ACTIVITIES OF DAILY LIVING (ADL)

BEHAVIORAL DEFINITIONS

1. Lack of independence with self-feeding, as evidenced by not opening the mouth in response to stimulation or not eating independently with proper utensils.
2. Assistance needed with dressing, as evidenced by not selecting appropriate attire, failure to physically put clothes on, or inability to manipulate fasteners.
3. Impaired identification of hygienic needs and/or initiation of response to hygienic needs, as evidenced by deficiencies in caring for a runny nose, toileting needs, bathing, washing hands, and brushing teeth, resulting in poor hygiene.
4. Lower than expected eating, dressing, toileting, and/or hygiene skills resulting from overprotection of client by caregiver.
5. Absence of initiating activities of personal interest.
6. Failure to complete required tasks.
7. Failure to seek assistance when needed.
8. Lack of initiative to resolve problems.
10. Difficulties in comprehending requests, emotions, greetings, comments, protests, or rejection due to limitations in receptive communication.
11. Difficulties in expressing requests, emotions, greetings, comments, protests, or rejection due to limitations in expressive communication.
12. Poor interaction skills characterized by limited eye contact, insufficient attending, and awkward social responses.
LONG-TERM GOALS

1. Strengthen existing ADL skills and develop independence with new ADL skills.
2. Develop and maintain appropriate eating habits that promote independence.
3. Develop and maintain skills for maintaining proper hygiene and personal cleanliness to promote good health.
4. Develop and maintain skills of dressing self to create greater autonomy from caregivers.
5. Maximize independence in all ADL areas.
6. Use adaptive equipment and training modalities that support independent functioning.
7. Reduce the frequency and severity of maladaptive behaviors that interfere with ADLs.
8. Caregivers and client reach a consensus on client’s identified goals.
9. Caregivers provide adequate supervision and assistance to ensure client’s safe treatment within a supportive learning environment.
10. Maximize the client’s choices and preferences whenever possible.
11. Caregivers reinforce all steps toward independence with ADL skill acquisition.

SHORT-TERM OBJECTIVES

1. Participate in a psychological assessment of adaptive and/or intellectual abilities. (1, 2, 3, 4)

THERAPEUTIC INTERVENTIONS

1. Arrange for or conduct a comprehensive intellectual and adaptive assessment to establish a baseline of the client’s
2. Complete neuropsychological testing to assess contribution of organic factors contributing to behavioral deficits. (4, 5)

3. Accept and adhere to recommendations made by the interdisciplinary team regarding appropriate interventions. (5)

4. Cooperate with a physical and occupational therapy assessment to facilitate ADL skill acquisition. (6, 7)

5. Cooperate with a speech/language evaluation. (8)

6. Cooperate with nurse’s monitoring of physical and medical conditions. (9)

7. Cooperate with a physician’s examination for annual check up and/or treatment of acute medical problems. (10)

8. Take medications as prescribed by physician to maintain physical health. (11)

9. Cooperate with dental examination to promote healthy teeth and gums. (12)

10. Cooperate with visual examination to ensure adequate vision for ADL tasks. (13)

11. Cooperate with psychiatric examination to assess the need for psychotropic medications. (14)

12. Parents communicate with caregivers regarding psychiatric symptoms. (15)

ability and gain insight into his/her strengths and weaknesses.

2. Attend person-centered planning (PCP) meeting with client, family, client advocate, school officials, and caregivers to determine educational, vocational, recreational, communicative, ADL, and health goals along with eligibility for special services.

3. Consult with client, family, school officials, and caregivers to obtain an overview of all multidisciplinary treatments wanted by the client.

4. Arrange for or conduct a neurological exam and/or neuropsychological testing to identify sensory modalities best suited for the client’s learning style.

5. Provide feedback to client, family, and staff on the results of intellectual, adaptive, psychological, behavioral, and neuropsychological testing.

6. Refer the client to a physical therapist to determine his/her level of motor functioning and whether ongoing physical therapy services are needed.

7. Refer the client to an occupational therapist for evaluation to determine what ADL skills training would be most appropriate.
13. Accept and follow dietician’s recommendations. (16)

14. Accept placement in appropriate residential setting. (17)

15. Accept placement in an appropriate day program or school setting for rehabilitation and/or vocational training. (18)

16. Attend physical therapy sessions designed to maintain and/or enhance range of motion. (19, 20, 21, 22)

17. Use relevant adaptive equipment to promote independence in ADLs. (22)

18. Participate in occupational therapy sessions designed to maximize independence via ADL skills acquisition. (23, 24, 25)

19. Take bath or shower, comb hair, brush teeth, and apply deodorant daily. (23, 24, 38)

20. Eat and drink to fullest capability of independence. (23, 24, 25, 28)

21. Attend speech therapy sessions to improve functional communication. (26)

22. Utilize augmentative speech materials to improve functional communication. (27)

23. Increase the frequency of unprompted expressive statements. (28, 38)

24. Use expressive/receptive language skills when interacting

8. Refer the client to a speech therapist to determine the client’s communicative strengths and weaknesses along with mode of communication best suited for him/her.

9. Refer the client to a nurse for ongoing monitoring of basic health, medical concerns, and medication management.

10. Arrange an appointment for an annual physical exam along with any follow-up or specialist care that is indicated.

11. Monitor the procedures for the administration of medications that have been prescribed for the client.

12. Arrange for biannual dental examinations and cleanings.

13. Arrange for yearly vision examinations.

14. Arrange for psychiatric evaluation to determine if a concomitant Axis I disorder may be contributing to poor ADLs and whether psychotropic medication may be helpful.

15. Enlist the help of family members and caregivers to monitor signs and symptoms of the client’s psychiatric condition to provide accurate information to the psychiatrist.

16. Facilitate the client’s obtaining dietician-approved
with others. (28, 29, 30, 38)

25. Initiate and respond to social greetings and smiles and make eye contact when involved in social situations. (30)

26. Begin to demonstrate and initiate independence by making all possible choices in daily events as evidenced by choosing clothing, food, leisure interests, and peer group. (30, 31)

27. Comply with prescriptive behavioral plan. (32, 33, 34)

28. Increase frequency of incompatible adaptive behaviors that compete with maladaptive behaviors. (35, 36, 37, 38)

29. Identify various emotions and their triggering events. (39)

30. Verbalize positive self-talk that reduces the level of frustration and anger. (40)

31. Parent increases positive feedback to the client. (41, 42)

32. Parents and caregivers develop realistic expectations of the client’s ADL abilities. (43, 44)

33. Parents increase and/or maintain involvement with their son/daughter and his/her treatment. (45, 46, 47)

34. Caretakers reduce the frequency of speaking for the client and/or performing activ-

foods and meals that he/she enjoys.

17. Consult with client, family, school officials, and assigned clinicians on different residential options (e.g., adult foster care home, group home, supported living environments, apartments, or community treatment homes) before making an appropriate referral.

18. Refer the client to a suitable program site, a day program with habilitative training, community based instruction, a sheltered workshop, enclave work, or vocational training that has vocational opportunities that are of interest to the client.

19. Coordinate follow-through on physical therapy to provide range of motion exercises to prevent contractures.

20. Assign the client suitable gross motor activities that will increase independence with ADL skills.

21. Seek advice and recommendations from a physical therapist regarding suitable positioning for the client.

22. Arrange for the client to obtain necessary adaptive and/or physical therapy equipment.

23. Develop a skills acquisition program designed to teach feeding, bathing, grooming, and/or dressing skills.
24. Specify suitable prompting levels for ADL skills acquisition programs (e.g., verbal prompts, physical prompts, or hand-over-hand guidance).

25. Assign the client suitable fine motor activities that will increase independence with ADL skills.

26. Provide or arrange for training in the client’s recommended form of communication (e.g., sign language, picture symbols, computerized device, or picture board).

27. Arrange for the client to obtain recommended augmentative speech materials, and provide for ongoing training using augmentative speed materials.

28. Expand the client’s receptive language by modeling pointing to body parts, objects, foods, clothing, animals, and responding to directions.

29. Expand the client’s expressive language by demonstrating naming objects, body parts, food, clothing, animals, and verbs; personal identification; and linking nouns and verbs together.

30. Teach the client effective basic communication skills (i.e., noninterruptive listening, good eye contact, asserting self with “I” statements,
and responding to greetings) to improve his/her ability to express thoughts, feelings, and needs more clearly.

31. Present situations such that the client is required to make a choice between two to three options, and reinforce independent choices.

32. Using behavioral analysis, determine motivating variables for the client’s maladaptive behaviors.

33. Identify several reinforcers that can be used to reward adaptive behaviors that are incompatible with maladaptive behaviors.

34. Assess ecological factors contributing to the maintenance of maladaptive behavior.

35. Design and implement a behavioral plan that reinforces desired behaviors coupled with behavioral techniques to decrease or eliminate maladaptive behaviors (e.g., shaping, fading, extinction, or differential reinforcement of other [DRO] behavior).

36. Conduct an in-service session with all caregivers on the client’s behavioral treatment program to ensure effective implementation of treatment to strengthen desirable, prosocial behavior.

37. Obtain approval from the client’s guardian and the
agency oversight committee for any restrictive or aversive programming.

38. Design a reward system to motivate the client to improve ADL, communication, and social skills.

39. Teach the client about the different emotions and how to identify the triggering event of an emotion (e.g., “I am angry because I was viewed as different”).

40. Teach the client positive self-talk that will help him/her accept and positively cope with his/her ADL difficulties.

41. Monitor the client’s progress at specified intervals and report information to client, family, and caregivers.

42. Encourage family members and caregivers to provide frequent and immediate positive feedback to the client for progress in ADL skills training.

43. Educate family members and caregivers on expected time frames of ADL skills training along with potential obstacles the client may face.

44. Assist family members and caregivers in developing realistic expectations of the client’s adaptive functioning.

45. Arrange for family members to read The Special Need Reading List (Sweeny) to provide information on
resources on general issues affecting lives of the disabled along with information on specific disabilities.

46. Encourage family members to maintain regular social contact with the client.

47. Encourage family members to maintain regular communication with involved clinicians regarding status of the client’s ADL skills, health, and maladaptive behaviors.

48. Provide family members and caregivers with training and/or in-service sessions needed to support the client’s advancement with ADL training.

49. Assess the client’s strengths and weaknesses in self-determination by using The ARC’s Self-Determination Scale (Wehmeyer) and use results to promote the client’s involvement in planning future goals with the support of his/her family.

50. Encourage family members and caregivers to agree to promote lifelong learning opportunities and experiences for the client to promote his/her choice making, decision making, problem solving, goal setting, and attainment along with self-awareness and knowledge.

51. Monitor, acknowledge, and reinforce all signs of the client’s pleasure, self-esteem,
52. Contact a recipient rights representative if the client’s rights have been violated.

53. Observe family members and caregivers for frustration, which may reduce their effectiveness to interact effectively with the client, and provide them with opportunities for venting feelings as necessary.

54. Teach deep muscle relaxation, abdominal breathing, and safe place imagery to caregivers to alleviate the stress of the many demands of caring for a person with ADL deficits.

55. Arrange for respite care for family members and caregivers.

56. Recommend that family members read *The Resourceful Caregiver: Helping Family Caregivers Help Themselves* (National Family Caregivers Association).

57. Teach the client stress reduction techniques (e.g., deep muscle relaxation, abdominal breathing and safe place imagery) to alleviate stressors encountered.

58. Refer the client to a recreational therapist to determine possible leisure and community activities available to the client.
59. Encourage the client’s participation in Special Olympics.

60. Assess the client’s and/or family members’ interest in faith-based activities and provide access to church ministry as indicated.

61. Refer family members and caregivers to *Dimensions of Faith and Congregational Ministries with Persons with Developmental Disabilities and Their Families* (Gavanta) to obtain information on many different faith-based books, videos, and programs available for persons with developmental disabilities and their families.

62. Observe the client for obvious and subtle signs of likes and dislikes and provide all possible enjoyable situations.
## DIAGNOSTIC SUGGESTIONS:

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
<th>DSM-5 Disorder, Condition, or Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>299.00</td>
<td>F84.0</td>
<td>Autism Spectrum Disorder</td>
</tr>
<tr>
<td>787.6</td>
<td>F98.1</td>
<td>Encopresis</td>
</tr>
<tr>
<td>307.6</td>
<td>F98</td>
<td>Enuresis</td>
</tr>
<tr>
<td>317</td>
<td>F70</td>
<td>Intellectual Disability, Mild</td>
</tr>
<tr>
<td>319</td>
<td>F71</td>
<td>Intellectual Disability, Moderate</td>
</tr>
<tr>
<td>319</td>
<td>F72</td>
<td>Intellectual Disability, Severe</td>
</tr>
<tr>
<td>319</td>
<td>F73</td>
<td>Intellectual Disability, Profound</td>
</tr>
<tr>
<td>319</td>
<td>F79</td>
<td>Unspecified Intellectual Disability</td>
</tr>
<tr>
<td>V62.89</td>
<td>R41.83</td>
<td>Borderline Intellectual Functioning</td>
</tr>
</tbody>
</table>
ANGER

BEHAVIORAL DEFINITIONS

1. Explosive, aggressive physical or verbal outbursts that are out of proportion to any precipitating stressors.
2. Swift and harsh judgment statements made to or about others.
3. Physical aggression toward self or others.
4. Property destruction and/or hostile opposition that occurs in response to correction, confrontation, or unwanted directives.
5. Body language characterized by tense muscles such as clenched fist or jaw, glaring looks, or refusal to make eye contact.
6. Use of verbally abusive language.
7. Hostile, threatening, and/or assaultive behavior in response to appropriate requests from others.
8. History of poor anger management resulting in significant impairments in family, social, and vocational relationships or opportunities.

LONG-TERM GOALS

1. Reduce intensity and frequency of all types of angry behaviors.
2. Identify early warning signs of anger or hostility.
3. Implement prosocial ways of expressing anger, frustration, embarrassment, or impatience.
SHORT-TERM OBJECTIVES

1. Participate in a psychological/neuropsychological assessment of anger problems, including developmental history, family history, and previous psychiatric involvement. (1, 2, 3, 4, 5)

2. Cooperate with medical examination to rule out medical etiologies for anger or aggression. (6, 7)

3. Cooperate with psychiatric examination to assess the need for psychotropic medications. (7, 8, 9)

4. Attend individual and/or group therapy sessions focused on resolving anger issues and teaching anger management skills. (10, 11)

5. Complete homework exercises that promote anger

THERAPEUTIC INTERVENTIONS

1. Arrange for a psychological assessment of the client’s anger symptoms, including a developmental history, family history, and previous psychiatric involvement.

2. Refer the client for a neurological exam or neuropsychological testing.

3. Operationally define and collect data on behaviors related to anger.

4. Assess the severity of the client’s anger/aggression through interviews, reports from caregivers, and rating scales such as the Reiss Screen for Maladaptive Behavior, Second Edition (Reiss) or the State-Trait Anger Expression inventory (Spielberger).
awareness and anger management. (12)

6. Correctly label and recognize emotions generated in self and others. (13, 14, 15)

7. Identify and list early signs of feeling and expressing frustration, annoyance, and anger. (13, 16, 17)

8. Identify personal triggers for anger. (13, 18)

9. Verbalize problem-solving techniques that will be used in future anger-arousing situations. (19, 20)

10. Carry written lists of problem-solving techniques to remind self of actions to implement in conflict situations. (21, 22)

11. Implement conflict coping strategies at early stages of anger arousal. (23, 24, 25)

12. List triggers for anger and alternate healthy responses to those triggers. (26)

13. Identify the negative impact uncontrolled anger expression has on others. (27)

14. Increase the usage of assertive responses to meet personal needs. (28, 29, 30)

15. Implement proper nutrition, increased exercise, and time management as means to reduce stress. (31)

16. Identify maladaptive responses to stress that create their own set of problems. (32)

5. Train family members and caregivers to monitor signs and symptoms of the client’s psychiatric condition to provide accurate information to the psychiatrist and psychologist.

6. Arrange for the client to obtain a complete physical to rule out any biomedical causes for his/her anger/aggression symptoms (e.g., temporal epilepsy, diabetes, or brain tumor).

7. Follow up on recommendations from the evaluation, including additional lab work, medications, or special assessments.

8. Arrange for a psychiatric evaluation to determine whether psychotropic medications may be helpful.

9. Monitor the client for compliance, effectiveness, and side effects associated with prescribed medications.

10. Arrange for the client to receive individual therapy using a therapeutic model best suited for him/her (e.g., cognitive, behavioral, developmental cognitive, or psychoeducational).

11. Arrange for the client to participate in group therapy to learn anger management skills.

12. Assign homework exercises (e.g., problem-solving sheets, mood log, utilizing action plan, and/or asking for
17. Report success at implementing relaxation techniques. (23, 33)

18. Attend group sessions that focus on enhanced social skills. (34, 35)

19. Identify reinforcers for angry and calm behavior. (1, 36, 37, 38)

20. Increase positive management of anger through behavior modification procedures. (39, 40, 41)

21. Family members, caregivers, and client modify the environment to reduce stress. (42)

22. Identify irrational beliefs and negative self-talk that mediates anger. (43)

23. Verbalize positive self-talk that mediates calm. (44)

24. List positive, adaptive alternatives for expressing anger. (45, 46)

25. Demonstrate independence and initiative by making all possible choices in daily events, as evidenced by choosing clothing, food, leisure interests, and peer group. (47, 48)

26. Family members and caretakers assist and support the client in his/her attempts to make positive behavioral changes to manage anger. (49, 50)

27. Increase participation in extracurricular activities and outings. (51, 52)

28. Assistance) from the Anger Workbook (Bilodeau) to promote anger management skills. Emphasize the client’s choice and power to make good decisions in managing his/her anger.

13. Teach the client to be aware of, to be able to label, and to understand the universality of different emotions through the use of modeling, pictures, and intermittent testing.

14. Present verbal or pictorial scenarios of conflict between two people. Request that the client verbally describe what is happening from both parties’ perspective and why each perspective is different.

15. Using real conflicts from the client’s life, discuss the differences in perspective between self and the other in order to foster development of empathy toward and understanding of others.

16. Request that the client identify his/her early signs of feeling and expressing anger and frustration, soliciting input from others who know the client’s anger expression patterns.

17. Request that the client verbally identify or demonstrate how our bodies change during anger (e.g., clenched fist and teeth, tense posture, narrowed eyes, or faster breathing); ask
18. Request that the client identify the situations and conditions under which he/she typically develops feelings of anger or frustration (e.g., “I am angry because my friend ignored me”). Direct the client to solicit input from others.

19. Teach the client problem-solving techniques (e.g., identifying the problem, listing possible solutions, selecting a solution, and evaluating the solution’s outcome; see Thinking It Through: Teaching a Problem-Solving Strategy for Community Living [Foxx and Bittle]).

20. Role-play several problem situations for the client to solve, and provide feedback on the client’s progress.

21. Provide the client with a notebook of problem-solving sheets (e.g., identifying the problem, listing possible solutions, selecting a solution, and evaluating the solution’s outcome) to use as situations occur and use as a reference if problems repeatedly occur.

22. Create small cards with pictorial or written reminders of conflict resolution techniques. Provide these for the client and caregivers.
23. Discuss several activities that the client can do when beginning to feel angry in order to reduce tension (e.g., talk with others, go for a walk, listen to soothing music, write a letter, keep a mood log, practice progressive muscle relaxation, do deep breathing, and use thought-stopping techniques).

24. Reinforce the client’s efforts to use healthy alternate activities to reduce tension and anger while emphasizing the importance of practice.

25. Read *Don’t Pop Your Cork on Mondays!* (Moser) to the client (or request that he/she read or view it) in order to promote his/her understanding of the importance of controlling anger.

26. Assist the client in creating a master list of his/her anger triggers, angry responses, personal signs of anger, and identified prosocial alternate responses. Encourage the client to keep the list close at hand for easy reference.

27. Use role-playing and role-reversal techniques to teach the client the impact of his/her negative behavior on others.

28. Model assertive, passive, and aggressive responses to situations, and request that the client identify which of the three is most effective.
Request that the client role-play assertive, passive, and aggressive responses to identify his/her current response type.

29. Use an assertiveness questionnaire to query the client about situations in which he/she would like to be more assertive (see The Relaxation and Stress Reduction Workbook [Davis, Eshelman, and McKay]).

30. Using specific examples from the client’s experience, request that he/she role-play assertive responses to a variety of situations. Provide feedback on the client’s progress with role-playing, and encourage him/her to use assertive responses when needed.

31. Review lifestyle changes that can help in reducing stress (e.g., proper nutrition, regular exercise, and time management skills). Encourage the client to adopt these healthy lifestyle changes.

32. Assist the client in identifying nonproductive means of expressing anger (e.g., alcohol, drugs, aggression, and venting) and request that he/she identify why these are not effective responses.

33. Review the different types of relaxation techniques (e.g.,
32 THE INTELLECTUAL AND DEVELOPMENTAL DISABILITY TREATMENT PLANNER

depth breathing, progressive muscle relaxation, or imagery) and provide training in the various relaxation techniques. Encourage and reinforce use and practice.

34. Arrange for the client to obtain the necessary social skills training to foster good interpersonal relationships (see Social Skills in this Planner).

35. Refer the client to a support group for individuals with developmental disabilities.

36. Refer the client to a behavior specialist in order to determine the eliciting stimuli and maintaining reinforcers for his/her maladaptive expression of anger.

37. Assess the ecological factors contributing to the maintenance of the client’s anger or aggression.

38. Identify several reinforcers that can be used to reward prosocial behaviors that are incompatible with anger outbursts. Request that the client identify or endorse desired reinforcers.

39. Refer the client to a behavioral specialist to design and implement a behavior plan that reinforces desired behaviors coupled with behavioral techniques (e.g., reinforcing low reactivity levels, reinforcing incompatible behaviors,
extinction, response cost, and overcorrection) to decrease or eliminate angry and aggressive behaviors.

40. Train all caregivers on the client’s behavioral treatment program to ensure consistent, effective implementation and strengthening of desirable prosocial behaviors (see Skills Training for Children with Behavioral Disorders [Bloomquist] for a guide covering basic behavioral techniques).

41. Obtain approval from the client’s guardian and the agency oversight committee for any use of restrictive or aversive programming.

42. Modify the client’s environment to remove physical and psychological conditions not conducive to healthy behaviors (e.g., noisy conditions, hunger, crowding, or heat). Replace with conditions that encourage calm, relaxed behaviors.

43. Review a list of irrational beliefs (e.g., “Everybody always picks on me,” “Nobody ever says anything nice to me,” and “My parents do not love me”) that are contributing to the client’s anger. Using client-specific examples, present alternative self-talk to demonstrate the importance of changing irrational beliefs.
44. Facilitate the client’s understanding that anger is due to how he/she perceives and interprets the situation rather than any external event, situation, or person. Model and role-play client-specific situations that demonstrate his/her control over the self-talk that governs how a problematic situation is perceived.

45. Request that the client read (or read to the client) *Don’t Rant and Rave on Wednesdays!* (Moser) or *Dealing with Anger* (Johnston) to facilitate an understanding of the universality of anger and the optional positive behaviors for dealing with this powerful emotion.

46. Demonstrate different ways to release anger to the client, and process the selected activity with him/her (e.g., forgiving, letting go, writing or drawing about feelings, and using humor or symbolic activities).

47. Present multiple choices in a variety of situations such that the client is able to make a selection between the options.

48. Encourage the client’s family to allow the client to make all possible choices and to demonstrate maximum independence in daily events.

49. Obtain the client’s consent to enlist support for his/her
anger management efforts from clinicians, residential staff, family members, and vocational and educational staff.

50. Encourage family members and caregivers to increase the frequency of positive interactions with the client while modeling desirable conflict resolution behaviors, positive demeanor, and helpful attitudes. Model these behaviors to family members and caregivers in formal and informal situations.

51. Refer the client to a recreational therapist to determine possible leisure, social, and community activities available to the client.

52. Encourage the client’s participation in Special Olympics or other athletic events.

_  ________________
_  __________________
_  ________________
_  __________________
_  ________________
_  __________________
### Diagnostic Suggestions:

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
<th>DSM-5 Disorder, Condition, or Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>312.34</td>
<td>F63.81</td>
<td>Intermittent Explosive Disorder</td>
</tr>
<tr>
<td>296.xx</td>
<td>F31.xx</td>
<td>Bipolar I Disorder</td>
</tr>
<tr>
<td>296.89</td>
<td>F31.81</td>
<td>Bipolar II Disorder</td>
</tr>
<tr>
<td>310.1</td>
<td>F07.0</td>
<td>Personality Change Due to another Medical Condition</td>
</tr>
<tr>
<td>309.81</td>
<td>F43.10</td>
<td>Posttraumatic Stress Disorder</td>
</tr>
<tr>
<td>294.11</td>
<td>F02.81</td>
<td>Probable Neurocognitive Disorder Due to Alzheimer’s Disease, with Behavioral Disturbance</td>
</tr>
<tr>
<td>294.10</td>
<td>F02.80</td>
<td>Probable Neurocognitive Disorder Due to Alzheimer’s Disease, without Behavioral Disturbance</td>
</tr>
<tr>
<td>294.10</td>
<td>F02.80</td>
<td>Major Neurocognitive Disorder Due to Traumatic Brain Injury, without Behavioral Disturbance</td>
</tr>
<tr>
<td>294.10</td>
<td>F02.81</td>
<td>Major Neurocognitive Disorder Due to Traumatic Brain Injury, with Behavioral Disturbance</td>
</tr>
<tr>
<td>294.8</td>
<td>R41.9</td>
<td>Unspecified Neurocognitive Disorder</td>
</tr>
<tr>
<td>299.00</td>
<td>F84.0</td>
<td>Autism Spectrum Disorder</td>
</tr>
<tr>
<td>317</td>
<td>F70</td>
<td>Intellectual Disability, Mild</td>
</tr>
<tr>
<td>319</td>
<td>F71</td>
<td>Intellectual Disability, Moderate</td>
</tr>
<tr>
<td>319</td>
<td>F72</td>
<td>Intellectual Disability, Severe</td>
</tr>
<tr>
<td>319</td>
<td>F73</td>
<td>Intellectual Disability, Profound</td>
</tr>
<tr>
<td>319</td>
<td>F79</td>
<td>Unspecified Intellectual Disability</td>
</tr>
<tr>
<td>V62.89</td>
<td>R41.83</td>
<td>Borderline Intellectual Functioning</td>
</tr>
</tbody>
</table>
ANXIETY

BEHAVIORAL DEFINITIONS

1. Feeling restless, keyed up, or on edge, as evidenced by increased motor activity, muscle tension, or shakiness.
2. Autonomic hyperactivity including dry mouth, nausea, diarrhea, shortness of breath, or rapid heartbeat.
3. Hypervigilance, as evidenced by difficulty in falling or staying asleep, difficulty with concentration, exaggerated startle response, or irritability.
4. Disorganization or agitated behaviors following exposure to a traumatic event.
5. Fears specific to a certain situation that interfere with daily life because of high levels of anxiety or avoidance of certain stimuli.
6. Excessive or unrealistic anxiety, worry, or apprehension.
7. Obsessions or compulsions that are time consuming, interfere with daily activities, and seem uncontrollable.

LONG-TERM GOALS

1. Reduce or eliminate anxiety symptoms.
2. Develop skills and strategies to cope positively with stressors.
3. Implement behavioral and cognitive coping techniques to reduce anxiety.
SHORT-TERM OBJECTIVES

1. Participate in a psychological assessment of anxiety symptoms. (1, 2, 3, 4)
2. Cooperate with medical examination to rule out medical etiologies for anxiety symptoms. (5)
3. Cooperate with a psychiatric examination to assess the need for psychotropic medications. (6, 7)
4. Attend individual psychotherapy sessions focused on anxiety reduction. (8)
5. Attend group therapy sessions focused on teaching anxiety reduction techniques. (9)
6. Keep records of anxiety symptoms, precipitating events, and resolution methods. (10)
7. Verbalize realistic beliefs that challenge anxiety-inducing thoughts. (11, 12)
8. Report a reduction in phobic anxiety after participating in

THERAPEUTIC INTERVENTIONS

1. Arrange for psychological assessment of the client’s anxiety symptoms, including developmental history, family history, and previous psychiatric involvement.
2. Operationally define and collect data on behaviors indicative of anxiety.
3. Assess the severity of the client’s anxiety (e.g., consider using a rating scale such as the Diagnostic Assessment for the Severely Handicapped, Second Edition [DASH-II; Matson] or the Reiss Screen for Maladaptive Behavior, Second Edition [Reiss]).
4. Train family members and caregivers to monitor the client’s signs and symptoms of anxiety to provide accurate information to the psychiatrist or psychologist.
5. Arrange for the client to obtain a complete physical to
systematic desensitization treatment. (13)

9. Increase frequency of relaxing, calm behaviors that compete with anxiety behaviors. (14, 15, 16)

10. Implement alternative activities that reduce agitation and anxiety at early stages of onset. (12, 17, 18)

11. Meet with a mentor regarding how to minimize problems between self and the environment. (19)

12. Attend a support group for individuals with developmental disabilities. (20)

13. Participate in social skills training to alleviate social anxiety. (21)

14. Implement environmental stress management techniques. (22)

15. Cooperate with recommendations from a speech therapist as to ways to improve communication. (23)

16. Family members and caregivers report increased understanding of the client’s communication and problematic behaviors. (24, 25)

17. Utilize an activity board to keep self informed of the day’s scheduled events in order to reduce confusion and ambiguity that could trigger anxiety. (26)

18. Identify reinforcers for nonanxious behaviors. (27, 28, 29)

rule out any biomedical causes for his/her anxiety symptomatology (e.g., substance abuse, medications, and hyperthyroidism).

6. Arrange for a psychiatric evaluation to determine whether psychotropic medications may be helpful.

7. Monitor the client for compliance, effectiveness, and side effects associated with prescribed antianxiety medications.

8. Arrange for the client to receive individual therapy using a therapeutic model best suited for him/her (e.g., cognitive-behavioral, behavioral, or psychoeducational) to facilitate changes in anxious feeling and thinking.

9. Arrange for the client to participate in group therapy to learn skills incompatible with his/her anxiety symptomatology (e.g., relaxation, visualization, and deep breathing).

10. Request that the client keep a daily mood record to better understand his/her anxiety patterns, precipitating events, and coping behaviors used.

11. Request that the client read (or read to the client) relevant portions of *SOS: Help for Emotions: Managing Anxiety, Anger, and Depression* (Clark) to help eliminate irrational beliefs that contribute to his/her anxiety.
19. Increase the frequency of calm and relaxed verbal, social, and motor behaviors. (30, 31, 32)

20. Family members and caregivers decrease the client’s stress through the implementation of a quieter, more routine environment. (29, 33, 34, 35)

21. Demonstrate independence and initiative by making all possible choices in daily events, as evidenced by choosing clothing, food, leisure interests, and peer group. (36, 37)

22. Family members and caregivers express greater understanding of the client’s emotional and developmental disorder. (38, 39, 40)

23. Family members and caretakers assist and support the client in his/her attempts to make positive behavioral changes to manage anxiety symptoms. (41, 42)

24. Increase participation in extracurricular activities and outings. (43, 44)

12. Instruct the client in cognitive restructuring techniques (e.g., replacing irrational, automatic thoughts with realistic self-talk that mediates calm confidence) to change his/her thoughts that perpetuate specific fears. Model these for the client and provide role-playing opportunities to facilitate mastery of the new skill.

13. Use systematic desensitization to assist the client in coping with his/her specific phobic responses. Construct a hierarchy of least-anxiety-provoking to greater-anxiety-provoking scenarios, gradually introducing each level until the client is anxiety free.

14. Request that the client generate a list of activities he/she enjoys and finds relaxing (e.g., listening to soothing music, taking baths, or going for walks) and request that the client specify times during the day to schedule calming activities.

15. Teach the client anxiety-reducing skills for managing anxiety symptoms (e.g., deep breathing, progressive muscle relaxation, or positive imagery). Model these for the client and provide him/her with practice opportunities to facilitate mastery of the new skill.
16. Prepare an audiotape of progressive muscle relaxation prompts or calm, soothing music for the client to use at early stages of anxiety. Provide a headset for the client.

17. Teach the client to recognize early signs of negative emotions and then to initiate alternative activities that will reduce expressed agitation (e.g., client’s preferred activities, deep breathing, progressive muscle relaxation, or positive imagery).

18. Provide training and in-service sessions to family members and caregivers to promote their identification of early signs of the client’s agitation. Direct family members to assist the client in utilizing distraction or coping techniques at low levels of agitation (e.g., deep breathing, relaxation, or positive self-talk).

19. Coordinate a mentor relationship with a volunteer or a peer who can assist in resolving conflicts between the client and his/her environment to promote more effective management of problems.

20. Refer the client to a support group for people with developmental disabilities.

21. Arrange for the client to participate in social skills training to reduce anxiety.
experienced in social situations (see Social Skills in this Planner).

22. Teach the client relevant environmental stress reduction techniques to alleviate stressors (e.g., time management, exercise, or improved nutrition).

23. Refer the client to a speech therapist for suggestions or hardware to increase his/her communication ability.

24. Use modeling and role-playing to teach family members and caregivers to listen for the client’s direct and indirect communications. Reinforce the client for cooperating with reasonable, routine requests.

25. Assist family members and caregivers in identifying what the client may be communicating through his/her problematic behavior (e.g., fear, helplessness, or frustration). Refer family members and caregivers to the Parent Survival Manual (Schopler) for examples of effective responses to the client’s behavior problems.

26. Recommend that family members and caregivers use an activity board to display the client’s schedule (written or pictorially) for the day, week, or month to minimize his/her anxiety related to uncertainty about what is upcoming.
27. Use behavioral analysis to identify reinforcers for the client’s anxious behaviors.

28. Identify several reinforcers that can be used to reward behaviors that are incompatible with the client’s anxiety behaviors. Ask the client to contribute to the list.

29. Assess ecological factors contributing to the maintenance of the client’s anxiety behaviors.

30. Refer the client to a behavioral specialist to design and implement a behavioral plan that reinforces desired behaviors coupled with behavioral techniques (e.g., reinforcing low reactivity levels, reinforcing incompatible behaviors, extinction, response cost, and overcorrection) to decrease or eliminate anxious behaviors.

31. Train all caregivers on the client’s behavioral treatment program to ensure effective implementation and strengthening of desirable nonanxious behaviors. (Consider using *Skills Training for Children with Behavioral Disorders: A Parent and Therapist Workbook* [Bloomquist] as a guide.)

32. Obtain approval from the client’s guardian and the agency oversight committee for restrictive or aversive programming.
33. Modify the client’s environment to remove physical and psychological conditions not conducive to low stress (e.g., noisy conditions, hunger, bright sunlight, and physical discomfort).

34. Recommend that family members and caregivers read *Helping People with Autism Manage Their Behavior* (Dalrymple) to learn how to create a structured, ordered environment that accommodates the client’s needs and minimizes anxiety.

35. Recommend that family members and caregivers read the *Anxiety and Stress Self-Help Book* (Lark) or the *Anxiety and Phobia Workbook* (Bourne) to examine environmental changes that could reduce the client’s anxiety and stress levels (e.g., dietary changes, physical exercise, and breathing exercises).

36. Present situations on a daily basis such that the client is required to make a choice between two to three options, and reinforce independent choices.

37. Encourage family members to allow the client to make all possible choices and to demonstrate maximum independence in daily events.

38. Obtain the client’s consent to enlist support from clinicians, residential staff, family
members, and vocational and educational staff.

39. Provide specific information to client, family, and caregivers about the client’s specific anxiety disorder (e.g., from the Anxiety and Phobia Workbook (Bourne) or from the National Institute of Mental Health Web site).

40. Recommend that caregivers read The Psychiatric Tower of Babble (Gabriel) to learn about the mental health needs of persons with developmental disabilities.

41. Arrange for family members and caregivers to spend time with the client doing only what the client expresses an interest in (e.g., planning a meal, playing a game, or watching a video) to promote unconditional, nondemanding interactions while the family members and caregivers provide verbal attention to the client’s activities.

42. Encourage family members and caregivers to increase the frequency of positive interactions with the client while modeling desirable behaviors, positive demeanor, and helpful attitudes. Model these behaviors to family members and caregivers in formal and informal situations.

43. Refer the client to a recreational therapist to determine
possible leisure, social, and community activities available to the client.

44. Encourage the client’s participation in Special Olympics or other athletic events.
**DIAGNOSTIC SUGGESTIONS:**

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
<th>DSM-5 Disorder, Condition, or Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>300.02</td>
<td>F41.1</td>
<td>Generalized Anxiety Disorder</td>
</tr>
<tr>
<td>300.09</td>
<td>F41.8</td>
<td>Other Specified Anxiety Disorder</td>
</tr>
<tr>
<td>300.00</td>
<td>F41.9</td>
<td>Unspecified Anxiety Disorder</td>
</tr>
<tr>
<td>309.24</td>
<td>F43.22</td>
<td>Adjustment Disorder, With Anxiety</td>
</tr>
<tr>
<td>309.21</td>
<td>F93.0</td>
<td>Separation Anxiety Disorder</td>
</tr>
<tr>
<td>300.01</td>
<td>F41.0</td>
<td>Panic Disorder</td>
</tr>
<tr>
<td>300.22</td>
<td>F40.00</td>
<td>Agoraphobia</td>
</tr>
<tr>
<td>300.29</td>
<td>F40.xxx</td>
<td>Specific Phobia</td>
</tr>
<tr>
<td>300.23</td>
<td>F40.10</td>
<td>Social Anxiety Disorder (Social Phobia)</td>
</tr>
<tr>
<td>309.81</td>
<td>F43.10</td>
<td>Posttraumatic Stress Disorder</td>
</tr>
<tr>
<td>308.3</td>
<td>F43.0</td>
<td>Acute Stress Disorder</td>
</tr>
<tr>
<td>317</td>
<td>F70</td>
<td>Intellectual Disability, Mild</td>
</tr>
<tr>
<td>319</td>
<td>F71</td>
<td>Intellectual Disability, Moderate</td>
</tr>
<tr>
<td>319</td>
<td>F72</td>
<td>Intellectual Disability, Severe</td>
</tr>
<tr>
<td>319</td>
<td>F73</td>
<td>Intellectual Disability, Profound</td>
</tr>
<tr>
<td>319</td>
<td>F79</td>
<td>Unspecified Intellectual Disability</td>
</tr>
<tr>
<td>V62.89</td>
<td>R41.83</td>
<td>Borderline Intellectual Functioning</td>
</tr>
</tbody>
</table>
CHEMICAL DEPENDENCE

BEHAVIORAL DEFINITIONS

1. Consistent use of alcohol or other mood-altering drugs until high, intoxicated, or passed out.
2. Inability to stop or cut down use of mood-altering drugs once started, despite the verbalized desire to do so and negative consequences associated with continued use.
3. Difficulty understanding the concept of substance abuse and its problem despite direct feedback from spouse, relatives, friends, or employer that the use of the substance is negatively affecting them and others.
4. Marked change in behavior as evidenced by withdrawal from family or friends, loss of interest in activities, or sleep disturbances.
5. Unpredictable mood swings, irritability, tantrums, aggression, property destruction and self-injury resulting from substance use.
6. Continued drug and/or alcohol use despite experiencing persistent or recurring physical, legal, vocational, social or relationship problems that are directly caused by the drug/alcohol abuse, or the inability to foresee legal and personal consequences of behavior.
7. Gradual increase in the consumption of the mood-altering substance in larger amounts and for longer periods than intended, in order to attain the desired effect.
8. Physical symptoms, including shaking, seizures, nausea, headaches, sweating, anxiety, or insomnia when withdrawing from the substance.
9. Long periods of time spent at home with lack of challenging activities due to health problems or employment difficulties, resulting in increased substance use.
10. Typical daily activities affected by time spent obtaining the substance, using it, or recovering from its effect.
11. Continued use of mood-altering chemicals after being told that it potentiates the effects of existing medications and chronic medical conditions such as epilepsy, cerebral palsy, or mental illness.
12. Family members and caregivers reluctant to address substance use because they do not consider substance use problematic or wish to avoid another stigmatizing label.

LONG-TERM GOALS

1. Accept chemical dependence and begin to actively participate in an integrated dual diagnosis recovery program.
2. Withdraw from mood-altering substance, stabilize physically and emotionally, and then establish a supportive recovery plan.
3. Gain an understanding of the negative impact of substance abuse on disability concerns and the effectiveness of prescribed medications.
4. Establish and maintain total abstinence while increasing knowledge of the disease and the process of an integrated recovery.
5. Identify and pursue relationships, groups, activities, and locations that will promote a healthy and satisfying lifestyle.

SHORT-TERM OBJECTIVES

1. Describe the amount, frequency, and history of substance abuse. (1)

THERAPEUTIC INTERVENTIONS

1. Gather a complete drug and alcohol history including the type, amount, and pattern of use, as well as the negative life
2. Participate in a psychological assessment of adaptive and intellectual abilities and current stressors. (2, 3)
3. Review extended family’s chemical dependence history and verbalize an acceptance of a genetic component to substance abuse. (4, 5)
4. Cooperate with a psychiatric examination to evaluate the need for psychotropic medications. (6, 7, 8, 9)
5. Participate in a medical examination to evaluate the effects of chemical dependence. (10, 11, 12)
6. Improve nutritional status relative to the effects of long-term substance abuse. (13, 14)
7. Begin the 12-step recovery process. (15, 16, 17, 18)
8. Cooperate with a supervised, medically supported detoxification program. (19, 20, 21, 22)
9. Implement the assertiveness and decision-making skills that promote a substance free lifestyle. (15, 23, 24, 25)
10. Identify the negative consequences of drug and/or alcohol abuse. (25, 26, 27)
11. Verbalize an understanding of the risks and the effects of substances on the mind and body. (25, 28, 29)
12. Identify the role substance abuse has played in meeting needs. (25, 30, 31, 32)

consequences resulting from substance use (e.g., social, legal familial, and vocational).
2. Assess the client’s intellectual, personality, and cognitive functioning as they relate to his/her chemical dependence.
3. Explore situational stressors contributing to the client’s substance misuse.
4. Explore the extended family’s chemical dependence history. Utilize a genogram to pictorially display family relationships and substance abuse concerns.
5. Educate the client about his/her genetic predisposition to chemical dependence.
6. Arrange for a psychiatric evaluation to evaluate whether psychotropic medications may be helpful (see Anxiety and Depression in this Planner).
7. Monitor the client for compliance, effectiveness, and side effects associated with prescribed psychotropic medications.
8. Train family members and caregivers to monitor the client’s signs and symptoms of mental illness to provide accurate information to the psychiatrist, psychologist, or other clinicians.
9. Emphasize to the client the difference between taking a prescribed medication for a
13. Verbalize an understanding of the risks associated with the use of mood-altering substances. (33, 34)
14. Eliminate denial behaviors and accept personal responsibility for substance use. (35, 36, 37, 38)
15. Accept legal consequences of behavior related to substance abuse. (39, 40, 41)
16. Verbalize increased knowledge of substance abuse and the process of recovery. (28, 42)
17. Verbalize an understanding of personality, social, and family factors that contribute to substance use. (3, 4, 25, 43)
18. Identify alternative coping behaviors to handle stressors. (25, 44, 45, 46)
19. Identify how sobriety could positively impact life. (47, 48)
20. Identify changes needed in social system and lifestyle to support recovery. (49, 50)
21. Increase number, duration, and intensity of social contacts. (16, 51)
22. Identify and alter living situation contributing to substance use. (52, 53, 54)
23. List recreational, social, and household activities that will replace substance abuse–related activities. (55, 56)

specific medical condition and the use of street drugs to achieve a high.
10. Arrange for the client to obtain a complete physical to determine the effects of his/her substance abuse.
11. Coordinate any follow-up to the physical examination, such as prescriptions, lab tests, or specialized assessments.
12. Coordinate with the physician to determine the safest way to decrease or eliminate the client’s dependence on substances.
13. Review the client’s eating habits and encourage the client to maintain healthy nutrition.
14. Refer the client to a dietician or nutritionist for assessment or recommendations regarding his/her dietary needs.
15. Review support groups available for persons with developmental disabilities experiencing difficulties with substance abuse (e.g., Alcoholics Anonymous [AA], Narcotics Anonymous [NA], community mental health agencies, drug detoxification centers, or support groups for persons with developmental disabilities). Refer the client to the most suitable programs.
24. Agree to make amends to significant others who have been hurt by the life dominated by substance abuse. (25, 57)

25. Write a goodbye letter to drug of choice telling it why it must go. (58)

26. Identify potential relapse triggers and develop strategies for constructively dealing with each trigger. (59, 60, 61, 62)

16. Arrange for volunteers to take the client to AA or NA meetings.

17. Arrange for the client to receive training on the jargon and customs of AA meetings so he/she can avoid feeling lost and inadequate.

18. Teach the client social skills such as assertiveness, reciprocity, and courtesy to ensure that he/she can fit socially into support groups (see Social Skills in this Planner).

19. Advocate with the substance abuse treatment program for the client to be able to utilize existing prescription medications for medical conditions while in treatment.

20. Coordinate with the treatment program to extend the length of treatment, simplify information, provide information repetitively, and use behavioral techniques as needed by the client to ensure that he/she gets maximal benefits from program.

21. Provide substance abuse professionals with information regarding intellectual disability (e.g., this Treatment Planner) as well as substance abuse training for intellectual disability professionals (e.g., The Chemical Dependence Treatment Planner [Perkinson and Jongsma]).
22. Coordinate the development of a multidisciplinary, interagency team to provide integrated treatment.

23. Arrange for the client to receive individual, family, and/or group counseling to discuss substance use.

24. Use a variety of activities to promote self-exploration, handling peer pressure, and decision-making skills, (e.g., see 101 Support Group Activities: For Teenagers Recovering from Chemical Dependence [Fleming]).

25. Assign appropriate homework assignments from the Chemical Dependence Treatment Homework Planner (Finley and Lenz). Modify the assignments as needed to meet the client’s level of intellectual functioning.

26. Request that the client make a list of the ways substance abuse has negatively impacted his/her life and process it with the clinician.

27. Assign the client to meet with two or three people who are close to him/her to discuss how they see his/her chemical dependence negatively impacting their lives.

28. Provide the client with factual information in concrete terms on the effects of substance abuse on physical and mental health (e.g., see The Addictions Workbook [Fanning and O’Neill]).
29. Arrange for the client to view a video on his/her drug of choice (e.g., the Gateway Drugs series: Binge Drinking Blowout, Tobacco X-Files, or Marijuana: The Gateway Drug [Discover Films Video]).

30. Discuss with the client his/her needs, real and perceived, met through substance use. Assist the client in identifying alternate, constructive ways to meet these needs while remaining abstinent.

31. Ask the client about the physical cravings he/she has experienced for the substance of choice; discuss coping behaviors to replace substance abuse.

32. Request feedback from the client on the ways in which the drug or alcohol has been used as a social icebreaker; discuss alternate social and relaxation skills that could be used.

33. Educate the client on the effects of substance misuse (e.g., increased tolerance, altered judgment, and negative medication interactions). Stress this concept by using specific examples of how his/her quality of life can be improved by eliminating substance use.

34. Arrange for the client to view a video on the effects of substance misuse (e.g., the Addiction and Recovery Series
35. Acknowledge and reinforce all statements made by the client indicating his/her personal responsibility for the substance abuse. Provide reassurances to limit fear or shame that might cause undue guilt and anxiety.

36. Use specific examples to describe positive and negative choices about substance use, and how each choice results in vastly different consequences. Determine the client’s interest in making positive future choices.

37. Model and reinforce statements made by the client indicating his/her understanding of the destructive consequences substance misuse has created for himself/herself and others.

38. Confront the client’s use of defense mechanisms to justify or rationalize behavior.

39. With proper release, provide information to the police or prosecutor regarding the impact of the client’s developmental disability on his/her behavior.

40. Facilitate the client’s involvement with legal appointments, court dates, and so on. (See Legal Problems in this Planner.)

41. Obtain documentation from law enforcement personnel regarding the client’s illegal
behaviors relative to substance abuse. Process with the client the role his/her use of addictive substances has had in illegal activities.

42. Modify educational materials (available from local substance abuse treatment agencies) to accommodate the client’s individual learning requirements (e.g., orally review written materials on a one-to-one basis, or use simplified pictures or videos).

43. Question the client about his/her understanding of how triggers contribute to substance abuse. Reinforce knowledge or understanding of these relationships.

44. Assist the client in identifying healthy alternatives for coping with problems (e.g., physical exercise, increased socialization, talking to an identified support person or peer). Provide the client with a written or pictorial list of alternative behaviors for him/her to refer to as needed.

45. Help to identify the client’s specific personal triggers for substance use (location, events, moods, thoughts, or peer group). Request that the client identify alternative healthy responses to each identified trigger.

46. Model and role-play with the client his/her identified
alternative responses until the client is able to do so independently and confidently.

47. Assist the client in identifying positive changes resulting from eliminating substance abuse (e.g., relationships, work, health, and home environment). Create a written or pictorial list of the positive changes.

48. Review the negative influence of continuing existing substance-related friendships (drinking buddies) and assist the client in making a plan to develop new substance-free friendships.

49. Discuss with the client life changes needed in order to maintain long-term substance-free living. Request that the client identify specific changes he/she believes are necessary. Contract with him/her to make the identified changes.

50. Practice a variety of social skills with the client (see Social Skills in this Planner).

51. Refer the client to drop-in centers, clubhouse programs, and community-based social programs.

52. Evaluate the role of the client’s living situation in fostering a pattern of substance abuse.

53. Assign the client to make a list of negative influences for chemical dependence.
inherent in his/her current living situation.

54. Encourage, support, and reinforce the client’s desire to seek alternative living arrangements that will foster recovery.

55. Assist the client in planning social and recreational activities that are free from substance use (see Recreation/Leisure Activities in this Planner).

56. Request that the client identify household or work-related projects to fill the time previously spent using substances.

57. Discuss with the client the negative effects his/her substance abuse has had on family, friends, and work relationships, and encourage a plan to make amends for such hurt.

58. Request that the client write a goodbye letter to the drug of choice, read it, and process related feelings with the therapist.

59. Help the client develop an awareness of relapse triggers and alternative ways of effectively handling them.

60. Develop an abstinence contract with the client regarding the use of his/her drug of choice. Provide the client with a copy in a format that promotes frequent independent review (e.g., written or
pictorial chart, audiotape, or videotape). Process the emotional impact of this contract with the clinician.

61. Develop with the client a comprehensive aftercare plan to ensure maintenance of changes, including a support network, treatment alternatives, a plan for coping with triggers, and a safety plan.

## Diagnostic Suggestions:

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
<th>DSM-5 Disorder, Condition, or Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>303.90</td>
<td>F10.20</td>
<td>Alcohol Use Disorder, Moderate or Severe</td>
</tr>
<tr>
<td>305.00</td>
<td>F10.10</td>
<td>Alcohol Use Disorder, Mild</td>
</tr>
<tr>
<td>304.30</td>
<td>F12.20</td>
<td>Cannabis Use Disorder, Moderate or Severe</td>
</tr>
<tr>
<td>305.20</td>
<td>F12.10</td>
<td>Cannabis Use Disorder, Mild</td>
</tr>
<tr>
<td>304.20</td>
<td>F14.20</td>
<td>Cocaine Use Disorder, Moderate or Severe</td>
</tr>
<tr>
<td>305.60</td>
<td>F14.10</td>
<td>Cocaine Use Disorder, Mild</td>
</tr>
<tr>
<td>305.70</td>
<td>F15.10</td>
<td>Amphetamine Use Disorder, Mild</td>
</tr>
<tr>
<td>304.40</td>
<td>F15.20</td>
<td>Amphetamine Use Disorder, Moderate or Severe</td>
</tr>
<tr>
<td>305.50</td>
<td>F11.10</td>
<td>Opioid Use Disorder, Mild</td>
</tr>
<tr>
<td>304.00</td>
<td>F11.20</td>
<td>Opioid Use Disorder, Moderate or Severe</td>
</tr>
<tr>
<td>305.90</td>
<td>F18.10</td>
<td>Inhalant Use Disorder, Mild</td>
</tr>
<tr>
<td>304.60</td>
<td>F18.20</td>
<td>Inhalant Use Disorder, Moderate or Severe</td>
</tr>
<tr>
<td>291.2</td>
<td>F10.27</td>
<td>Moderate or Severe Alcohol Use Disorder, with Alcohol-Induced Major Neurocognitive Disorder, Nonamnestic-Confabulatory Type</td>
</tr>
<tr>
<td>291.1</td>
<td>F10.26</td>
<td>Moderate or Severe Alcohol Use Disorder, with Alcohol-Induced Major Neurocognitive Disorder, Amnestic-Confabulatory Type</td>
</tr>
<tr>
<td>V71.01</td>
<td>Z72.811</td>
<td>Adult Antisocial Behavior</td>
</tr>
<tr>
<td>304.10</td>
<td>F13.20</td>
<td>Sedative, Hypnotic, or Anxiolytic Use Disorder, Moderate or Severe</td>
</tr>
<tr>
<td>299.00</td>
<td>F84.0</td>
<td>Autism Spectrum Disorder</td>
</tr>
<tr>
<td>301.7</td>
<td>F60.2</td>
<td>Antisocial Personality Disorder</td>
</tr>
<tr>
<td>317</td>
<td>F70</td>
<td>Intellectual Disability, Mild</td>
</tr>
<tr>
<td>319</td>
<td>F71</td>
<td>Intellectual Disability, Moderate</td>
</tr>
<tr>
<td>319</td>
<td>F72</td>
<td>Intellectual Disability, Severe</td>
</tr>
<tr>
<td>319</td>
<td>F73</td>
<td>Intellectual Disability, Profound</td>
</tr>
<tr>
<td>319</td>
<td>F79</td>
<td>Unspecified Intellectual Disability</td>
</tr>
<tr>
<td>V62.89</td>
<td>R41.83</td>
<td>Borderline Intellectual Functioning</td>
</tr>
</tbody>
</table>