Best Practice in Assessment & Diagnosis ID/MI

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NADD

Harbor Regional Center
Long Beach, CA
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Presentation Outline

- Vulnerability Factors
- Assessment Principles & Practices
- Diagnostic Principles & Practices
- Diagnostic Manual – Intellectual Disability (DM-ID)
Vulnerability Factors
And
Complex Interactions
Vulnerability Factors and Complex Interactions

Persons with ID are at increased risk of developing psychiatric disorders due to complex interaction of multiple factors:

• Biological
• Psychological
• Social and
• Family
Vulnerability factors for psychiatric disorders

Biological

- Brain damage/epilepsy
- Vision/hearing impairments
- Physical illnesses/disabilities
- Genetic/familial conditions
- Drugs/alcohol abuse
- Medication/physical treatments
Vulnerability Factors and Complex Interactions

Vulnerability factors for psychiatric disorders

Psychological

• Rejection/deprivation/abuse
• Life events/separations/losses
• Poor problem solving/coping strategies
• Social/emotional/sexual vulnerabilities
• Poor self-acceptance/low self-esteem
• Devaluation/disempowerment
Vulnerability factors for psychiatric disorders

Social

- Negative attitudes/expectations
- Stigmatization/prejudice/social exclusion
- Poor supports/relationships/networks
- Inappropriate environments/services
- Financial/legal disadvantages
Vulnerability Factors and Complex Interactions

Vulnerability factors for psychiatric disorders

Family

- Diagnostic/bereavement issues
- Life-cycle transitions/crises
- Stress/adaptation to disability
- Limited social/community networks
- Difficulties “letting go”
ASSESSMENT PRINCIPLES AND PRACTICES
Best Practice Assessment: Bio-psychosocial Model
Best Practice Assessment: Bio-psychosocial Model

1. Review Reports
2. Interview Family
3. Interview Care Provider
4. Direct Observation
5. Clinical Interview
Mental Health Data & Interview

I. Source of Information
II. Reason for Referral
III. History of Presenting Problem
IV. Past Psychiatric History
V. Family Health History
VI. Social/Developmental History
I. Source of Information
   • I.e., patient, patient’s mother, medical records

II. Reason for Referral
   • Who made the referral (i.e., agency, parent)
   • Presenting problem
   • Expectations of referring source
   • Person’s perception of the problem

III. History of Presenting Problem
   • Chronological history of problem
   • Significant symptomatology
   • Precipitating factors
IV. Past Psychiatric History

- Outpatient mental health services including diagnoses, therapies, medications and response to treatment

- Inpatient mental health services including diagnoses, therapies, medications and response to treatment
VI. Family Health History

- Medical, psychiatric, and substance abuse history
- Psychotropic medications
- Medical conditions
  - Genetic disorders
  - Hypo/hyper thyroid condition
  - Constipation
  - Epilepsy
  - Diabetes
  - Gastrointestinal problem
VI. Social/Developmental History

- Developmental milestones
- Relevant school history
- Work/vocational history
- Current work/vocational status
- Legal issues
- Relevant family dynamics
- Drug/alcohol history
- Abuse history (emotional/physical/sexual)
Minimal Data Collection

- Physical Health
- 24 Hours Sleep Chart (month cycle)
- Medication Changes
- Eating Patterns
- Environmental Changes
- Mood Charting
  - Symptoms and Behavioral manifestations
24-Hour Framework

Sleep Patterns
Eating Patterns
Mood Patterns
DIAGNOSTIC PRINCIPLES
AND
PRACTICES
Four Factors Associated with ID which Influence the Diagnostic Process

- ID affects the types of information which can be used for diagnostic decision-making
- The main difficulties in examination and interpretation of symptoms during the mental health interview are:
  1. Intellectual Distortion
  2. Psycho-social Masking
  3. Cognitive Disintegration
  4. Baseline Exaggeration
1. **Intellectual Distortion**

*Definition:* Refers to the affects of the person’s diminished ability to think abstractly and communicate effectively

*Clinical Impact:* The person cannot accurately understand the questions posed by the clinician, nor adequately respond with the correct information

*Example:* When asked if person “hears voices”, the person may respond with “yes”, without fully comprehending the implication in the question
Four Factors Associated with ID which Influence the Diagnostic Process

2. **Psycho-Social Masking**

*Definition:* Refers to the affect of the ID upon the content of psychiatric symptoms, due to impoverished social skills and limited real word experiences.

*Clinical Impact:* Unsophisticated presentation of symptoms can result in missed symptoms and misattribution of nervousness and silliness as a psychiatric feature.

*Example:* The grandiose content of mania may go unrecognized unless the presence of the ID is taken into account. When a person from the typical population becomes manic, the person may think that he/she is God. On the other hand, when a person with ID becomes manic, he/she may think that they are “normal”
3. **Cognitive Disintegration**

*Definition:* Refers to a person with ID to become disorganized under emotional stress. It causes stress-induced disintegration of information processing.

*Clinical Impact:* Person has lack of “cognitive reserve” available during the course of psychiatric illness. It is important, also, to clinically consider developmental impact on the presentation of behaviors and content of material expressed by the person.

*Example:* A person with ID talking to oneself out loud, fantasy play, or imaginary friends, maybe within the “normal range” of behavior for a person with ID, although it might be considered bizarre behavior in a typical person.
Four Factors Associated with ID which Influence the Diagnostic Process

4. **Baseline Exaggeration**

*Definition:* An increase in the frequency and intensity of pre-existing maladaptive behaviors during the course of a mental illness.

*Clinical Impact:* Creates difficulty in establishing illness features, target symptoms, and outcome measures. Signs and symptoms of a psychiatric disorder may be a mix of new behaviors and an increase in severity of pre-existing behaviors.

*Example:* Chronic SIB or aggression which occurs infrequently, may suddenly increase in severity. Mania may cause an increase in the level of pre-existing destructibility and poor judgment.
Eight Diagnostic Principles For Recognizing Psychiatric Disorders In MR Persons

1. Persons with Intellectual Disabilities suffer from the full range of psychiatric disorders

2. Psychiatric disorders usually present as maladaptive behavior

3. The origin of psychopathology is multi-determined
Eight Diagnostic Principles For Recognizing Psychiatric Disorders In MR Persons

4. An acute psychiatric disorder may present as an exaggeration of longstanding maladaptive behavior

5. Maladaptive behavior rarely occurs alone

6. The severity of the problem is not necessarily diagnostically relevant
7. The clinical interview alone is rarely diagnostic

8. It is very difficult to diagnose psychotic disorders in persons with very limited verbal skills
## Mental Status Exam

<table>
<thead>
<tr>
<th>1. General Description</th>
<th>Appears</th>
</tr>
</thead>
</table>
| **2. Emotional State** | A. Mood (Subjective)  
B. Affective (Objective)  
1. Quality  
2. Range  
3. Liability  
4. Appropriateness |
| **3. Speech** | Volume-latency-rhythm-pressure |
| **4. Thought Process** | A. Form  
B. Content  
C. Perception |
| **5. Cognitive State** | Orientation  
Memory  
Attention and concentration  
Abstraction  
Intelligence |
| Judgment & Insight | Understand current situation |
## Multi-Axial Diagnoses

<table>
<thead>
<tr>
<th>Axis</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Axis I</strong></td>
<td>Clinical Disorders&lt;br&gt;Other conditions that may be a focus of clinical attention</td>
</tr>
<tr>
<td><strong>Axis II</strong></td>
<td>Personality Disorders&lt;br&gt;Intellectual Disability</td>
</tr>
<tr>
<td><strong>Axis III</strong></td>
<td>General Medical Conditions influencing diagnosis, treatment, or prognosis of Axis I or II disorders</td>
</tr>
<tr>
<td><strong>Axis IV</strong></td>
<td>Psychosocial and Environmental Problems, i.e., problems with primary support group, problems related to the social environment, educational problems, occupational problems, housing problems, economic problems, problems with access to health care services, problems related to interaction with the legal system/crime, other</td>
</tr>
<tr>
<td><strong>Axis V</strong></td>
<td>Global Assessment of Functioning&lt;br&gt;This scale is for reporting the clinician(s) judgment of the individual’s overall level of functioning. This information is useful in planning treatment and measuring its impact and in predicting outcome. The scale ranges from “0” – inadequate information to “100” – no symptoms and superior functioning in a wide range of activities</td>
</tr>
</tbody>
</table>
Increased Likelihood Of Mental Illness

- Symptoms/behaviors present themselves in all setting
- Symptoms persist despite consistent appropriate behavior intervention
- Sleep and Appetite are affected
- Change in behavior or symptoms, especially when abrupt and lasts more than a month
Diagnostic Manual
*(DM-ID)*

Editors
Robert Fletcher, DSW, ACSW, Chief Editor
Earl Loschen, MD
Chrissoula Stavrakaki, MD, PhD
Michael First, MD
DM–ID: Two Manuals

Diagnostic Manual – Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability

Description of DM-ID

- An adaptation to the *DSM-IV-TR*

- Designed to facilitate a more accurate psychiatric diagnosis

- Based on Expert Consensus Model

- Covers all major diagnostic categories as defined in *DSM-IV-TR*
Description of DM-ID

- Provides a wealth of information to help with diagnostic process
- Provides clear examples of how diagnostic specific symptoms should be interpreted
- Addresses pathoplastic (presentation of symptoms) effect of ID on psychiatric disorders
- Designed with a developmental perspective to help clinicians to recognize symptom profiles in adults and children with ID

Fletcher, 2008
Description of DM-ID

- Empirically-based approach to identify specific psychiatric disorders in persons with ID

- Provides state-of-the-art information about mental disorders in persons with ID

- Provides adaptations of criteria, where appropriate
Description of DM-ID

• Information on how to recognize challenging behaviors

• Information on how to differentiate behavioral problems from psychiatric disorders

• Addresses the major diagnostic categories and use the same codification system as the DSM-IV-TR

Fletcher, 2008
Chapter 1 - Introduction
Chapter 2 - Assessment and Diagnostic Procedures
Chapter 3 - Behavioral Phenotype of Genetic Disorders
Chapter 4 - Intellectual Disability
Chapter 5 - Learning Disorders
Chapter 6 - Motor Skill Disorders
Chapter 7 - Communication Disorders
Chapter 8 - Pervasive Development Disorders

Fletcher, et al, 2007
Chapter 9 - Attention Deficit and Disruptive Behavior Disorders
Chapter 10 - Feeding and Eating Disorders
Chapter 11 - Tic Disorders
Chapter 12 - Elimination Disorders and Other Disorders
Chapter 13 - Other Disorders of Infancy, Childhood or Adolescence
Chapter 14 - Delirium/Dementia

Fletcher, et al, 2007
Chapter 15 - Mental Disorders Due to a General Medical Condition Not Elsewhere Classified
Chapter 16 - Substance-Related Disorders
Chapter 17 - Schizophrenia and Other Psychotic Disorders
Chapter 18 - Mood Disorders
Chapter 19 - Anxiety Disorders
Chapter 20 - Obsessive-Compulsive Disorder
Chapter 21 - Posttraumatic Stress Disorders
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Somatoform and Factitious Disorders</td>
</tr>
<tr>
<td>23</td>
<td>Sexual And Gender Identity Disorders</td>
</tr>
<tr>
<td>24</td>
<td>Eating Disorders</td>
</tr>
<tr>
<td>25</td>
<td>Sleep Disorders</td>
</tr>
<tr>
<td>26</td>
<td>Impulse Control Disorders</td>
</tr>
<tr>
<td>27</td>
<td>Adjustment Disorders</td>
</tr>
<tr>
<td>28</td>
<td>Personality Disorders</td>
</tr>
</tbody>
</table>
Two Special Added-Value Chapters

- Assessment and Diagnostic Procedures
- Behavioral Phenotype of Genetic Disorders
• Historical data to collect
• Use of language/communication
• Assessment of medical factors
• Understanding and interpreting symptoms
• Behavioral Phenotype of Genetic Disorders
• Psychometric assessment tools
• Axis IV
  • Suggest general considerations for Psychosocial Environment problems for people with ID
Assessment of Medical Conditions

- Constipation $\rightarrow$ distress
- Hypothyroidism $\rightarrow$ depressive symptoms
- Hyperthyroidism $\rightarrow$ manic episode
- Diabetes $\rightarrow$ behavioral side effects
<table>
<thead>
<tr>
<th>Genetic Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angelman Syndrome</td>
</tr>
<tr>
<td>Cri-du-Chat (5p-) Syndrome</td>
</tr>
<tr>
<td>Down Syndrome</td>
</tr>
<tr>
<td>Fetal Alcohol Syndrome</td>
</tr>
<tr>
<td>Fragile-X Syndrome</td>
</tr>
<tr>
<td>Phenylketonuria</td>
</tr>
<tr>
<td>Prader-Willi Syndrome</td>
</tr>
<tr>
<td>Rubenstein-Taybi Syndrome</td>
</tr>
<tr>
<td>Smith-Magenis Syndrome</td>
</tr>
<tr>
<td>Tuberous Sclerosis Complex</td>
</tr>
<tr>
<td>Velocardiofacial Syndrome</td>
</tr>
<tr>
<td>Williams Syndrome</td>
</tr>
</tbody>
</table>

# Behavioral Phenotype of Genetic Disorders: Chapter 3

## Phenotype and Proposed Behavioral Phenotype for Down Syndrome

<table>
<thead>
<tr>
<th>Phenotype</th>
<th>Proposed Behavioral Phenotype</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenotype</td>
<td>Childhood</td>
</tr>
<tr>
<td></td>
<td>Small head, mouth; upward slant to eyes; epicanthal folds; broad neck; hypothyroidism; hearing loss; visual impairments; cardiac problems; gastrointestinal; orthopedic, and skin disorders; obesity</td>
</tr>
</tbody>
</table>
DM-ID
Diagnostic Chapter Structure

• Review of Diagnostic Criteria
  • General description of the disorder
  • Summary of *DSM-IV-TR* criteria

• Issues related to diagnosis in people with ID

• Review of Literature/Research (Textbook)
  • Evaluating level of evidence
DM-ID
Diagnostic Chapter Structure

• Application of Diagnostic Criteria to People with ID
  • General considerations
  • Adults with Mild to Moderate ID
  • Adults with Severe or Profound ID
  • Children and adolescents with ID
DM-ID
Diagnostic Chapter Structure

- Etiology and Pathogenesis (Textbook)
  - Risk Factors
  - Biological Factors
  - Psychological Factors
  - Genetic Syndromes
### DM-ID
#### Diagnostic Chapter Structure

## Diagnostic Criteria

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria Mild-Moderate ID</th>
<th>Adapted Criteria Severe-Profound ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fletcher, et al, 2007
## Diagnostic Criteria

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for ID (Mild to Profound)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fletcher, et al, 2007
Adaptation of the DSM-IV-TR Criteria

- Addition of symptom equivalents
- Omission of symptoms
- Changes in symptom count
- Modification of symptom duration
Adaptation of the DSM-IV-TR Criteria

- Modification of age requirements
- Addition of explanatory notes
- Criteria Sets that do not apply
### Adaptation of DSM-IV-TR Criteria
#### Change in Count and Symptom Equivalent

## Major Depressive Episode

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for Mild to Profound ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Five or more of the following symptoms have been present during the same 2 week period and represent a change from previous functioning. At least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.</td>
<td>A. <strong>Four</strong> or more symptoms have been present during the same 2 week period and represent a change from previous functioning. At least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure or (3) <strong>irritable mood</strong>.</td>
</tr>
</tbody>
</table>

Charlot, et al, 2007
# Adaptation of *DSM-IV-TR* Criteria

## Modification of Symptom Duration

### Intermittent Explosive Disorder

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for ID (Mild to Profound)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Several discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.</td>
<td>A. <strong>Frequent episodes that last for at least two months</strong> of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.</td>
</tr>
</tbody>
</table>

Rifkin & Barnhill, 2007
### Adaptation of DSM-IV-TR Criteria

**Modification of Age**

#### Antisocial Personality Disorder

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for Individuals with ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:</td>
<td>A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age <strong>18</strong> years, as indicated by three (or more) of the following:</td>
</tr>
<tr>
<td>B. The individual is at least age 18 years</td>
<td>B. The individual is at least age <strong>21</strong> years</td>
</tr>
<tr>
<td>C. There is evidence of Conduct Disorder with the onset before age 15 years</td>
<td>C. There is evidence of Conduct Disorder with onset before age <strong>18</strong> years</td>
</tr>
</tbody>
</table>

Lindsay, et al, 2007
# Adaptation of DSM-IV-TR Criteria

## Change in Symptom and Count Equivalent Panic Attack

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria Mild-Moderate ID</th>
<th>Adapted Criteria Severe-Profound ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>A panic attack is a discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes :</td>
<td>No adaptation</td>
<td>A panic attack is a discrete period of <strong>observed</strong> intense fear or discomfort, in which <strong>three</strong> (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes (i.e., Panic Attacks might be observed rather than self-reported in this population. The person appears to be intensely frightened/ agitated/ distressed) :</td>
</tr>
</tbody>
</table>

Cooray, et al, 2007
# Adaptation of DSM-IV-TR Criteria

## Omission of Symptoms

### Obsessive Compulsive

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria Mild-Moderate ID</th>
<th>Adapted Criteria Severe-Profound ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. (3). The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.</td>
<td>A. (3). The person’s attempts to ignore or suppress thoughts, may not be possible to determine due to cognitive and communicative deficits.</td>
<td>A. (3). The person <strong>may make no attempt</strong> to suppress compulsions and obsessions. They may be unable to report wanting to ignore, suppress, or neutralize such thoughts/urges.</td>
</tr>
</tbody>
</table>

*King, et al, 2007*
## Manic Episode

<table>
<thead>
<tr>
<th>DSM-IV-TR Criteria</th>
<th>Adapted Criteria for Mild to Profound ID</th>
</tr>
</thead>
</table>
| **A.** A distinct period of abnormally persistently elevated, expansive or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary) | **A.** No adaptation.  
**Note:** Observers may report that the individual with ID; has loud inappropriate laughing or singing, is excessively giddy or silly; is intrusive, getting into other’s space; and smiles excessively and in ways that are not appropriate to the social context. Elated mood may be alternating with irritable mood |
Field Trial Research on DM-ID Clinical Guide

- N = 845
- Number of Clinicians = 63
- Number of Countries = 11

Citation:
### Field Study of the Clinical Usefulness of the *DM-ID*

#### Table 1: Clinician Impressions by Level of Intellectual Disability (%YES)

<table>
<thead>
<tr>
<th>Item</th>
<th>Level of Intellectual Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mild n=305</td>
</tr>
<tr>
<td></td>
<td>Moderate n=237</td>
</tr>
<tr>
<td></td>
<td>Severe/ Profound n=285</td>
</tr>
<tr>
<td>Was the DM-ID easy to use (user friendly)?</td>
<td>72.4</td>
</tr>
<tr>
<td>Did you find the DM-ID clinically useful in the diagnosis of this patient?</td>
<td>74.9</td>
</tr>
<tr>
<td>Did DM-ID allow you to arrive at an appropriate psychiatric diagnosis for this patient?</td>
<td>85.6</td>
</tr>
<tr>
<td>Did DM-ID allow you to come up with a more specific diagnosis than you would have with the <em>DSM-IV-TR</em>?</td>
<td>36.1</td>
</tr>
<tr>
<td>Did DM-ID help you avoid using the NOS category?</td>
<td>63.2</td>
</tr>
</tbody>
</table>

*Fletcher, et al, 2009*
Table 2: Clinician Impressions of DM-ID for new patients, previously seen (follow-up) patients, and both groups combined (All)

<table>
<thead>
<tr>
<th>Item</th>
<th>New (n=121)</th>
<th>Follow-up (n=687)</th>
<th>All (n=845)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the DM-ID easy to use (user-friendly)</td>
<td>73.6</td>
<td>68.2</td>
<td>67.9</td>
</tr>
<tr>
<td>Did you find the DM-ID clinically useful in the diagnosis of this patient?</td>
<td>62.0</td>
<td>50.7</td>
<td>51.7</td>
</tr>
<tr>
<td>Did DM-ID allow you to arrive at an appropriate psychiatric diagnosis for this patient?</td>
<td>82.6</td>
<td>82.9</td>
<td>83.1</td>
</tr>
<tr>
<td>Did DM-ID allow you to come up with a more specific diagnosis than you would have with DSM-IV-TR?</td>
<td>40.0</td>
<td>36.2</td>
<td>36.5</td>
</tr>
<tr>
<td>Did the DM-ID help you avoid using the NOS category?</td>
<td>66.4</td>
<td>59.4</td>
<td>60.3</td>
</tr>
</tbody>
</table>

Fletcher, et al, 2009
### Table 3: Changes in Diagnosis from *DSM-IV-TR* to *DM-ID*

<table>
<thead>
<tr>
<th>Description of Change</th>
<th>Anxiety</th>
<th>Mood</th>
<th>Psychosis</th>
<th>PDD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change from NOS to specific diagnosis in same broad category</td>
<td>15</td>
<td>42</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Change from NOS to specific diagnosis in a different broad category</td>
<td>2</td>
<td>1</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Change from one specific diagnosis to another in the same broad category</td>
<td>2</td>
<td>11</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Change to a specific diagnosis in a different broad category</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Number of new diagnoses by <em>DM-ID</em></td>
<td>10</td>
<td>4</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>
For more information, please contact
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