the survey.

 Dr. Eileen Trigoboff is the director of program evaluation at the Buffalo center of psychiatric. She is board certified in four areas. She is an author and co-author to 14 books and dozens of articles.

 We are going to talk about the practical consideration. We will talk about the PowerPoint program that is in front of you. We will cover the development disability [Indiscernible]. Assessment strategies. Typical medication. Options, barriers and tools for care givers. Whether it is a family member or a staff member. We will talk about the disabilities. It ranges from 1.6% to 3%. You can have mild disabilities and all the way to seven years cash -- steadier. If you have not participated in a webinar, we no longer call it retardation but rather a disability. This will impact their quality of life. The most common is epilepsy or if no ability Bash -- in modality. There is John movement, -- job movement and [Indiscernible]. They are not swallowing, the -- and also pneumonia. And there are life issues. They eat quickly. It makes them a higher risk for choking. Another, mild cognitive impairment life expectancy. They may have illnesses layered on top of the disability. But the impairment [Indiscernible-low volume]

 If the person has an intellectual disability and whatever physical disability is going on at the time they may have psychiatric conditions. Diagnosed more frequently with the developmental disability population. You have schizophrenia. It is 1/2% to 1% worldwide. The descriptions MS symptoms remain the same which is an amazing to us. As clinicians we have this idea, we thought there would be more schizophrenia as a result of drug use. It remains about the same 1/2% to 1% but with someone that has an intellectual disability it is three times more prevalent. Bipolar illness. This is something that may not be treated right away. If it is not treated competently passed which we -- at which we will talk about later. Attention deficit. The abbreviation is ADHD. And my children population is between 8% to 15%. And people who have any level of intellectual disability are 17% to 52% of adults. Self-injurious behaviors require treatment and 3% to 15%. Major depression, artistic spectrum, obsessive-compulsive disorder, anxiety disorder, conduct disorder, post traumatic syndrome, and another behavior is more common in this population. What this light is saying that we have a lots of information about people living with an intellectual disability. And this is what we are going to talk about today. Five times the rate of emotional or behavioral or -- behavioral or problem. When it is, founded -- when it is compounded with a diagnosis of& He -- epilepsy it increases the risk of center it -- psychiatric problems up to 50%. All cold visual -- Occult visual and audio death affects -- deficits occur more than 50%. One in five people who have intellectual disability also have searchable palfrey -- cerebral palsy. As many as 20% have seizures. G.I. complications, feeding dysfunction, access the ruling, -- drooling, reflux esophagitis, and constipation. The asset that is supposed to stay within the stomach, will be reflux back into the is fast test -- esophagitis which is asset and is painful. And it can also carry bacteria. And of course constipation which exists normally with someone who has an intellectual disability because of the G.I. system. But also adding the medication will increase constipation. Urinary, locations, and or hygiene. Profound social morbidity. They are not able to work at the level with someone who does not have intellectual disabilities. They have difficulty with long-term relationships. They also have emotional lacking relationships. They can be considerate of everyone and not mention something that would be embarrassing to the individual. They are not very good at different trading between -- differentiating between constructive comes -- criticism. If someone said, boy you are short. And this impairs their ability to have a long-term relationship. And then there is emotional suffering. They may not understand or they do not feel understood by others. And either of those situations is difficult. Psychiatric problems they can have. There is a question. -- There is aggression. They could feel they are at eight disadvantage -- a disadvantage is not getting what they want. They are -- can become confused and act out. They can also have self-injury. They can cut, or bird, -- burn themselves. There can be defiance on how the person is reacting with people. Inattention. They are not willing to spend what intellectual currency they have, to whatever they are -- you present to them. Some people can have hyperactivity. Anxiety, depression, sleep disturbance this can be a result of trauma or miscommunication. And they could be also uncomfortable. It could be a symptom of a society -- psychiatric issue. You have stereotypical behaviors such as hand movement and facial movement. Before it can be identified, were very young ones such as infants. They can have a difficult temperament. Before we can diagnose someone we are looking at a child that is difficult to soothe or not getting along or not cuddling or resting. They are giving us choose -- cues.

 They may be non-compliance. On what is going on such a simple rules. They may be hyperactive or disordered sleep and also collect. -- Colic. There are four -- poor social skills. Or delay in playing skills. What kind of other clinical observations can we make? How there is an overlap between developmental disability and other psychiatric disorders. This is a simple way of paying attention to the various development disabilities. Such as autism or intellectual disability. At other psychiatric disabilities that are common. One out of -- 1 out of 4 women will have an episode of depression. You can have post traumatic syndrome and OCD. You can have withdrawal from social situation; you can see that these overlapping symptoms can happen. When you have both at once, you have to pull the thread on where this symptom is coming from? Is it coming from autism? Are they able to make eye contact? Or is it coming from depression? Or they do not care if someone else is in the room. Pessimism is a symptom of a psychiatric condition. It is not part of their regular personality. If it is from someone who is neutral -- and all of a sudden they become pessimistic this is a symptom of depression.

 Irritability. If this is normal for a person is not a psychiatric problem at all. If it is late -- lasting day after day, we are looking at depressive system or a bipolar system. -- [Captioners transitioning]

 It could be part of an as Burger or and an inter remembering you'll disability. And acting out behavior could come from just feeling uncomfortable or being some situations that don't suit you. So let's talk about treatment. There's no treatment available specifically for cognitive deficiencies. There's no medication I can give you to make a cognitive piece go away. That doesn't happen. And something important to pay attention to. We're going to cover that when we do the poll. Such as [INDISCERNIBLE]

 And you're not taking it. Then the disease will continue and it will establish pathways that are going to make it much more difficult for people to function, and for them to have a better quality of life. So you want to always be able to assess for these symptoms. Side effects are the reason so many people don't like to take their medications as prescribed. There are some benefits. But there are certainly risks to taking a medication that has side effects. I just wanted to mention about the side effects that happen particularly with psychiatric medications. There's a neurological process in our brain that's actually shaped like a pyramid and it's called imaginatively enough the pyramidal system, because it's shaped like a pyramid, and then just outside the pyramidal system is the extra pyramidal it's just outside, that's where the side effects occur from the psych at that time tick medication, they're called extra pyramidal side effects. EPSE, sometimes people say EPS KS not newer logically accurate but probably letting it slide but I will say EPSE. And these are the major extra pyramidal categories. DisSOEM I can't, dys in front of something is bad, and tone is tone. It's bad tone it's a muscle spasm and it hurts a lot and sometimes people can have [INDISCERNIBLE] reactions that are very sustained. So that's difficult and there are problems with that kind of side effect. And actually I'm not sure if I go into in great detail, let he just check myself here. Otherwise I'll do it right now. I don't. Okay. I'll do it now. When somebody has a distone I can't reaction from a psychiatric medication, it happens in particular muscle groups I can like if you're a runner then you know To put on weight around the middle, and the rather medications that they're taking for the physical problems they also put the medication weight around the middle.

 Weight gain is a huge problem and we are always trying to stand top of that.

 There's a side of talked called QT prolongation or QTC prolongation. That's basically how long it takes the heart to go through it love double, from the Q wave, QRST those are the waves that you read on an EKG machine.

 If that gets spread out too far it can cause some heart arrhythmias which can lead to some major health problems.

 Most antipsychotics cause a prolongation, a stretching out of the QT complex but Mellaril is the most problematic. It will stretch it out very far. That's why we tend not to give Mellaril very often, because it is a problem for cardiac problems.

 That's not counting people who have, for example, syndrome X who have mitral valve prolapse or argue -- cardiac problems on their own.

 Things that help people improve and recover, schizophrenia are intensive case management where the person really needs to have some help.

 That's really just with get the for need, not necessarily adding the intellectual text -- disability on top. You do need to have this intensive case management.

 Let me talk about that for a few minutes.

 We are dealing with a very special population of people who have intellectual disabilities and they more than likely have more than one physical problem.

 They might have a seizure disorder, cerebral palsy, and they're more than likely to have a psychiatric problem.

 It might be intermittent like depression, they might have a depressive episode and they get treated for it and they do very well for a significant period of time, but then they have a recurrent episode of depression.

 When you have somebody with an intellectual disability who has any kind of a problem like schizophrenia you have to keep in mind that they can also get depressed.

 Anybody with any problem can also have a layering of depression on them.

 The intensive case management is very important because it helps the individual be tracked by people who know them very well so they will know if their symptoms of schizophrenia are a little out of control. Sometimes when people who have a higher level of stress, their symptoms worse, their delusions worsen and if it's a very pungent stressor they might even change their symptoms.

 They might have always been delusional any certain regard and everybody has been able to manage that delusion, but then there has been some major stresses the came along and now their delusion is in a completely different way and now they are hallucinating.

 The intensive case manager or, if you don't have some of the with that specific title cut somebody who knows that individual very well would be able to tracks the changes that are going on with the symptomology. That's important feature of the intensive case management. To not only take -- pay attention to the schizophrenia specifically, but also to be on guard for a depressive episode that can happen as well or if the person is drinking or drugging it's a much more recognized problem with people who have intellectual disabilities than it has been in previous years.

 We know that people who have ID are pretty quickly -- frequently drinking and drugging and it makes everything worse.

 No antipsychotic medication will be effective with any amount of alcohol in the person.

 Richards has shown that it's mostly -- research has shown that it's mostly antipsychotic medicine that doesn't work but just by logic an antidepressant will not work either if you are drinking alcohol because alcohol is a depressant. That is a practical issue about how somebody is coping with their illnesses or with their social situation.

 If they are coping by drinking, if they are depressed and they want to feel better some people think that alcohol will actually elevate their mood. They have had a stressful day and they want a well-deserved drink of some kind but actually alcohol is a depressant and it will make the person more psychologically direct -- depressed. It's also a physical depressant in a number of ways and I think we go through that and another workshop.

The case manager is also able to detect if the individual is using, are they drinking or drugging? Are there symptoms of getting worse with a depression layered on top of that? That is where the person who is spending the most time with that individual is able to perform observations that are priceless and managing the illnesses and maintaining a healthy quality of life.

 Also you need intensive case management because somebody who has a develop until disability and if the patient needs a lot of doctors’ appointments. They need to go see the people who are prescribing for them, they need to go CDER therapist, they need to work with Iraq additional therapist copy probably need -- their occupational therapy and a case manager is going to be able to organize all of that and make people -- make sure people get where they're supposed to be going.

That's a lot but I put into that one little bullet of intensive case management, but it is an extremely important feature. If somebody wants to recover that would increase the odds significantly.

Anti-psychotic drugs were put on the market in 1990 and forward. The first one was clozapine. That's the generic name, the generic -- the drug is Clozaril. Especially in people who use high hospitalization, they are in the emergency department or in a psychiatric hospitalization situation more than twice a year or more than once a year, I would say. If they tend physically -- if they can physically management that would be the drug of choice. Atypical antipsychotic medications are very useful for people because it not only helps them with their positive symptoms, the positive symptoms being if you have that symptom you are sick. If not positive, yes, you have this symptom, if not positive in that regard, the positive symptoms are psychosis. There is some break with reality, they are either hallucinating and one of the five senses, and hearing is the most common hallucination and the most common thing that the person here’s not a voice. If you say to somebody who has auditory hallucinations are you hearing voices and they say no you just missed the opportunity to assess what is really going on with them.

 Are you hearing something that I might not be hearing? Or if you know the person very well are you hearing a lion roar? Are you hearing crickets in the room? Are you telephones ringing? Those are much more common auditory hallucination.

 Visual hallucinations, seeing things that are not there, and this also excludes illusions. Illusions are mistakes that we make in perceiving our environment. Everybody does it and it has nothing to do with the psychiatric disability. Icon in the dead of winter in -- I, in the dead of winter in Nome Alaska if I glance out the window at the palm trees that are growing their I know when I look back that there are really evergreen trees and for trees and blue spruce that I have the illusion of a palm tree when I first looked at it, it was a mistake in how I was processing my information. The mistake was quickly correctly -- corrected. That's evolution. A visual hallucination is when you see something that just isn't there. Would be seeing a palm tree and the bathroom where there is no plans at all. There's just a blank wall and you are seeing a palm tree. That's a visual hallucination.

 The old factory, the smell of something. And tactile copy when something hallucinations, those last three are much less common and usually caused by infections or maybe a fist or a mass on a cranial. The most common ones are auditory hallucinations followed very far as a second by visual hallucinations.

 Clozapine and all of the atypical antipsychotic drugs, Risperdal, Zyprexa, Seroquel, Geodon, Abilify, fact, staffers, these are all atypical antipsychotic drugs.

 They are also wonderful in helping people recover because in addition to addressing the positive symptoms of schizophrenia they also address the negative symptoms. Negative symptoms are things that are not there that should be there if you are normal and healthy.

 For example, one of the negative symptoms is a loggia, meaning it's not there, if the person is not talking a lot, it's also called poverty of speech. If you ask them how their day was and is a fine. It's kind of like talking to a teenager but without dodgy -- scatology attached to it. They don't have a lot of words and another negative symptom is called a motivational syndrome. Motivation is not there. Or a bullish and. It's not there and volition is voluntary activity. They don't have ambition for motivation and they are not moving and doing what people would normally move into. It's not due to spasticity and it's not due to any other physical problems, the negative symptoms -- there symptoms that are missing out of that person's experience of life.

 The atypical antipsychotic medications will address those negative symptoms.

 It might take two years to see a difference but the older conventional antipsychotics don't do anything for the negative symptoms. As a matter of fact, they make them worse.

 Rehabilitation therapy.

 Let me harken back to the atypical antipsychotic drugs. A lot of competent research has shown that taking the medication on a regular basis without drinking or drugging is the best neuroprotective situation to be in.

 They have a lot of very robust outcomes that show the people who routinely take their medications early on after their diagnosis can go down to very low doses or maybe even off their antipsychotic medication when they are in middle age. Mostly because it's a pretty a -- schizophrenia usually attacks than adults and adolescents to a certain extent. If you get them on medication fairly early you can protect the brain from any degradation and they will be able to stabilize more easily.

 Of course, if you drink and drug on top of that is going to interfere with the effectiveness of these medications.

 Rehabilitation therapy. Teaching people how to enjoy their leisure time, how to feel accomplished and like they are contributing something, how to keep them active and intellectually stimulated, how to give them something to learn, something to work towards and also a way to teach others.

 The adult research, regardless of intellectual capacity, shows that when you learn something if you don't use it on a regular basis you will lose it. Use it or lose it is actually a good phrase.

 The best way to keep something is to turn around and teach it to somebody else.

 When you teach somebody how to do something you learn it there yourself.

 Rehabilitation therapy needs to accommodate the peer experience so that the individual who is being treated is offering some kind of information for help or contact for support to somebody else with a similar problem.

 Family treatment is pretty important although my definition of family and the research division of family is very open.

 Family is anybody who cares about that individual. It could be a landlady, the staff at the residence, neighbors blood relatives, adopt of relevance, just people who have been friends for many years, that is a family. The people who care about what happens to you and what the recent research shows is that people recover from major mental illnesses like Schizophrenia better when somebody cares about their life.

 Not that somebody is jumping in and solving all their problems and addressing something so that they don't have any negative experiences whatsoever, that's not the efforts. The effort needs to be put into communicating that you care about that individual and what their experience of life is.

 Across-the-board that is what people say help them the most. That some of you cared about them. You didn't have to problem solve or buy them things or take them to the dollar store every Tuesday, they just had to care.

 Social skills training is always important. Everybody could use a little buffing up on their social skills but especially people who have asked workers or autism. Social skills are going to be a very big challenge and people who have schizophrenia on top of that disability are going to be extra challenged because their thinking is very different, their logic is different and how you interact with people are going to be different challenges. Social skills training is pretty important in managing somebody who wants to recover from Schizophrenia.

 Whether they have an intellectual disability or not.

 I imagine -- I called this next slide the break slide. Let's take a break. I would like to try to fix some of the technology that we are dealing with. Why do you give us about 10 or 15 min. to do that and then we will come back.

 [Event is on a 10 - 15 minute break. Captioner is on standby. ]

 We are back from the break. There is some kind of a problem with the connection here to Go to Meeting. I wanted you to take a look and see this is who I am. It would be nice if you could see me throughout because I tend to use a lot of hand movements, but risk some problem -- there is some problem. The remember the space and now we're going to get back to work.

 Okay. Let's talk about mood disorders. Major mood disorders, the major ones that we have, our major depressive disorder, a number of other depressions like depression not otherwise specified and bipolar disorders. The most common one that we have is depression.

 Depression is an incredibly common issue. I mentioned before that one out of four women and one out of six men in the general population will have a depressive episode at some time in their life.

 We’re not just talking three or four days of doing really down, we are talking at least or team days of the person having a significant set of symptoms that interferes with their functioning. Antidepressants are one of the most common things that we give for people who have depression or depressive episodes.

 Keeping also in mind that people who have development will this abilities are more likely to become depressed than people who don't.

 We are talking a great number of people who have developmental disabilities who can be exposed to a depressive episode.

 It's called the common cold of mental health issues because it's so common and even more so with people who have double mental does -- disabilities.

 Before I go on to bipolar illness let me just talk a little bit, I will back up, about what it means to be depressed.

 If you are somebody who has a couple of bad days, not a problem. It's just something you have to learn how to cope with.

 If you have a depressive disorder where you start to have trouble sleeping, eating, by trouble sleeping I mean you're just not getting much sleep, you have what we call high sleep latency where you try to go to sleep but were not getting to sleep. A normal sleep latency time interval is 40 to 45 min. If you're going to sleep in about a half an hour that's great, you are healthy. But if you're taking to, three, four hours of lying there and trying to get to sleep that is too high.

 It's a signal.

 All by itself it doesn't mean anything, it might just mean you're stressed or you're coming down with something or you have money problems or something going on. It doesn't necessarily mean oppression by itself.

 Something else to help with depression and sleep problems is that around 330 or four clock in the morning the cortisol levels change in your body and you have what's called early morning awakening. You just wake up and can't get back to sleep.

 If you got to sleep around one in the morning, after laying there for three hours, if you go to bed at 10 a clock and you go to sleep at one a clock and you wake up at 3:30 AM you're not going to have enough breast. That's one of the most common constellations of sleep problems that we see with depression.

 The other problem with depression is people sleeping too much. It was the 14, 13, 16 hours a day.

 The kicker is that they are waking up tired. They don't feel refreshed from having slept that long.

 Every once in a while we will get a good 10 or 12 hours of sleep and it feels great and we feel better or you take a look at adolescence teenagers need a lot of sleep and their rhythm is a little bit different. It's tipped in a slightly different way. They need more sleep than we do. Teenagers sleeping 14 hours a day and waking up refreshed, that's not a symptom of depression.

 It were talking about somebody who, for at least 14 days in a row, has trouble with their sleep, trouble with eating, eating too little, these people don't understand or eating too much and usually whether eating too much of our base things, like cookies and pie and candy and cake and mashed potatoes and gravy and macaroni with white cheese or something that is very carbohydrate filled. That tends to be very common with people who have depression.

 Not enjoying life. Taking something that you used to enjoy and now you do not enjoy it. You do not have any enjoyment from it whatsoever.

 There are different kinds of depression. There are three different kinds of depression and want them is very intuitive. Somebody is feeling very sad and distressed and they are upset and we can get that. They are sad and crying, depressed.

 There are two other kinds of depression that frequently get missed and they don't get diagnosed as often and the longer you have any psychiatric symptom without treating it competently the longer it takes to try to address that, and those are anxious depression where the person is so anxious and their kind of moving and discharging energy but they're not getting anything done and have this theme to what is going on with them but they're stressed but it's nonfunctional and not like they're motivating themselves to go do something that they're nervous about, they're just nervous.

 That's an anxious depression in which we got a little differently than we do with that depression.

 The least common diagnoses, but I would be willing to bet it is are more common than people would say, is irritable depression.

 Typically as social beings at we -- if we have a superficial relationship with somebody and we passed them in the hall and say hi, good morning and all of a sudden they say what's so good about it and they're ripping your head off if you ask them a reasonable question and it's not just one or two days, it's day after day and different from who they were its irritable depression.

 Again, which we got a little bit differently than we do a sad depression. The medication is different, the talk therapies different and the treatment for depression is typically an antidepressant but it also can be an antigravity -- anti-Saudi -- anti-anxiety medication or talk therapy. Many people with development of disabilities respond beautifully to talk therapy. Positive behavioral therapy. It's something that a lot of people research has been done on, it's a very competent approach, and you don't necessarily have to go to a medication. The reason we frequently do is that we need to address the symptoms quickly and sometimes talk therapy is more time-consuming. It could take 4 to 6 weeks before you see a response we are with an antidepressant, especially the more recent ones, use a response within a few days to a week.

 With somebody has the -- depression because it is so common it's something that we need to pay attention to and get addressed as quickly as possible and try not to respond to any stigmatizing framework that people have.

 Many times I have heard from other clinicians that of course this person who has autism has depression because their life is very difficult. They have a disability that is interfering with their functioning. Of course they're depressed. No. Depression is not a normal reaction to stress.

 Depression is a standalone, separate problem and it can be treated separately.

 There's no way I can take autism away from somebody but I can teach them how to cope with their symptoms. I can teach them how to live in the world where their quality of life is better. And the people who are around them can be taught how to manage this particular illness.

 Oppression is special. -- Depression is special.

 You need to have an address, especially if there is equality issues; you have to get into the medications.

 But if the person is able to learn, just about everybody is able to learn to a certain extent, want to be able to teach people who have development disabilities how to take care of themselves when they are prone to depression. This is just like if you are prone to diarrhea or prone towards high blood pressure or diabetes, you have to learn about rest, your symptoms, your illness.

 You have to learn about depression if you are a person who is prone to that you have to take care of it.

 Therapy, talk therapy, can be in are mostly helpful. Even in conjunction with an antidepressant medication.

 It can last a reasonably brief period of time orchid be more durable and supported in nature.

 -- -- Of time or it can be more durable and supportive in nature.

 Let's talk about bipolar disorder.

 The layman's term is manic-depression. It's barely out because it is a digression -- it's barely adept because it is eight aggression in a polar opposite direction. It can go too high with a person is manic or it can go too low for the person is depressed. Manic-depression is not inappropriate it just doesn't happen to be the clinically appropriate term.

 An estimated by point 7 million Americans have bpi and keep in mind that it happens 2 to 3 times greater in people who have any cognitively impaired diagnosis. Anything like that. It will increase the chance that the person will have a mood instability problem. With a mood instability problem you're going to have complications. That person is going to be burning up more energy if they are manic; they're going to be having sustained depressive syndromes.

 Most often people who have bipolar illness have depressive symptoms. Very seldom do you have a problem with manic -- mania being on a sustained basis.

 These are the manic-depression -- depression acronyms.

 DIGFAST.

 It stands for distractibility; the person is not going to really be able to pay attention to something for very long. They are often moving and pay attention to 16 different things at the same time. It's not the same as attention the seventh -- deficit disorder. Qualitatively and quantitatively is different.

 There is usually insomnia.

 The person can be up and not sleeping and not tire.

 Someone who has attention deficit disorder you should doesn't have a sleep disorder. It might be a different hours or have odd hours but they rest. They get the rest that they would normally get.

 The G is for grandiosity. The person has an inflated view of who they are and what they can do. They might feel richer, smarter, sexier, and more powerful than they really are. That grandiosity can reach level of delusion. Usually when people who have bipolar illness are delusional if the delusion of grandeur where they think that they have some special title or some special skill, they are famous in some way.

 Flight of ideas. Ideas, to the head very fast with somebody is having a manic episode. At first it can feel integrating and exciting and interesting. Visit -- this person has all of is coming in but in my experience people who have a lot of intellectual challenges find the flight of ideas overwhelming at a far lower level than people who don't have a development will disability -- developmental disability. Frequently what happens with people who have bipolar illness is that when the mania, when a manic episode starts to get out of control where they're not able to catch up with the thoughts and not able to manage their thinking was they will frequently do is drink alcohol. It's usually vodka to cut off the top of that manic Spike. It's so uncomfortable.

 The problem is that anybody who has any major mental illnesses not going to be able to handle drinking or drugging as someone in the general population would. You know how difficult it is for people in the general population to stop drinking or drugging.

 People with a mental illness has problems that are different. It metabolizes, drinking and drugging very differently than people who don't have any problems with their neurology and pathology.

 Drinking, even a very little bit of alcohol to try to squelch the peak of that mania can actually propel the person down into a depression because alcohol is a depressant. The person is unstable in their mood. Even though they are manic they can either be shoved, pushed, propelled down into depression or into a mixed episode, a mixed episode is where the person house a lot -- has a lot of manic energy that they have a lot of negative comment depressive, help was thinking behind all of that energy.

 A mixed episode my semi--- them out so Mike everything is terrible and it can be done like this and I can't allow this to happen and only power in all of my many changes -- there's a depressive streak through all of their ideas and it's very energized.

 That's a big problem whether the person is diagnosed with mixed episodes or whether they have generated a mixed episode by using alcohol or a stimulant of some kind when they are in the manic phase because the individual is not going to be able to process the information well. It's a pretty serious problem.

 That's usually when it kicks in. We will don't usually use drugs or drink when they feel fabulous. They don't want to lose that so the not going to get rid of that. They're not going to do much because -- about the strike ability because they are observing what's going on around them. They feel quite stimulated. It's usually the flight of ideas for people will try to stem the tide because it's so uncomfortable.

 They are physically agitated. They will move around quickly and not holding still. If you have somebody that has manic symptoms and they have some mobility problems they're going to have mobility problems with whatever mobility they have in place. If they have crutches they are probably going to poke somebody with them or swing them around in some way. If they are in a wheelchair they might ram people. There's going to be agitation to their movements.

 The speech is remarkable when somebody is manic. They produce a level of information that is likened to a firehose. It is too much information, too fast at a very large volume of words.

 It's hyper productive and very voluminous. They will be talking a lot and talking very fast.

 I don't have hypomania listed, that's a low level of mania, a low level of manic symptoms. Hypomania, the person might just be talking a little bit past. They might have a little over productivity to their content.

 You might be talking to them if you have ever had this happen a personal situation, you are talking to somebody who's talking too fast and at a little higher level than what you're used to processing and you might think this person is really smart and I'm just not smart enough to be in this conversation with them. I'm here to tell you, don't do that. Just automatically think I wonder if they are hypomanic. The speech is remarkable in that regard.

 The last piece, the T in DIGFAST is thoughtfulness -- thoughtlessness.

 The person can't think about the next logical steps to a process. They are thoughtless in that regard. Something comes into the had in a do it. They are impulsive and away. You have this layered on top of somebody with a development disability who already has some impulsivity issues and it's going to ratchets up to a pretty high and problematic level.

 Those are the major manic symptoms. There are others. Hyper sexuality, that doesn't fit into my abbreviation for people will consciously and not in a psychotic manner have in discriminate sex. They feel terrible about it later than their manic symptoms start to normalize but they have a great deal of difficulty with the fact that they did that.

 They are compelled to seduce and compelled to be seduced when they are in a manic phase.

 There are a number of other symptoms.

 PowerPoint has such a wonderful and thoughtful features to it.

 This is what we do to form clots? Address what happens with -- pharmacologically address bipolar disorders.

 As I said most people need to be medicated. There is about a .1% of people with bipolar illness that can manage themselves at an extraordinarily strict regimen of sleep, rest activity, diet and structure.

 There are a couple of organizations that don't have many people in them, but people who feel strongly that they don't want to take a mood stabilizer or because they don't want to lose the feeling of feeling good and wonderful about themselves and their skills, necessarily wanting to mania but they want to have that good feeling and when you take a mood stabilizer it can be very dulling. We will talk about some of the effects and side effects of mood stabilizers.

 An important consideration is that the vast majority of people need to be on mood stabilizers. The mood stabilizers we have right now is the old standby, lithium. That has been around since the last century as a Pacific pharmacological value for people with bipolar illnesses. It's a little tough on the kidneys so when you finally get somebody to take lithium it might happen that in their middle years or when they are older they have to go off of it because their kidneys are challenged by this lithium. Lithium is basically a fault. It's natural; we all have lithium in our bodies which is interesting because people with bipolar illness have exactly the same levels of lithium intersystem as we do. The people who don't have bipolar illness. It's not that they have a deficit of lithium and we are trying to replace it, is that the lithium has a common feature and if our ecological he and -- pharmacologically an interesting process and were not exact sure how it works.

 That's a major treatment and has been for decades.

 We find out quite by accident when we were doing research on Clozaril that anticonvulsants, some anticonvulsants have a mood stabilizing feature to them. The accidental discovery of this, clinically there had been a lot of empirical evidence clinicians had been saying and they said I put somebody on bipolar disease I put someone on anticonvulsants -- there would be some anecdotal evidence that these anticonvulsants were stabilizing people's moods. When we were doing the research in the United States in the late 80s I Clozaril, a side effect of Clozaril at higher doses is a seizure disorder or an occasional feature. To anticipate that and to be proactive and prevent a seizure from happening people in research, at least several research sites that I know of, he would put on anticonvulsants proactively with a have a higher doses of Clozaril.

 We noticed that moods evened out a little bit.

 That with the instigation for doing specific research on mood stabilizing features of some anticonvulsants.

 For many years we have had a typical antipsychotics that have been used as mood stabilizers. Sampler them were designed specifically to have an impact on the mood as well as having antipsychotic features.

 Bipolar illnesses are so specific and that it can interfere with somebody's logic and the way they process information and the way they interact with other people that there are a lot of similarities to how the drug can really help them.

 Atypically antipsychotics are considered antipsychotics in many regards these to have held all and lithium in years past. Mostly in the 70s and 80s when somebody was having a particularly grandiose delusions that was interfering with functioning or putting them at risk in some way held all can be difficult because of -- held all can be difficult because of the side effects. It makes people feel uncomfortable and they don't want to take it.

 The atypical antipsychotics have your side effects and they are more manageable so that's something to keep in mind as a mood stabilizing feature.

 The general rule with mood stabilization as it is with any major mental illness is to start minutes on the mood stabilizer earlier to predict greater and movement -- improvement in general. The degradation of these major mental illnesses on the brain is supported and it's arrested to a certain extent. It's kind of like if I broke my leg and you put a cast on my leg and the cast would extend to the joint above and to join below the break, the cast is just holding the phone in position so it can heal. The cast does not heal. It just interferes with anything throwing that bone out of alignment so that the phone has a chance to read it and to heal.

 The medications for major mental illness is doing the same thing to help the pain -- help the brain to stabilize while the brain to heal itself.

 It can take quite a long time that at least the brain is not being so negatively affected by the on this

 I have to say that any of the psychiatric medications, for a major mental illness, is approximating what's going on in a brain that does not have his challenges to its. Neurotransmitter functions are very complex.

 We don't have a lock on how all of these dozens of neurotransmitters work in our brain.

 Our brain is chemically optional, electrically functional and electromagnetically functional. It has many different ways of working.

 That's why electroconvulsive therapy, we don't convulse anymore, and transmit treatments for oppression are so very effective -- it addresses other ways that the brain works. It works by electrochemical and electromagnetic fields.

 [Captioners Transitioning.]

 They are not at the levels they need to be. But they are also not at levels they need to be at different parts of the brain and different levels. Given medication that will address that level but they dopamine, if you have too much dopamine right in the center of your brain one of the oldest parts of your brain you will be psychotic. You will hear things that aren't there, see things that aren't there, believe things that are not to you will be delusional, that is because you're too much dopamine.

 If you don't have enough dopamine in the newest parts of your brain the part right behind her for head for you logically organize information and process and decide what to pay attention to and it nor for the time being or put in the background for the time being you need a certain amount of dopamine to do that. If you have too little dopamine you will not feel good. You will not feel motivated you will not be able to function very well. You will not talk the way people who do not have these problems the.

 How to get a medication to give you less dopamine in one-party brain and less -- and more in another part.

 It is something to keep in mind when people are frustrated by psychiatric medications that are not working well it's an approximation of what is going on with our normal nerve transmitters and when our neurotransmitters are out of balance and putting it back into balance in a chemical weight is very challenging. Sometimes we hit it and get very lucky but sometimes it is an approximation and the rest has to be taught in the person has to learn how to deal with it as best as possible.

 Kind of like taking somebody with diabetes and they are insulin dependent. While it is a natural product and we can approximate the insulin beautifully it might not completely control their diabetes. They still need to learn about their behaviors. They still need to learn about getting rest and went to be active and what to eat and when not to eat. It is not so much the interactions with other people that is where the major mental illness [Indiscernible] it gives you clue to how complex any disease process is and I think psychiatric illness is layered in a can make it much more difficult.

 We want somebody to be stabilized on their route stabilizers in a very reliable way as possible we want to be able to also detect if they are coming out of the illness. Let's say they have been on a mood stabilizer and have done fairly well for a certain period of time but they hit another stressor or their body has changed in some ways, they have gained 10 pounds or lost 10 pounds, it changes what goes on with her body. Or [Indiscernible] lithium and pickles have all whole lot of salt in them and they ingest Wendy's pickles that somebody made for them and it goes off the salt balance in the body and then their mood is different. You need to pay attention to orally changing in what is going on with their mood so you can quickly try to correct or the prescriber can correct their brain chemistry to the extent possible. You want to make sure that they have access to something that will help them.

 I wanted to make a comment about a couple of the mood stabilizers. As a clinician all of you have had these experiences and I understand it is very frustrating, but when we put somebody on certain mood stabilizers certainly be AEDS like Topamax or [Indiscernible] we have to start the dose very low. Lori -- lower than what would be effective for managing the mood and we have to change the dose slowly and gradually [Indiscernible] them up to a higher dose level. For example Topamax, one of its clinical nicknames is stupimax if I give you too much and raise it too fast I can drop your IQ by two points. That is not something that anybody needs. You need all of the positive power [Indiscernible] somebody with developmental disability does not need a challenge like that.

 We want to pay attention to how these medications can take quite a long time to reach a therapeutic blood level. In the meantime the person will not be very stable.

 One thing I want to comment about is that many times people who are on a mood stabilizer that is also antiepileptic -- epileptic drug it can serve many purposes but its major purpose is to be a mood stabilizer. Even if it is acting as an antiepileptic drug you might need a couple of different drugs to do that, to adjust the seizures and address the mood stabilization features.

 A few words about dress and -- stress and relapse. Everybody has a stress reaction, everybody has stress. Everybody can relapse the previous function without any illness. Let's say you have someone living in a group home and let's say for example you have a young woman who has learned how to get all of the breakfast dishes into the dishwasher and has done a beautiful job at that and is proud of that accomplishment that every single morning she takes care of the breakfast dishes and get them in the dishwasher and space in the kitchen until the cycle is completed and empty the dishwasher and put them all away and feels good about that. It took a long time to get that skill in place.

 Then her mother falls on the ice and breaks her leg and she is not able to visit once or twice a week. That is very disruptive to that individual so this young woman might not be able to do quite the level of records this glaring that she was doing before she has been extra stressor. Anybody who is taught a coping skill -- skill or a skill in general needs to be able to anticipate what I am going to do if there is a problem. And caretakers need to have in mind what this individual will do if they have an extra stressor.

 Teaching people how to pay attention to themselves is always a good skill. A need to know when they are starting to slip. Maybe their hygiene is slipping or their interactions with others. They walk into a room or workplace or they walk into their workshop, or program area and they don't say hello when they walk in the room. Does kind of slippages they need to be able to say I forgot to do that or some kind of awareness so that the individual can adjust when they know they are being stressed. They can still get some satisfaction from doing previously learned skills.

 Everybody gets stressed and everybody will relapse the previous level of functioning and it is not by choice but it is something that can be anticipated and to be prepared for.

 The reason I bring it up is any major mental illness layered on top of developmental disability is going to have stress associated with it. That is why we will talk about stress and anxiety and the medications we use.

 Certainly anxiety disorders can exist on their own but anxiety is also a normal feature of who we are as human beings. We do have anxious circumstances and anxiety low or moderate levels that blue bar on the graph is motivating and instructive and it gives you cues to your environment. You wake up in the morning anything where my supposed to be today what am I doing, and as my cell phone charged and to have my bus card with me and what time is it. There are little things that can promote some anxiety. But it is not destructive it is [Indiscernible]. You look at the clock and see you got a 10 min. later then you're supposed to well then you move it you will move faster so you will not be late.

 It will give you cues to your environment because you will be more sensitive to what is going on. But when anxiety passes that moderate level [Indiscernible] then you will not be absorbing information quite as well. High levels of anxiety usually interfere with functioning.

 And extreme anxiety is not motivating at all, as a matter fact people become immobilized. Or they do not know how to learn at that point. They cannot absorb information and process it. Or they retreat back to a primitive way of being. That is some have where bytes, flight or freeze comes in. Fight, flight, or freeze is something that describes how people feel they freeze up world locked up, or they run away or they just fight. They scream or have some kind of interaction that is much lower level of functioning. That is something to pay attention to. Anxiety is a normal part of our lives.

 Extreme anxiety is not a normal part of our lives. So there has to be a sensitivity to the particular level of anxiety that will be produced. And what do you do about it? You have to have an awareness and a certain ability to gauge what the person is experiencing. And some people with developmental disability they are more than capable of understanding that. The people who are at higher levels of dysfunction are going to need somebody else in their environment to have that sensitivity for them.

 When somebody is at a mild to moderate level of anxiety that is usually someplace we talked to people about how they can cope. If it is uncomfortable, if they are being affected in the functioning level to a certain extent in you teach the individual how to cope, how to function.

 When anxiety reaches those high levels or the divisional is not able to learn quickly enough to be able to manage the anxiety state, then you have to give medications which is another word for anti-anxiety medication.

 Anti-anxiety [Indiscernible] also called benzos [Indiscernible] Burr said -- verset you have received if you had a colonoscopy. There are medical uses for these things. There are non-meds [Indiscernible].

 The feature about anxiolytics has a slightly different side effect in addition to the main effect. Benzodiazepine is like value it will relax you. It will take away your anxiety to a certain extent and depending on the dose it will take the anxiety too low because you need a certain amount of anxiety to be Fox -- functional and motivated. [Indiscernible] has an unusual feature that it can create a muscle relaxation in a certain set of muscles that have gone into spasm. So if you have a net spasm -- neck spasm you might be prescribed Valium for a couple days because the side effect of the [Indiscernible] if it releases the spasm just in the neck level. It does not do it anyplace else. If you have a Charlie horse, or [Indiscernible] or shin splints it will not do anything, it might but it's claim to fame if you have a stiff neck a couple days of valuable do it.

 Most of them have a couple of other features for example first set [Indiscernible] verset it is a benzodiazepine and it is anti-anxiety in its effect. Usually verset is used when you have a procedure done and they need you awake but not upset.

 If you have a colonoscopy for example, you have done the prep the day before and everything is cleaned out and they will start an IV and give you verset. Decided that in addition to anti-Zaidi medication is you are not able to create a new memory as long as it is active in your system.

 There are always exceptions to this rule. I know of several people who have been given verset an it didn't change their memory [Indiscernible] they were totally remembering rethink. But for the vast majority of people verset [Indiscernible]. When you wake up you will be told when we will start with this, then they say it's already over. You will not remember anything about that because of the memory. You will not be upset having the procedure done because as an anti-[Indiscernible].

 Along a similar topic non-benzodiazepine such as [Indiscernible] there are a number of them on the market can create a sense of calm but also there is an -- is a psychological dependent even though [Indiscernible] is a non-[Indiscernible] benzodiazepine you can start the tell yourself you can get to sleep in as you take your [Indiscernible] and you start the common behavioral framework you start to believe that you need the MBM to go to sleep so while it is not as addictive as benzodiazepine it is psychologically creating a dependency for you so it is something to keep in mind.

 That when people have a great deal of anxiety and they're not able to learn anything new they certainly will not be able to learn how to cope with their anxiety when it is super high. We want the medication to bring anxiety down to a lower level. We do not want anti-anxiety medication to be given as set -- at such a dose that the person has zero anxiety. That they are totally calm, totally mellow as then they are not motivated and not absorbing information from a environment. They are chilling and having a fabulous time.

 In general in life a low level of anxiety stress, perfectly normal. From time to time a moderate level of stress you are going to have your performance evaluation at work, teenagers learning how to drive, you are going for an interview someplace, and you have a medical test on. All of these things so raise your anxiety but that is not a problem. Is not a problem level of anxiety it is more motivating. If you go for a medical procedure and your anxiety level is at the moderate level you ask a lot of questions and hopefully digest the answers. You will pay attention to what is going on and you will proceed. The test will be over with and your anxiety level will go down.

 It is when the anxiety level is very high that you will not be able to learn and talk. Therapy will not be helpful for you at that point and a was at the low to moderate level behavioral therapy even support psychotherapy is very useful at those frameworks, not at extreme levels.

 The anti-anxiety medication that we are giving to people who are at high levels, there are a number of different ways of conceptualizing how we [Indiscernible] and anxiety to be used. For general in a buddy specially people with disabilities you want people to feel like they can cope to a certain extent. The more coping you can help them have the better they feel about themselves. Being able to cope with higher levels of anxiety is an important feature. You take the medication at a high level of anxiety and it prevents the individual from learning how to do anything for themselves except taking the pill.

 That is all that can happen at that high level.

 You want to not give the medication on a PRN basis, as needed basis. That tends to reinforce issues about anxiety. Because the person learned at high levels of anxiety that when I take a pill I feel fabulous. It doesn't really teach them how to take care of themselves; it teaches them how to take a pill. At very high levels that needs to be done, but the dose needs to be such that the person still has some level of anxiety which is motivating for them to learn how to cope.

 You don't want to remove all of the anxiety with the dosage of medication it has to be at a certain place.

 And giving it as a regular dose instead of PRN tends to remove the classical conditioning that can take place if somebody complains about anxiety and then they get a pill that makes them feel fabulous, then they are going to do that again, and again, and again. There is an amount that you give three or four times a day because as a short life. It stays in your system [Indiscernible] you are constantly having some protection against a high level of anxiety. It does not completely wipe you out it is not benzodiazepine so the person is able to continue to cope with what is going on. It is important to teach people how to rely on themselves instead of relying on the medication.

 Having talked about schizophrenia, depression, bipolar disorder and anxiety disorder we didn't specify anxiety disorder but you know what they are, obsessive-compulsive disorder, posttraumatic stress disorder, and just generalized anxiety disorder is an anxiety disorder. Anxious feelings are endemic. We all have them and it is what you do about them that counts.

 With those general diagnostic categories in mind, let's not talk about how do you overcome the communication barriers that can take place with people who have developmental disabilities and they May or may not have all of these other features going on. Not surprisingly some of the strategies are not pharmacological they are behavioral and interactional. They take a look at what the person is doing and how they are functioning in the world. There are a lot of ways to overcome barriers that does not involve giving somebody additional medication.

 Let's talk about routines. Anybody who has the development of disability needs a structure to the life. Sometimes the structure is overwhelming it is way too structured and they can't deal with anything being a little off their structure, but one of the issues that people frequently ask me about is what do I do if somebody wants -- the schedule has to change. Let's say 70 moves from one residence to another residence and it is farther away from the program area or the family members have to come at a different time. Let's say for example the one I have up here is that the person has to wake up earlier and that is very disruptive for the individual.

 You could substitute waking up earlier for any other issue that would be difficult. For many people who have any developmental disability it is important that they have a morning routine. All of us have a morning routine. It can reduce some of the challenging mornings, some of the more difficult stressful aspects of change in the life.

 I have an example here. If Joshua has been [Indiscernible] in his pajamas and watching his favorite television show for an hour before he gets dressed, but then he moves to another residence after he is been there for two or three years and now his routine is very different. How do we manage that? How do we take care of Joshua so it is not so difficult for him to make this change marks

 One of the things you can do is to start early with making this routine change. Even while he is in his previous residence you have the luxury of figuring out what to do with these things, you can start adjusting and molding his routine week ahead of time so it does not have to be done all at once.

 Let's say for example he has to change and hour of watching TV to 15 min. to 15 min. And you have two months to do that. Every single day you move it up so that he is sitting there watching TV force several less minutes. And it depends on the individual for Joshua it was better to do a chunk of 10 min. and then leave him there for three or four days and let him get used to it and then do another chunk of 10 min. and leave him there so that was his routine for a week or so. Sometimes a couple of weeks. That helps.

 On the other hand you might have people who become so disruptive that it is better to them all adjusted all at once so you do very quickly. You have to know your client very well and you have to know what is best for them in coping and managing. Routine changes can be difficult. It can be something as difficult as somebody has moved out of the group home and somebody has moved in. That other person who moved in is different in a significant way, or I had one resident it was in a group home, they had decorated the place in the 60s so the walls were this avocado green which is actually not a bad color but it was out of style for a long time. They came in and repeated. They repainted all the rooms this page, Excel can -- egg shell, can tan -- it was very disruptive to some the people there big could not get used to it.

 It is good to try to help people to cope to adjust to something that is different.

 Getting a different routine around it can help. This does not show up very well, in quieting the storm, when somebody is disruptive somebody has a developmental disability it can be [Indiscernible] for them what is going on in their minds about what is happening in their quality of life. Disruption is a [Indiscernible] of something very important to them. You want to give them back some quiet time. So if they are very disruptive by their routine being changed, sometimes you can get a quiet activity at a specific time and place and you routinized that particular thing just to hold them over just so it has the intention of providing a special experience for them.

 Whenever they were really good at before, they were really good at playing cards, and then try to shape something around card playing. If they really like writing in the journal or drawing or coloring or crossword puzzles or word find, whatever the activity was that they were good at, put that back into place but in a small compartmental space of time so they can feel the difference that here is this disruptive routine and here is this special routine that I have every single day.

 It is not required that it be done in exactly the same way every single time, but that it has the feature of being quiet and it is calming to somebody who has been very disruptive.

 Communicating and motivating.

 I did not specifically talk about post-traumatic stress disorder as a standalone. I've mentioned it as an anxiety disorder, but when somebody who has a developmental disability also has posttraumatic stress disorder which is extraordinarily common given how many people have been brutalized or abused, it is very common to have communication and motivation problems. It will raise the specter in the clinical care.

 Keeping that in mind this is to for any situation where you have communication and motivation [Indiscernible] that need to be paid attention to.

 One way to do that is to use, these are examples, use external motivation system in order to get the person to communicate and get them to motivate. Let's say someone really like to go to a certain coffee shop and have coffee. If you want them to do something like go to their sister's graduation, you can say I would like you to go to the graduation and after that we can go to this particular coffee shop. That would be a really good way for you to externally motivate the individual.

 On the other hand if you have somebody who is internally motivated to go to the graduation you don't need to have an external motivation but many times you have to have some idea about what could be put from the outside into this individual so that they can feel like they would like to get going on something.

 When you are using an external motivator and I have a list of some examples here and I'm sure you have several more, watching a particular TV show, playing a favorite game, running an errand to a favorite store, points and tokens in certain token economy are exchangeable for something that he or she wants. Remember the motivation has to be powerful and it has to be immediate. It can't be months down the line or even days down the line that will not really work.

 You need to have a powerful reinforce for that individual.

 For me popcorn will not be a powerful motivator. But for somebody who loves popcorn that could very well be the ticket to what you want to be doing. So you have to individualize it. You have to pay attention to what motivates that individual. What would be a powerful draw for helping them to get done what needs to be done? And of course the immediate [Indiscernible] is important especially if they have attention issues.

 Just as issue of close, many times people with development disabilities, autism in the killer, anywhere in the autism spectrum, 10 have issues about [Indiscernible] sensation and sensory integration issues. I have had any number of clients who will only wear a certain item of clothing. When you find that item of clothing, by 10 of them. Little tip from hard earned experience, when you buy 10 of a certain shirt have them try on all 10 shirts if you can get that done. It might be that one of them is mailed in a different way or this theme is a little off kilter and that can be very distracting. You want there to be an acknowledgment of what is going on with their clothing. But you also want to make it as easy as possible for them to be able to function around clothing.

 Give the person who has a developmental disability time to get used to wearing new clothes is something has to be done.

 In some cases wash them several times and if you use a fabric softener use one that does not have a fragrance to it, they tend to be universal that people do not like that.

 Plan wearing the new close for gradually longer periods of time and not before a major event. You don't take the brand-new shirt and put it on just before they are supposed to go to their sister's wedding because they might be uncomfortable, they might be reaching and scratching and pulling just restlessness around this new piece of clothing that they are not used to. It might be ethically appropriate piece of clothing, but they don't need the extra burden of having to wear this piece of clothing in a social setting. Plan ahead of time.

 When you have an active relationship with people who have developmental disabilities, you want to have a good relationship of course with them. You are a service provider, you are taking care of somebody, you have expertise in a particular area wonderful you have chosen this population to put your energies into and give them a better quality of life but that is not the only person you A good relationship with. You have to have a good relationship with people in their world who are important to them. Family members, friends, land ladies, other residents you need to have a stage set for having a good relationship.

 In general consider how having a flexible attitude on your part, I am not talking you have no standards, no boundaries whatsoever that would be the extreme, but also not be totally rigid, have a flexible attitude and make everything you do every task and every issue run more smoothly. Take a look at the last two struggles you had with somebody that has a developmental disability and see if maybe what was going on if it was a control issue, a power issue of some kind and there needs to be some kind of a relaxed attitude.

 Let's say for example you want the recipient of your care to do something in a particular way. They are resisting having your assistance. They are digging in their feet and saying absolutely no I will not do that.

 One way to do it is be a bulldog and bulldozer and force your way into the situation. But remember a little bit of flexibility on your part can go a long way. Another way to handle it and many have had great success being a bulldozer and getting things done, and I have seen many cases where people do respond to that level of intense direction, but consider distracting the individual with something you like to do. Then slowly read introducing the resistance toward the intended goal. By slowly I mean it is not on your timetable it is on a different time table. It does not have to be on no timetable whatsoever [Indiscernible] you would never get your work done. But if you distract, pull back emotional energy away from that situation for just a few moments you will notice that you are able to come up with more ideas about how to handle the situation.

 You might be surprised I'm fine individual is more cooperative. So distracted and re-introduce whatever it is you are trying to do. Little flexibility goes along way. You don't have to be Gumby but you need to have some bent.

 In general we do with people who have developmental disabilities in their family and friends and people in their environment you need to have some positive experiences but they might not happen spontaneously. If they do great war power to you. But planning for some positive experiences is a very powerful thing to do.

 Prior to starting anything new let's say a social situation [Indiscernible] who will be involved in a social activity with a person involved with the development of disability usually one person at a time -- planning or relaxing adult they. That's what we’re having a relaxing adult they. Ibo who have disabilities need an advocate. We all could use advocates of various aspects of our lives but somebody who has a developmental disability has a different set of things to deal with. The factors that are controlling whether they feel productive or whether they have a good life or not are much more challenging than what we have. The efficacy is never ending. It goes on as long as you have that relationship with that in the visual.

 Teaching is a major component of relaxation. You are teaching somebody how to deal with their stress, but you are also teaching yourself how to deal with the stress of the person who has a developmental disability. You have to take care of your own needs in order to have the time and energy to deal with others. It is like when you go on airplanes and they go through the safety briefing and they tell you what to do when oxygen masks fall out of the compartment. They say you must put your own oxygen mask on before you go to help somebody else like a child or an older person. Because as you can imagine if you needed oxygen and you were struggling to get the oxygen mask on a child or on somebody who needed help and you didn't have your own oxygen on you will pass out and you will be of no use to nobody. If you did not finish getting everybody else ready they will not get ready. You have to take care of yourself.

 The exact same thing happens when you deal with people with developmental disabilities. It is a very specialized population and you have wonderful special skills in order to deal with this population, in order to contribute to the quality of their lives, in order to help them cope and get through their day. But you need to take care of your day and your coping as well otherwise you will not be much use to anybody else you are working with.

 What we have covered despite the fact that you can't see me is the discussion about the common presentations of people who have developmental disabilities with certain comorbidity. The assessment strategies we are always assessing all the time. We cannot assess. Depending on our professional activities we know that assessment is constant with us.

 We talked briefly about the typical medications, what was taken with comorbidity and have to pay attention to the main effects of medication. But the more practical aspect to keep in mind is with these typical medications what the side effects are. We talked about the side effects of the medications for major mental illnesses and that can be extrapyramidal side effects with very uncomfortable. If you're taking a medication that makes you very uncomfortable chances are you will stop taking it, or you will take it inconsistently which will not help you very much.

 The main effect of the medication is certainly something to keep in mind as is the side effect. Sometimes you can very effectively use this mechanism is having trouble sleeping and given a mood stabilizer that is the dating, all the better one lesson that you have to give them. Give them medication at bedtime and then they are sleepy when it is time to go to sleep.

 We talked about communication tools how it is important to have a plan and a strategy, and the time to do it. Sometimes you don't have the luxury, one place closes another place opens, you have to jerry-rigged things, but when you have it is nice to be able to talk about how things can be done in an effective way.

 In general coping with resistance to assessment and treatment is use the knowledge you have of the individuals you work with. Are they distractible? Do they have things they really like to do? Use it as motivators. Use it as something that will reinforce where they are going and the goals they have for themselves and the goals they have for family and loved ones. We need to keep in mind just because somebody is resistant this not mean that is the end of the road for us. Distraction can be enormously helpful in that regard.

 After going over all the contents of today's presentation, we have some old questions for you. They are on the PowerPoint but they are also going to pop up in terms of you answering them.

 The first question is one of your recipients who is always self-stimulating begins to significantly scratch and cut herself as well. What could this mean?

 The recipient is having emotional problems, they are having a new physical complaint, the recipient's blood pressure is changed, and the recipient medication needs to have the [Indiscernible] the gradual dose reduction?

 The correct answer is A&B. Recipient is having an emotional problem. Self-stimulating is an ongoing teacher but to significantly scratch and cut herself could be having an emotional problem, could be having a new physical complaint. You note dermatological problems with people in development of disabilities is a far-reaching and there are many issues around eczema and psoriasis that can make somebody scratch. It might be self-injurious behavior; it might look like it would certainly would be an emotional problem. But look at the physical constraint.

 Poll 2. Assessment of a newly admitted recipient with developmental disability takes into consideration the recipient’s communication skills. How are they talking? How are they indicating that they are selectively mute or really mute not able to speak? What are they communicating? Are they showing preferences, are they showing dislikes or appreciation for things? What is the functional level? What are they able to get done? What is their living environment? Are they living at home with elderly parents who have Parkinson's disorder, one has Parkinson's and the other struggling dealing with the child who has autism and the husband has Parkinson's. What is going on in the environment, what is being talked about, what is being done, how are they eating, how are they sleeping box what is their physical status? How are they doing do they have comorbidity? Are they constipated do they have a lot of urinary tract infections, do they have a lot of rashes? All of these choices you have.

 The correct answer is all of the above. All of these things need to be taken into consideration. Not all of them will be addressed practically with pharmacology. We certainly need to have pharmacology on hand, but when we are dealing with the practical issues of people who have comorbidity including developmental disability we need to take all of this into account and try to work it into a program that will be best for that individual.

 Poll 3. You are conducting a group with five recipient to have developmental disabilities and one recipient suddenly for the first time is screaming and acting out in aggression. The most likely explanation could be, this person has dementia, or this person has an infection, or this person is having a reaction to the environment in some way, or they are having an allergic reaction to something.

 You see the choices they're. The first choice is the person has an infection of some kind and they are reacting to the environment. The second choice is they are reacting to the environment. The third choice is they are obviously demented they're having some dementing process go on. The fourth choice is all of these things need to be taken into consideration as an explanation.

 The correct answer is number 2. Something is going on in the environment all of a sudden the person screaming out in acting in aggression is never done before; something is going on in the environment. You need to look [Indiscernible] is the room to cold, is there somebody out in the hall slamming the door over and over again, is the ice cream truck making its little sound and they want to get out there and they can't get out there because they are in group and their agitated. What is going on in the [Indiscernible] environment and bring your observation in closer to what is going on with the group; the interactions with the other people in the group or the environment in terms of are they sitting in an old chair. Is there clothing a problem in some way, the zipper has broken or a poke is digging into them in some way.

 Whether the environment whether it is distal or proximal needs to be taken into account.

 4 Poll. When giving directions to recipients with developmental disabilities and they resist assistance, repeat what they should be doing until they comply. Just keep repeating it over and over again. Or distract with something they like to do then slowly reentered use it -- reintroduce it. Or expect approval verbally and with appropriate facial expression. Or explain three problems with what they are doing.

 You can't make this stuff up. I have actually had people tell me all of these other response to when somebody is resisting a system. The correct answer is 2. Distract them with something they like to do and then slowly reintroduced the resistance. You don't of the push or get into control struggles, you don't have to totally ignore the issue and do something else, and you don't have to overwhelm them with cognitive information by carefully explaining three problems with what they are doing.

 In general you want somebody who has a developmental disability to feel like they can interact with you as a human being and you are not completely rigid and also somebody who has absolutely no structure whatsoever to what is going on. You have to find the middle ground and know your recipient.

 The last poll question is regarding medications commonly used with people with development of this abilities there are a variety of medication specifically indicating for the treatment of development of disabilities. The medications treat the various systems Butternut indicated for the disability. C [Indiscernible] are not relevant when discussing medications. D No medications are commonly uses lucidly for those with settlement of disabilities.

 The choices you have there are A7B C&D C and. The answer is [Indiscernible]. Medications can treat [Indiscernible] there is no medication we can get the somebody to treat that development of disability, to make their cognitive functioning increase in that very specific way. There is no medication for that -- down syndrome, there is no medication for syndrome X, there is no fragile X syndrome I should say, there is no medication specifically for development of disabilities. But if they're having different symptoms, if they're having trouble coping that we can bring their anxiety level down with a medication that will help them to be able to learn how to cope better. If they are depressed we certainly have medications that can treat depressive episodes etc.

 Even though there is not a specific medication for developmental disability we do give, as you know, a great deal of medication.

 I finished a little earlier than I planned I probably talked way too fast in the beginning, but you will have a survey that will pop up on your Internet rouser and if anybody does not see that survey, then you will be sent and e-mail tomorrow and there will be a link in there. Please follow that link and you will be able to answer the survey that way. We really do appreciate your feedback. It is extraordinarily helpful to us to make your work life and expenses with development disabilities better. This is to be useful for you in some practical and realistic way. Anything you have to say please share it with us we would be happy to hear it.

 If you have any questions or comments about the program in general, then you can give Lisa Zimmerman a call or e-mail her telephone number is there as well as her e-mail [Indiscernible].

 There is certainly time for questions if in a buddy can't think of a question they would like to ask me right now, click on the hand component [Indiscernible].

 I am going to try to fix what is going on with the [Indiscernible] honest pewter.

 Together question click on the hand it will come up on Lisa's computer and I will answer it.

 No questions. Apparently either I covered every consideration or you found more information -- far more experience and information that I do.

 That concludes pharmacology for people with development of disabilities. We appreciate you joining us.

 Lisa do have any departing words?

 They give for attending this afternoon and we will see you next time.

 Goodbye.

 [Event Concluded]