F*E*G*S City-wide & Brooklyn Blended Case Management Programs & The Institute for Urban Family Health

"Integrating Behavioral Health & Primary Health Care for Persons with Serious Mental Illnesses"

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April 1, 2009 & June 2, 2009

Introduction

As per recent studies, persons with serious mental illnesses have a life expectancy twenty-five years shorter than the average American. This represents a decline of fifteen years since the early 1990's, and is accounted for, only in part, by death by suicide, homicide or accident.

The several causes, all considered *remediable*, are as follows:

- Lack of access to primary health care
- A fragmented service delivery system, particularly the disconnect between behavioral health and primary health care
- Life-style choices, including abuse of substances, unprotected sex and related self-destructive practices
- The psychopharmacological treatment they receive, particularly the prescription of the 2nd generation Atypical Ant-psychotic medications
- Stigma, poverty & racism.

Remediation Strategies

1. Removal of Barriers to Access to Primary Health Care via comprehensive care coordination carried out by behavioral health case managers, as per the Integrated Collaborative Case Management Protocol.

2. Removal of Barriers between Behavioral Health & Primary Health Care providers via close inter-provider collaboration involving tacit &/or written memos of understanding, cross-provider treatment referrals and cross-training of staff.

3. Empowerment of Consumers as Self-Advocates via specialized training, viz., the Integrated Collaborative Training program, to promote use of Metabolic Syndrome Monitoring Protocol by treating physicians and treatment coordination & communication between treating physicians.

CONTEXT

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Consumer Mortality: 1995 – 2009

Deaths: 59 – 37 Men, 22 Women

By Natural Causes*: 43 – 24 Men, 19 Women

*(23 since July, 2006)

Cardiac-related: 16 Men, 9 Women

Cancer: 4 Men, 6 Women

AIDS-related: 3 Men, 2 Women

Respiratory: 1 Man, 1 Woman

Peritonitis: 1 Woman

By Suicide: 12 – 10 Men, 2 Woman

By Accident – 1 Man; 1 Woman

By Drug OD: 1 Man

By Homicide – 1 Man

Consumer Mortality: Additional Demographics

Causes	1995-2006: Men/Women	2007-2009: Men/Women	Mean Age 95-06: M/W	Mean Age 07-09: M/W
Suicide	7/2	3/0	31/65	37/NA
Homicide	1/0	0/0	35/NA	NA/NA
Accident	1/0	0/1	31/NA	NA/25
Drug OD	1/0	0/0	53/NA	NA/NA
CDV	8/3 (.67/.25)	8/6 (3.2/2.4)	40/49	49/57
U.S. Incidence (2004)	.348 males/ .177 females per 100	SMHD Study (2006)	CDV Death Rate: 2.3 x U.S. Incidence =s 1.2 per 100	Program Incidence 1.4 male +.5 female =s 1.9 per 100
Cancer	3/3	1/3	58/53	58/67
AIDS-related	3/2	0/0	37/46	NA/NA
Other	0/2	1/0	NA/50	58/NA

C ONTEXT

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Health Care Survey: November, 2006

N = 466

Chronic Medical Illnesses – 234/50.2%

- Hypertension – 20.4%
- Diabetes II – 18.5%
- Asthma – 14.8%
- Cardiovascular Disease – 6.0%
- Obesity – 6.0%

Ongoing Medical Treatment – 192/234/82.0%

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Health Care Survey: June, 2008

N = 687

Diagnosed Chronic Medical Illnesses – 325/47.3%

- Hypertension – 8.9%
- Diabetes II – 19.4%
- Asthma – 11.0%
- Cardiovascular Disease – 6.7%

Ongoing Medical Treatment – 294/325/90.7%

CONTEXT

CLINICAL ANTIPSYCHOTIC TRIALS OF INTERVENTION EFFECTIVENESS – CATIE Studies

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PHASE I (September, 2005) -- EFFECTIVENESS:

- no significant differences in ameliorating (+) symptoms of Schizophrenia in comparison of 4 atypicals – Zyprexa, Risperdal, Seroquel & Geodon – with older anti-psychotic, Trilafon;

- no significant differences in discontinuation of medications due to inadequate symptom control or side effects.

CATIE, cont. …

PHASE II (April, 2006) – Efficacy:

- CLOZARIL prescribed for study subjects who discontinued medication in Phase I due to inadequate symptom response
- Higher efficacy and lower discontinuation rate when compared against Zyprexa, Risperdal or Seroquel

PHASE II (April, 2006) – Efficacy:

- ZYPREXA prescribed for study subjects who discontinued medication in Phase I due to side effects
- Higher efficacy and lower discontinuation rate when compared against Geodon, Risperdal or Seroquel

CATIE, cont. …

Metabolic & Cardiovascular Risk in Patients with Schizophrenia

N = 689

In addition, with the exception of Geodon & Abilify, the other atypical or 2nd generation anti-psychotics, i.e., Zyprexa, Risperdal & Seroquel + Clozaril, cause weight gain and insulin resistance as significant side effects in many patients

- **Stimulate appetite as ANTAGONISTS to HISTAMINE & SEROTONIN 2c neuroreceptors**
- **Reduce insulin release and elevate triglycerides as ANTAGONISTS to MUSCARINIC 3 neuroreceptor**

Diabetes	13%
Hypertension	27%
Low HDL	43.7 mg/dl (mean)
Smoking	68%

CONTEXT, cont. ...

National Association of State Mental Health Program Directors

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"Morbidity & Mortality in People with Serious Mental Illness"

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October, 2006

16 State Survey

"Morbidity & Mortality in People with Serious Mental Illness"

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SUMMARY

- People with serious mental illness die, on average, 25 years earlier than the general population
- Suicide & Injury account for 30-40% of excess mortality
- 60% of premature deaths in persons with schizophrenia are due to medical conditions: cardiovascular, pulmonary & infectious diseases

"Morbidity & Mortality in People with Serious Mental Illness"

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Schizophrenia :: Mortality

Persons with Schizophrenia

Natural Causes of Death :: Higher Mortality Rates

- Diabetes :: 2.7X
- Cardiovascular Disease :: 2.3X
- Respiratory Disease :: 3.2X
- Infectious Disease :: 3.4X

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Schizophrenia :: Cardiovascular Disease

CVD associated with largest # of deaths:

- Mass. Study, 1998-2000: among Mass. DMH clients with schizophrenia, cardiovascular mortality :: 6.6X general population
- Archives Gen'l Psychiatry, 2001: Mortality post-Myocardial Infarction increased by 19% among persons 65 & older with any mental disorder, 34% among those with schizophrenia
- AGP, 2001: Increase mortality explained by measures of quality of care

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MORTALITY/MORBIDITY :: PREVENTABLE CONDITIONS

This increased mortality & morbidity due largely to *preventable conditions*:

- CARDIOVASCULAR DISEASE
- DIABETES & RELATED KIDNEY FAILURE
- RESPIRATORY DISEASE,

i.e., Influenza & Pneumonia

- INFECTIOUS DISEASES,

i.e., HIV & AIDS

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MORTALITY :: RISK FACTORS

Persons with SMI also suffer from a high prevalence of *modifiable risk factors,* i.e., obesity & tobacco use

+

Have poorer access to established monitoring and treatment guidelines for physical health conditions

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MORTALITY :: CARDIOVASCULAR RISK FACTORS

Modifiable CDV Risk Factors:: Gen'l Pop.:

- Smoking :: Schizophrenia :: 50-80%/2-3X
  :: Bi-Polar DO :: 55%
- Obesity :: Schizophrenia :: 45-55%/1.5-2X
  :: Bi-Polar DO :: 26%
- Diabetes :: Schizophrenia :: 10-14%/2X
  :: Bi-Polar DO :: 10%
- Hypertension :: Schizophrenia :: 18%
  :: Bi-polar DO :: 15%
- Dyslipidemia :: Schizophrenia :: 5X

MORTALITY :: OTHER RISK FACTORS

Other Modifiable Risk Factors:

- ETOH consumption
- Poor nutrition
- Lack of exercise
- Unsafe Sexual behavior
- IV drug use
- Residence in group homes & shelters & exposure to TB & other infectious diseases

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MORTALITY :: SOCIETAL RISK FACTORS

Increased vulnerability due to increased rates of ...

- Homelessness
- Victimization/trauma
- Poverty
- Incarceration
- Social isolation

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MORTALITY :: SMI-Specific RISK FACTORS

- Psychiatric Sxs., i.e., paranoid ideation, disorganized thinking
- Consequently, masking of physical sxs.
- Lack of access to appropriate health care
- Polypharmacy
- Increased vulnerability to development of METABOLIC SYNDROME consequent to prescription of *second generation antipsychotic* medications, termed the "atypicals"

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MORTALITY :: SGA MEDICATIONS

Modifiable risk factors associated with SGAs, particularly *Zyprexa & Clozaril:*

- Obesity/dramatic weight gain
- Insulin resistance, i.e., elevated glucose
- Diabetes/hyperglycemia
- Dyslipidemia
- Hypertension

In sum, METABOLIC SYNDROME

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MORTALITY :: METABOLIC SYNDROME

Identification of … 3 risk factors for dx. …

- Abdominal (visceral) obesity:
  - Men: > 40" waist; Women: > 35"waist
- Trygliceride: >150 mg/dl
- HDL Cholesterol:
  - Men: < 40 mg/dl; Women: < 50 mg/dl
- Blood pressure: > 130/85
- Fasting blood glucose: > 110 mg/dl

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METABOLIC SYNDROME

Monitoring Protocol – Diabetes & Obesity
(American Diabetes Association, 2004):

- Personal & Family Hx: at start & annually
- Weight: monthly
- Waist Size: start & annually
- Blood pressure: start/3 mos/annually
- Fasting glucose: start/3 mos/annually
- Fasting lipids: start/3 mos/annually

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MORTALITY :: BARRIERS TO HEALTH CARE

- Patient Factors: amotivation, fearfulness, social instability
- Provider Factors: competing demands, stigma
- System Factors: fragmentation, exacerbated by
  - Overuse: of somatic emergency services
  - Underuse:
    - Fewer routine preventative services
    - Lower rates of CDV procedures
    - Worse diabetes care
  - Misuse: higher post-op incidence of deep-vein thrombosis & sepsis among persons with schizophrenia

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RECOMMENDATIONS: What Should be Done?

National Level:

- Designate persons with SMI as a HEALTH DISPARITIES population
- Adopt ongoing surveillance, i.e., data-gathering, methods
- Support education & advocacy

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RECOMMENDATIONS: What Should be Done?

State Level:

- Prioritize morbidity/mortality of persons with SMI as a public health problem
- Improve access to physical health care
- Promote coordinated/integrated mental health & physical health care for persons with SMI
- Support education & advocacy
- Address funding requirements
- Establish a QI process that supports improved access to physical health care & ensures appropriate prevention, screening & tx. services

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RECOMMENDATIONS: What Should be Done?

Provider Agencies:

- Adopt as policy the integration of mental health and physical health care
- Promote the message of *recovery* + enable clients as equal partners in their care & tx.
- Support the *wellness & empowerment* of persons served
- Ensure the provision of *evidence-based* physical & mental health care
- Implement *care coordination* models

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RECOMMENDATIONS: What Should be Done?

Persons served/Families/Communities:

- Promote among them the vision of integrated care
- Promote advocacy, education & successful partnerships to achieve integrated care
- Pursue individualized, person-centered care that is wellness & recovery focused

The Integrated Collaborative Training Program

CONSUMERS AS SELF-ADVOCATES

Training Consumers to "ASK Questions & Get Answers"
In Collaboration with Case Managers

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A Training Program comprised of EIGHT two-hour sessions conducted weekly & attended by volunteer clients and case managers and the latter's supervisors:

The Integrated Collaborative Training Program, cont. …

- Session I – "Introduction to & Overview of the Integrated Collaborative Case Management Protocol," Dr. Jack Carney, Sr. Program Director
- Session II – "Overview of the 2nd Generation or 'Atypical' Anti-Psychotic Medications," Dr. David Nardacci, Director of Psychiatry, Gouveneur Hospital
- Session III – "Overview of Metabolic Syndrome & the Recommended Monitoring Protocol," Dr. Nardacci
- Session IV – "Communicating Effectively with Psychiatrists & Primary Care Physicians," Dr. Carney (courtesy Ms. Leora Lowenthal, Oncology Social Work, NYU Medical Center

The Integrated Collaborative Training Program, cont. …

Session V – "Role-play: Practicing the PACE System of Doctor/Patient Communication," Dr. Carney

Session VI – "Overview of Diabetes II: Causes & Treatment," Ms. Maura O'Malley, Nurse Practitioner, Long Island College Hospital

Session VII – "Overview of Cardiovascular Illness: Causes & Treatment," Ms. Maura O'Malley, Nurse Practitioner, LICH

Session VIII – "Post-Training Tasks: Primary Care Physicians; Annual Physicals; Ongoing Medical Care …," Dr. Kamini Geer, Medical Director, & Ms. Sandra Schatanoff, Director of Social Work, Institute for Family Health

The Integrated Collaborative Case Management Protocol

This Protocol is designed to assist consumers who are at risk of developing Metabolic Syndrome and their case managers to put into practice what they have learned in the Integrated Collaborative Training Program.

Specifically, and subsequent to discussion with treating psychiatrist to avoid duplication, consumer and case manager, in collaboration, will …

1. Secure an appointment with the consumer's primary care physician; should the client have no PCP, the case manager will assist the client to obtain one
2. Request that the PCP order the blood tests and related medical procedures recommended by the several professional organizations that have endorsed the Metabolic Screening & Monitoring Protocol

The Metabolic Syndrome Monitoring Protocol, cont. …

3. Request that the results of these blood and related tests be forwarded to the consumer's psychiatrist , with a copy to the case manager to be filed in consumer's chart
4. Ensure that the consumer's psychiatrist receives all test results and request that the psychiatrist review the results with consumer and case manager
5. Ask her/his psychiatrist what actions, if any, the psychiatrist will take in response to the results, as well as the psychiatrist's rationale for her/his actions
6. Request that the psychiatrist communicate her/his course of action to the client's PCP
7. Request that the consumer's PCP continue to monitor all necessary blood and related values in accordance with the schedule recommended in the Metabolic Syndrome Monitoring Protocol; promote ongoing communication between psychiatrist and PCP; promote ongoing access to this information by all other treatment providers with whom the consumer is involved; secure the support of all in providing the consumer with appropriate treatment …

The Integrated Collaborative Case Management & Monitoring Protocol, cont. …

During the life of the research project currently being undertaken to evaluate the efficacy of Training Program and Monitoring Protocol, both participating consumers and case managers will regularly report outcomes to the Project/Program Director; who, in turn, will convey this outcome information to the CQI Committee at its regular monthly meetings.

The outcomes information will be regularly evaluated to determine the efficacy of this Protocol, the most effective methodology to be used in training other consumers and case managers, and whether changes in it and program policy and procedures are required.

A final outcomes report will be compiled at the conclusion of the Research Project, i.e., before the end of FY 2010.

FEGS Case Management/ Institute for Family Health Collaboration

- Centrality of Case Management to promote access and ensure compliance
- Facilitative referral and admission process by IFH
  - 30 CM admissions – 12/08 – 5/09
- Cross-training and inter-provider coordination to promote transparent communication and cooperation
- Tracking of clinical outcomes commencing 7/09 to determine effectiveness of medical treatment provided
- Planned establishment of Metabolic Syndrome Registry, analogous to Diabetes Registry, as repository of clinical outcomes
- Periodic review of foregoing by FEGS and IFH program administrators to allow for problem-solving and change.

Recommendations: Clinical & Practical

Given these individuals' vulnerability to diabetes and cardiovascular disease, the following is recommended:

1. All persons who have or are being prescribed any of the Atypical Anti-psychotic medications should be administered the Metabolic Syndrome Monitoring Protocol
2. A history of substance abuse must be included when taking a patient's personal history, with any mention of current or past crack or cocaine abuse as possibly predictive of cardiovascular disease *RED-FLAGGED.*
3. Again, when taking the family history of any person who has or is being prescribed any of the Atypical Anti-psychotic medications, which can promote insulin resistance, *RED-FLAG* any mention of diabetes, contact the patient's treating psychiatrist and discuss the possibility, immediate or future, of changing medications

Practical Recommendations, cont. ...

4. Ditto a patient prescribed Geodon, which can cause dangerously prolonged QT intervals
5. Be sure to involve in any discussion with the patient re. history or treatment recommendations the person, if any, who has accompanied the patient, particularly if the companion is a case manager. The latter will be able to provide support in a very stressful situation & help to calm the patient's anxiety, assist the patient to communicate her/his concerns, as well as to comprehend the physician's assessment and comply with the physician's treatment recommendations and instructions.
6. Arrange to have test results transmitted promptly to the patient, case manager and treating psychiatrist. Have patient sign an authorization to release test and related information to case manager and psychiatrist.
7.- Consult directly and promptly with the patient's treating psychiatrist re. findings and treatment recommendations, particularly those involving medications.

PRESENTERS

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REFERENCE

Metabolic Screening & Monitoring Form

by

John W. Newcomer, M.D.

&

Dan W. Haupt, M.D.

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produced by Compact Clinicals

Kansas City, Mo., 2007

as a service by *Pfizer*

"Morbidity & Mortality in People with Serious Mental Illness"

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ON-LINE ACCESS

A Summary of this study can be found at *Psychiatric News:*

http://pn.psychiatryonline.org

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The study itself is posted at

http://www.nasmhpd.org

"Clinical Antipsychotic Trials of Intervention Effectiveness – CATIE"

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ON-LINE ACCESS

A Summary of this study can be found at

www.nimh.nih.gov

&

www. catie.unc.edu

Additional Information: Metabolic Syndrome

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ON-LINE ACCESS

"Awareness, Recognition & Treatment of Metabolic Issues in the Severely Mentally Ill"

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www. neiglobal.com

Introductory Article by Dr. Carney

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ON-LINE ACCESS

"Access to Care:

Training Consumers

&

Case Managers"

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www.MIWatch.org

ADDITIONAL REFERENCE

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ON-LINE ACCESS

Smith, TE, Sederer, LI,

"A New Kind of Homelessness for Individuals with Serious Mental Illness?

The Need for a 'Mental Health Home' ",

Psychiatric Services, April, 2009, Vol. 60, #4. pp. 528-533

* * * * *

ps.psychiatryonline.org

Sobriety Services

A Medical Model for Detection, Diagnosis, and Treatment Interventions for Substance Abusing DD Individuals

PRESENTERS

Barbara Cajdler, LCSW, CASAC
Director of Sobriety Services

Sean Flanigan, MA, RDT, LCAT
Drama Therapist

AGENDA

Prevalence of substance abuse in DD population.

Diagnosis and treatment for this special population.

Clinical and intervention skills in the treatment of persons with MR and AOD use.

Treatment service options for this special population.

Studies document that persons with developmental disabilities occupy an inferior status in our society.

- Individuals with DD are severely disadvantaged socially, vocationally, economically, and educationally.
- Most persons with DD have household incomes of 15,000 or less.
- Most persons with DD between the ages of 16-64 are not working at all.
- Persons with DD participate in social activities (dining out, movies, sporting events) far less frequently than persons without disabilities.

(Louis Harris & Associates)

Being intellectually challenged does not rule out the possibility of being chemically addicted. Persons with developmental disabilities, including mental retardation, are just as vulnerable to the process of addiction as anyone else.

The prevalence, diagnosis, and treatment of alcohol and drug addiction in persons who are developmentally disabled has rarely been reported. Current estimates regarding the incidence of alcoholism and substance abuse in persons who are developmentally disabled are inconsistent. However, recent studies suggest that the incidence of alcoholism and drug addiction in the general population is directly mirrored in the DD population.

(Westermeyer, Phaobtong, and Neidor)

One of every eight Americans has a significant problem with alcohol and/or drugs. In addition, SAMHSA (U.S. Substance Abuse and Mental Health Services Administration) estimates that 40% of individuals in treatment for substance dependency have a coexisting disability, whether physical, affective, or cognitive.

A developmental disability is not a mental illness.

- This is not a MICA client.
- Developmental Disabilities effect 2% of the overall population.
- The NYS OMRDD estimates that developmental disabilities affect up to 325,000 residents of New York State; 200,000 of which are individuals with mental retardation.
- According to The Journal of American Psychiatric Nurses, as many as 60% of persons with DD meet the criteria for a coexisting psychiatric disorder.
- 60% of the time we are treating a triply diagnosed population: developmentally disabled, chemically dependent, and mentally ill.

What is a Developmental Disability?

- A developmental disability is considered to be a severe chronic disability of a person that is:
- Attributable to a mental or physical impairment or a combination of both.
- Is manifested before the age of 22.
- Is likely to continue indefinitely.
- Which results in substantial functional limitations in three or more areas of major life activities that affect an individual's capacity for independent living and/or economic self-sufficiency: self-care, mobility, communication, learning, problem-solving, social skills, executive functions.
- Reflects a person's need for life long special services.
- An individual must meet all five of the above components to be diagnosed with a developmental disability

Developmental Disabilities Screening Instrument

- This screening device is designed to reveal the possible existence of a developmental disability. The following questions serve only as indicators to the need for further evaluation.

- What season are we in?
- What day was it 2 days before today?
- How many months are in one year?
- How many minutes are in 1 ½ hours?
- Can the individual provide accurate personal information?
- During your formal schooling, were you ever placed in special education classes?
- Write a sentence using the word tree and grass.

The Five Types of Developmental Disabilities

- Cerebral Palsy
- Epilepsy
- Autism
- Other Neurological Impairments
- Mental Retardation

Mental Retardation

- Is characterized by significantly sub-average intellectual functioning (an IQ of approximately 70 or below) with related limitations in two or more of the following applicable skill areas:

- Communication
- Self-care
- Home living
- Social skills
- Community use
- Self-direction
- Health and safety
- Functional academics
- Leisure and work

Unlike other developmental disabilities mental retardation manifests before the age of 18.

Functioning Levels

- Borderline IQ score of 71-75
- Mild IQ score of 50-55 through70
- Moderate IQ score of 35-40 through 50-55
- Severe IQ score of 20-25 through 35-40
- Profound IQ score below 20-25
- As per the DSM-IV

Causes of Developmental Disabilities

- Infections and Intoxications
- ADDICTION TO DRUGS
- Trauma and Physical Agents
- Metabolic and Nutritional Factors
- Postnatal Brain Diseases
- Other Prenatal Influences
- Chromosomal Abnormalities
- Gestational Disorders

Why providers fail to acknowledge need for addictions treatment.

- Service providers unwilling to further stigmatize population by assigning yet an other diagnostic label.
- Myth that population has no access to alcohol/drugs.
- Myth that persons with MR do not like to drink or use drugs.
- Population already saturated with need. Unwillingness to identify yet an other area in which service must be provided.

Risk Factors for Alcohol and Drug use for Persons with MR/DD

- Low self esteem/poor self concept.
- Lack of drug education and prevention skills.
- Feelings of frustration regarding disability.
- Wanting to feel normal and accepted.
- Vulnerability.
- Stress and anxiety.
- Culture of inclusion/deinstitutionalization.
- Difficulty predicting and learning from consequences.
- Deficits in coping skills, money management, travel skills, and socialization skills (difficulty taking turns in conversation, lack of facial expression, poor eye contact, failure to follow conversation, responding impulsively, sharing information that is inappropriately intimate).
- Low expectancy of success and high expectancy of failure.

Mental Retardation: Areas of Limited Functioning/Issues in Treatment:

- Practical and Social Intelligence
- Role Taking
- Person Perception
- Moral Judgment
- Cognition (memory, judgment, abstract thinking, mental flexibility, impulse control, spatial relations)
- Self-regulation
- Meta-cognition
- Executive Functioning

Medical Risks

Research suggests that individuals with pre-existing neurological deficits may suffer the physiological, medical, and psychosocial complications of abuse and addiction at lower doses of the substances than the general population including: seizures, black-outs, and other alcohol related injuries.

- Combined with anticonvulsant medications, alcohol use can cause: severe mental confusion, sedation, dementia, coma, or death.
- Alcohol withdrawal can exacerbate seizures among those with existing neurological conditions.

Diagnosing Alcoholism/ Substance Abuse in Persons with Developmental Disabilities

Adapted Alcohol/ Drug Screening Tool

The following is intended to help service providers make a pre-determination regarding an individual's need for chemical dependency services.

- Have you ever had any alcohol including beer, wine, or liquor?
- Have you ever used drugs (non-prescription) such as marijuana, cocaine, or heroin?
- Do you ever feel bad or guilty about your drinking or using?
- Have you ever tried to cut back on your drinking or using?
- Do you keep alcohol and /or other drugs in your home? Do you keep them hidden?
- Does someone you care about keep liquor in his or her home? Is it hidden?
- Have your family or friends ever complained about your alcohol or drug use?
- Have you ever complained to someone you care for about his or her alcohol/drug use?

- Has anyone official like a doctor, nurse, or counselor ever asked you to reduce or stop using alcohol or drugs?
- Have you ever missed an appointment or responsibility because of your drinking or using? Too "hung over "or "burnt out?"
- Have you ever gone to an AA or NA meeting? Have you ever been in treatment?
- Do you feel that you have a problem? Current or in the past?
- Would you like a referral for treatment?

Scoring: 0-2 No apparent problem; 3-4 suggestive problem; 5 or more, indicates problem

Barriers to Effective Treatment of individuals with DD and AOD

- Later access to treatment
- Slower rates of recovery
- Greater chance of multiple relapse
- Poor memory recall
- Impaired cognition and insight
- Difficulty making cause and effect connections
- Difficulty reading and writing
- Financial inaccessibility
- Exclusionary referral policies leading to treatment discrimination
- Lack of cross training between service systems

The Adaptive Recovery Model

This is a new approach that addresses the areas of limited functioning in the MR/DD individual that create barriers to effective treatment and acknowledges the need for an extended treatment length. The new goal of treatment is to develop routines of daily living that are sustainable and support abstinence.

Treatment Modifications

Many of the treatment needs for persons with developmental disabilities are the same as those for typically functioning individuals, such as the need for:

- Detoxification
- In- or out- patient treatment
- Abstinence
- Long term maintenance through AA/ NA

In addition, however, individuals with developmental disabilities need more support. Treatment modifications should include:

- Extended length of treatment to promote understanding
- Using more supportive and less confrontational treatment techniques
- Being more directive in treatment
- Using a simplified educational model and repeating key concepts regularly
- Developing more concrete and specific short term goals tailored to each individual
- Engage clients family/significant others in treatment
- Collaborate with all providers in the client's service system
- Arrange support for AA/NA
- Employing more behavioral therapy techniques
- Treating clients with more patience
- Furnishing a combination of intensive individual therapy, coupled with family and educational counseling that systematically address what has been learned in the program and how it will be applicable in the next stage of treatment or aftercare.

Recommendations for Treatment Providers

- Ask clients to provide specific examples of a general principle
- Talk slowly
- Ask 1 simple question at a time
- Repeat questions and ask clients to repeat, in their own words what has been said
- Keep it concrete
- Use role-playing/creative arts therapies
- Use visual aides and concrete objects
- Adapt pre-existing learning material
- Avoid the “R” word
- Make sure lessons learned in treatment are not context bound but, applied in the outside world
- Stay flexible
- Repetition, repetition, repetition, repetition

Twelve Ideas for My Improvement

1. I believe that when I drink I cannot control my life.
2. I must begin to believe in a God that will help me become well.
3. I must decide that I will allow God to help guide me in my life work and my relationships with other people.
4. I must search my past life and search life now to see what is good and what still must be changed.
5. With God's help I am able to share my past, both good and bad things, with another person I trust.
6. I am ready to change my life now.
7. I ask God to help me change my life now.
8. I am ready to say I am sorry to the people I hurt during the time I drank too much.
9. I will go to the people I hurt before and show with my present actions that I am truly sorry.
10. I will always look for my mistakes and quickly admit any wrong things I do.
11. Each day I will think how God will help me become a better person.
12. Now that I have a new life, I will gladly search for other persons who drink too much and together we will follow these twelve ideas one day at a time.

GOAL=ABSTINENCE FROM ALCOHOL & DRUGS.

EMPHASIS ON SKILL BUILDING AND COMMUNITY INTEGRATION. OBTAINING PRODUCTIVE, FULFILLING WORK LEADING TOWARD AUTONOMY AND INTERRELATEDNESS.

ACCESS COMMUNITY HEALTH CENTER

Sobriety Services

212-780-2563

Sobriety Services

- Individual Therapy
- Group Therapy
- Family Therapy
- Psychiatric Services
- Urine/Breath Testing
- Preventive Services
- Art Therapy
- Drama Therapy
- Recreational Activities
- Respite Services
- Alumni Services
- On-Site AA Meetings

Complementary Services

- Medical Services
- Psychological Testing
- Physical Therapy
- Speech Therapy
- Nutritional Counseling
- Employment Programs
- Adult Day Services
- Home Health Care
- Service Coordination
- Residential Services
- Legal Services
- Camping and Recreation

NEW CHOICES

A project designed to determine the impact of participation in a dedicated day rehabilitation program on the lives of homeless men with substance abuse or co-occurring disorders (CODs) that reside in a large urban shelter.

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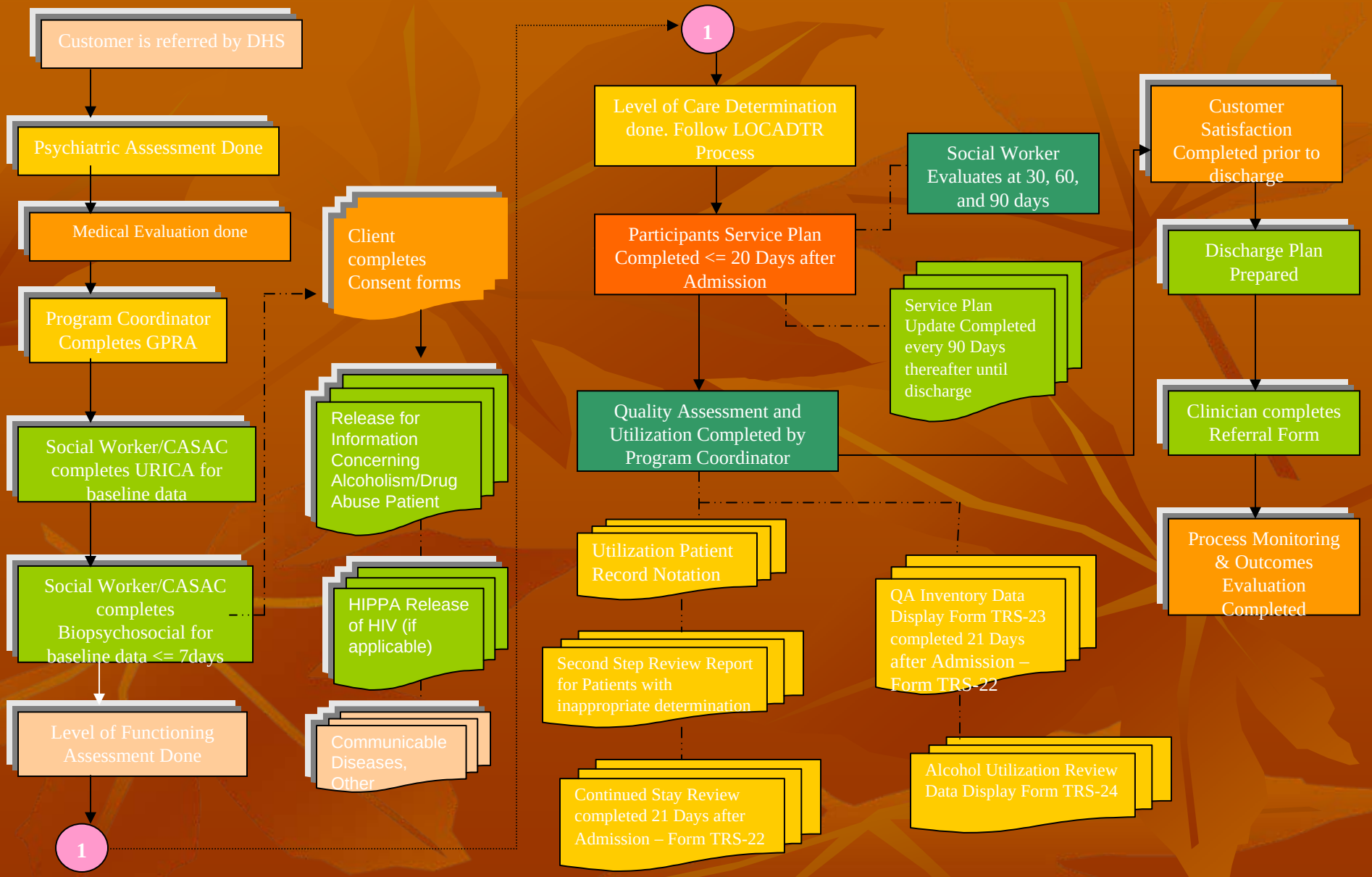
Disclaimer

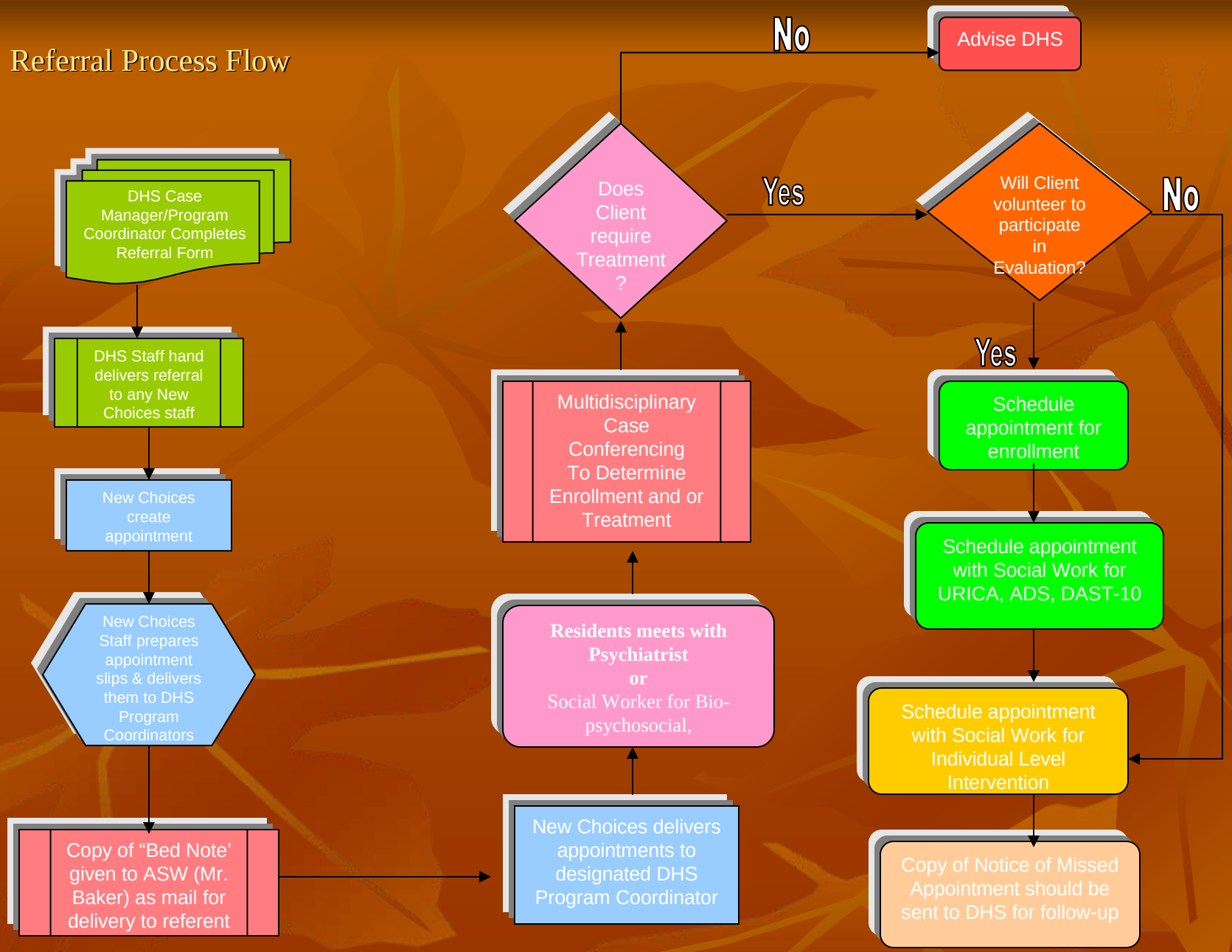
"This study is approved by the NYC Department of Homeless Services (DHS). The analyses and interpretations expressed herein do not necessarily reflect the opinions of DHS or its staff."

Project Work Flow – Comprehensive Ambulatory Substance Abuse Mental Health Program

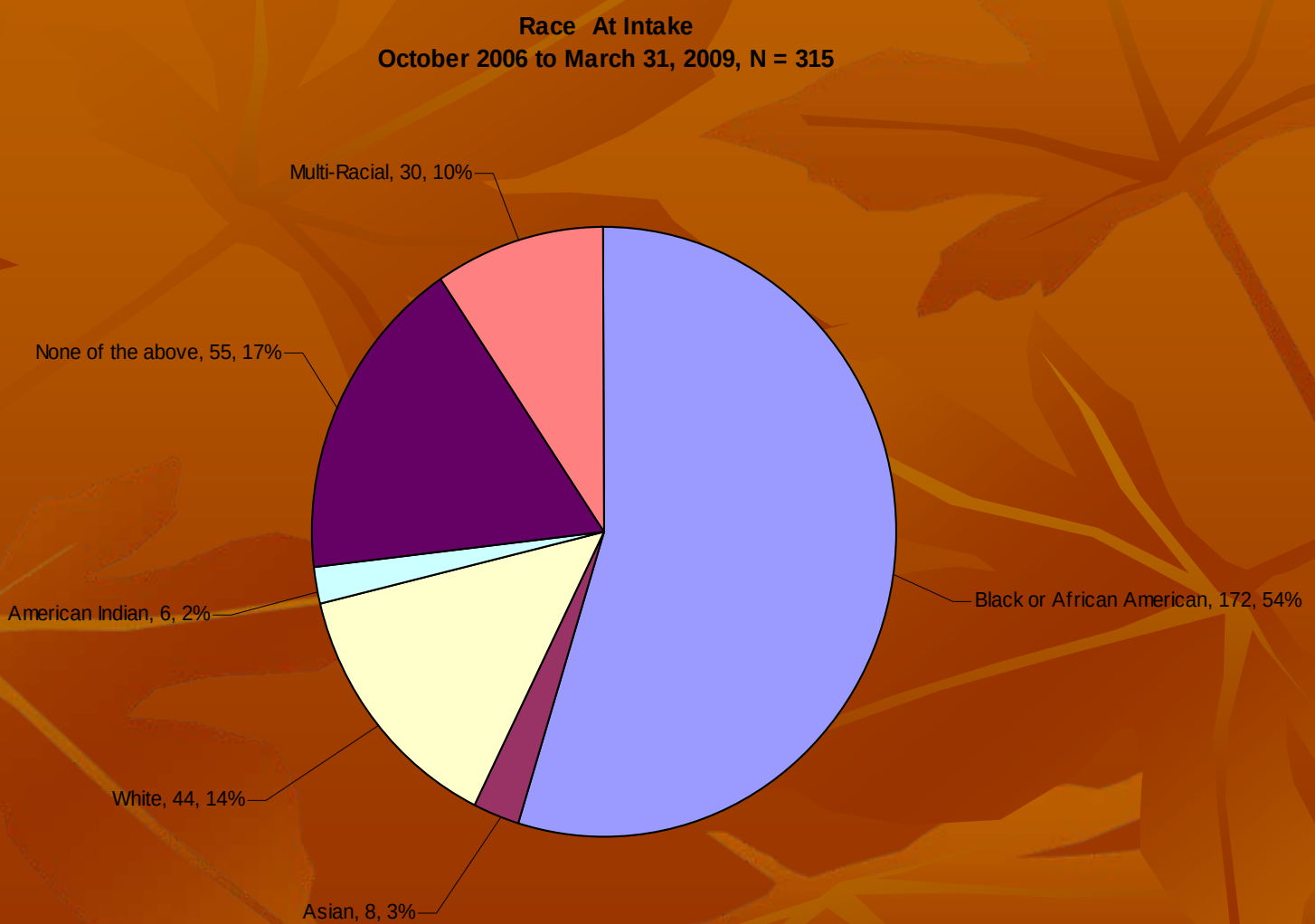


Referral Process Flow

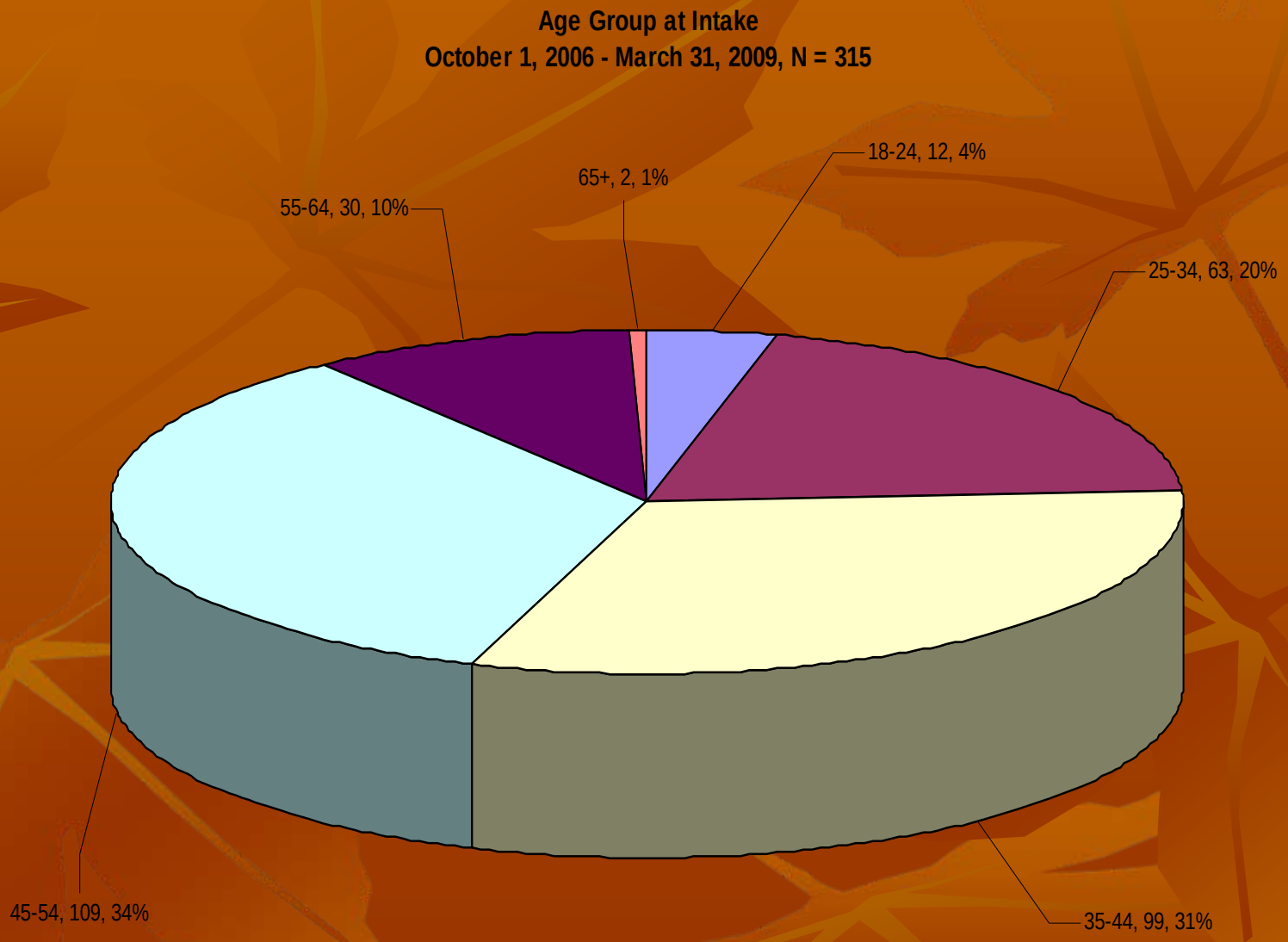
Resident meets with Psychiatrist



Race at Intake

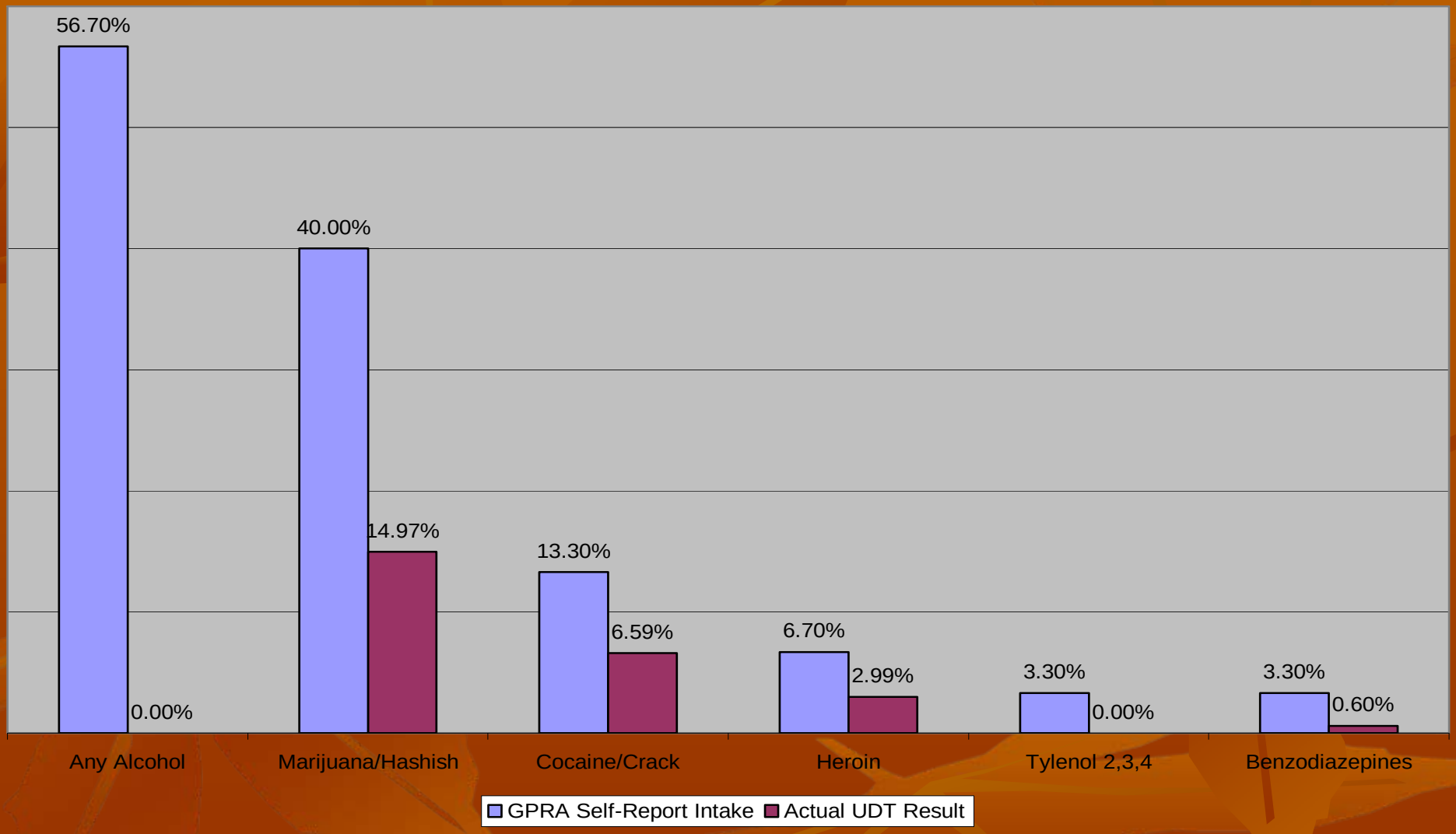


Age Group at Intake

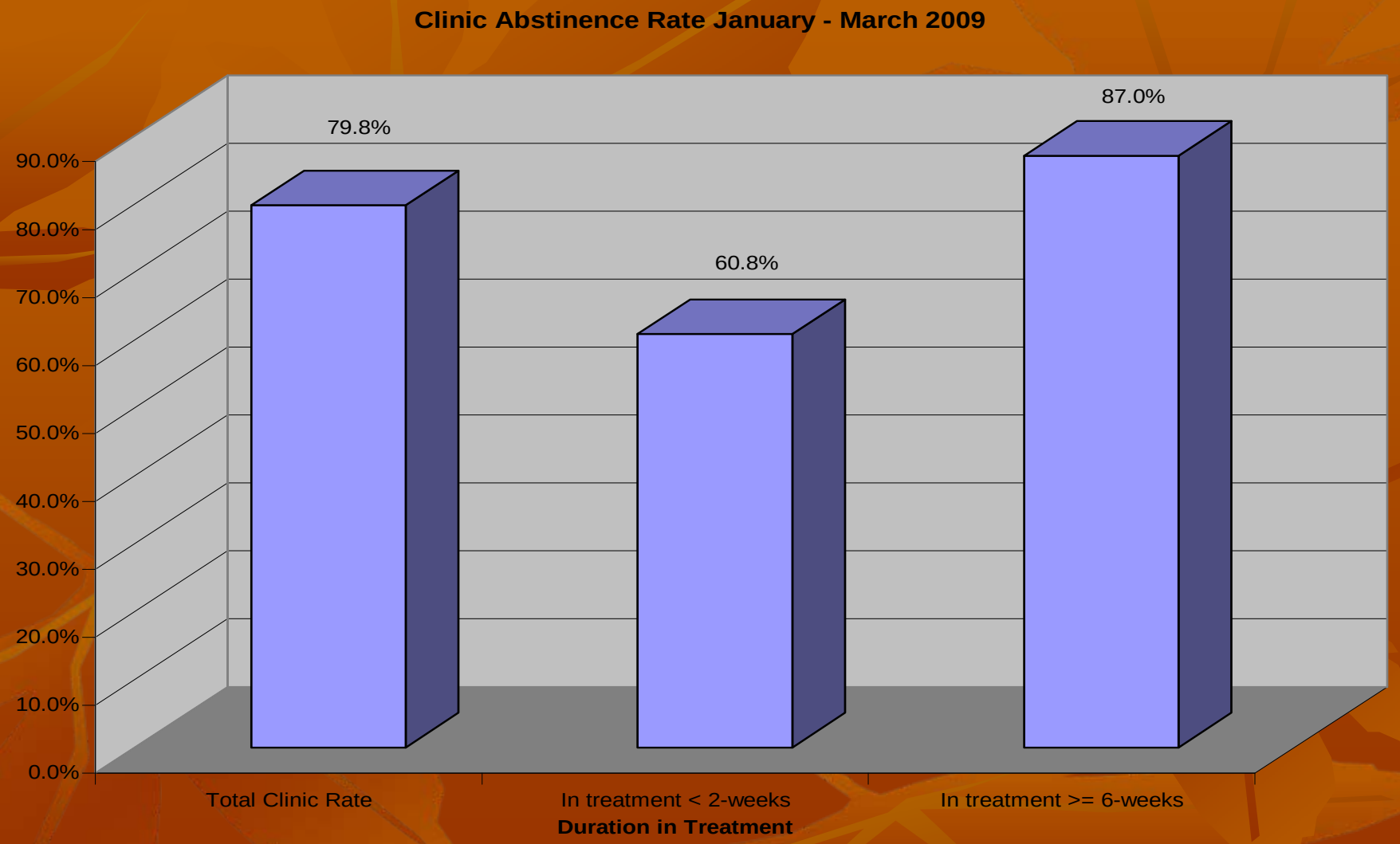


Alcohol & Illegal Drug Use

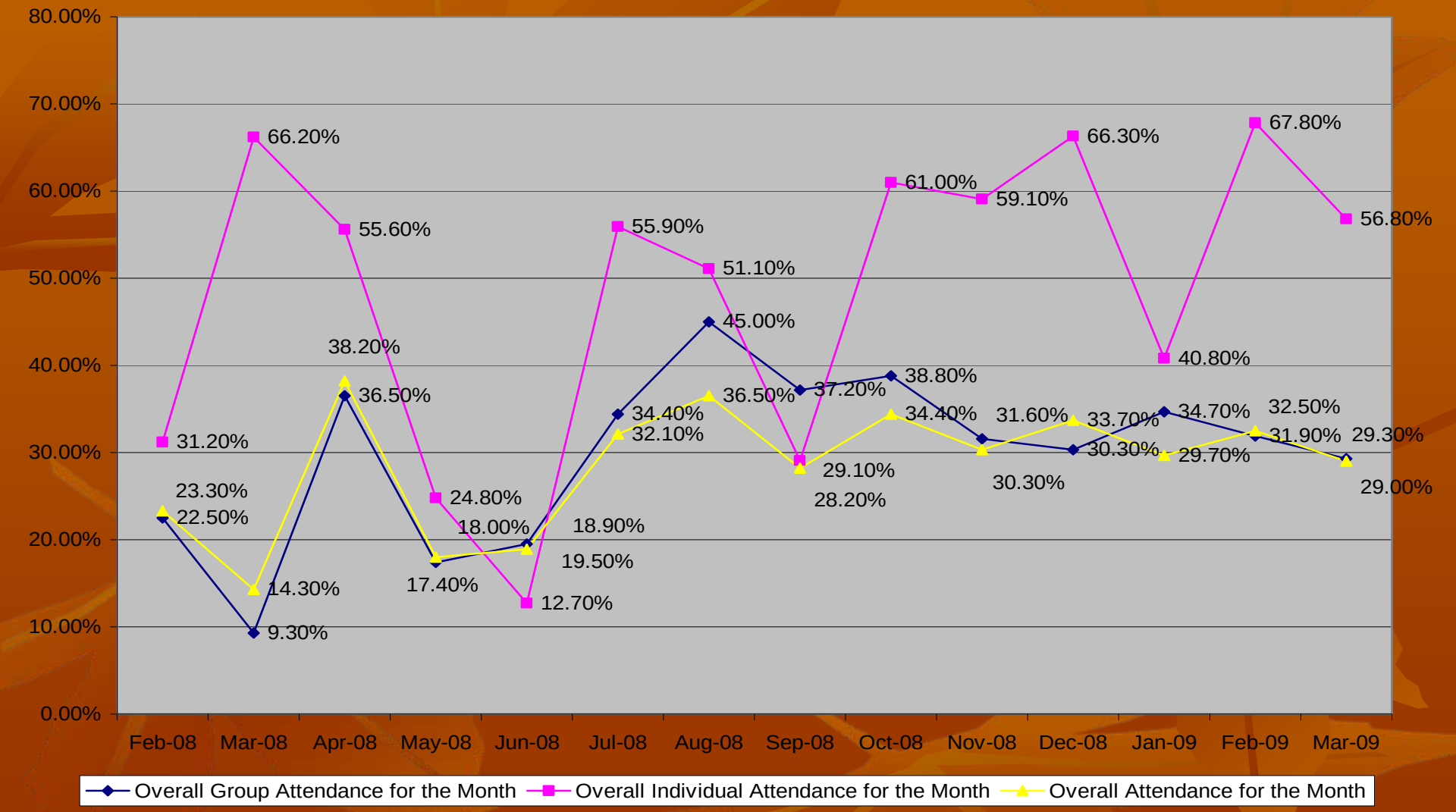
Alcohol & Illegal Drug Use Intake vs Actual UDT Jan-Mar 2009



Abstinence Rate



Monthly Accumulated Retention Rates

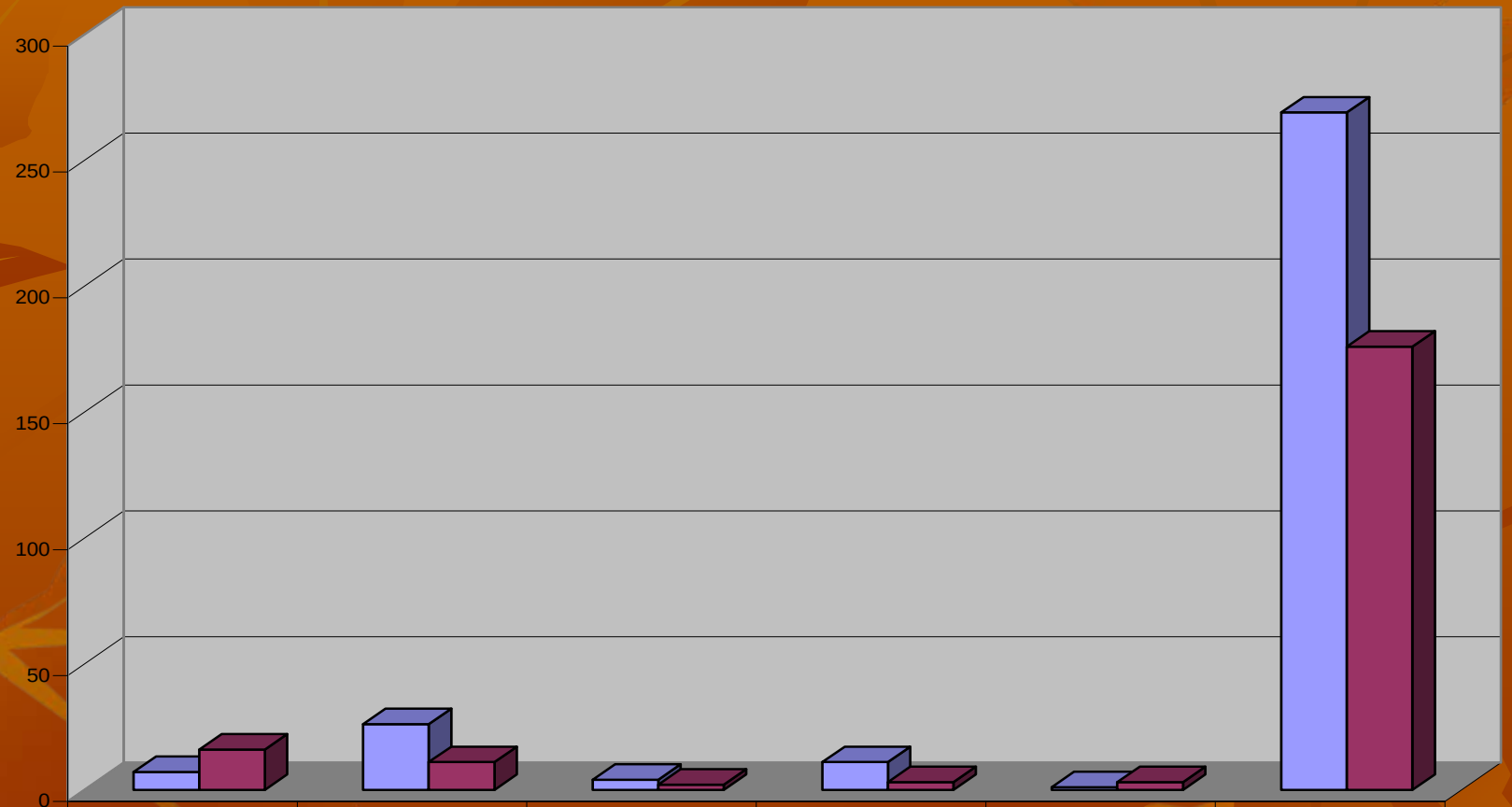


Monthly Accumulated Retention Rates

Table 4 Retention Measure	As at 01/31/09 N = 59	As at 02/28/09 N = 59	As at 03/31/09 N = 59
Overall Group Attendance for the month	34.70%	31.90%	29.30%
Overall Individual Attendance for the month	40.80%	67.80%	56.80%
Overall Attendance for the month	29.70%	32.50%	29.00%

Housing Situation Intake & Follow-up

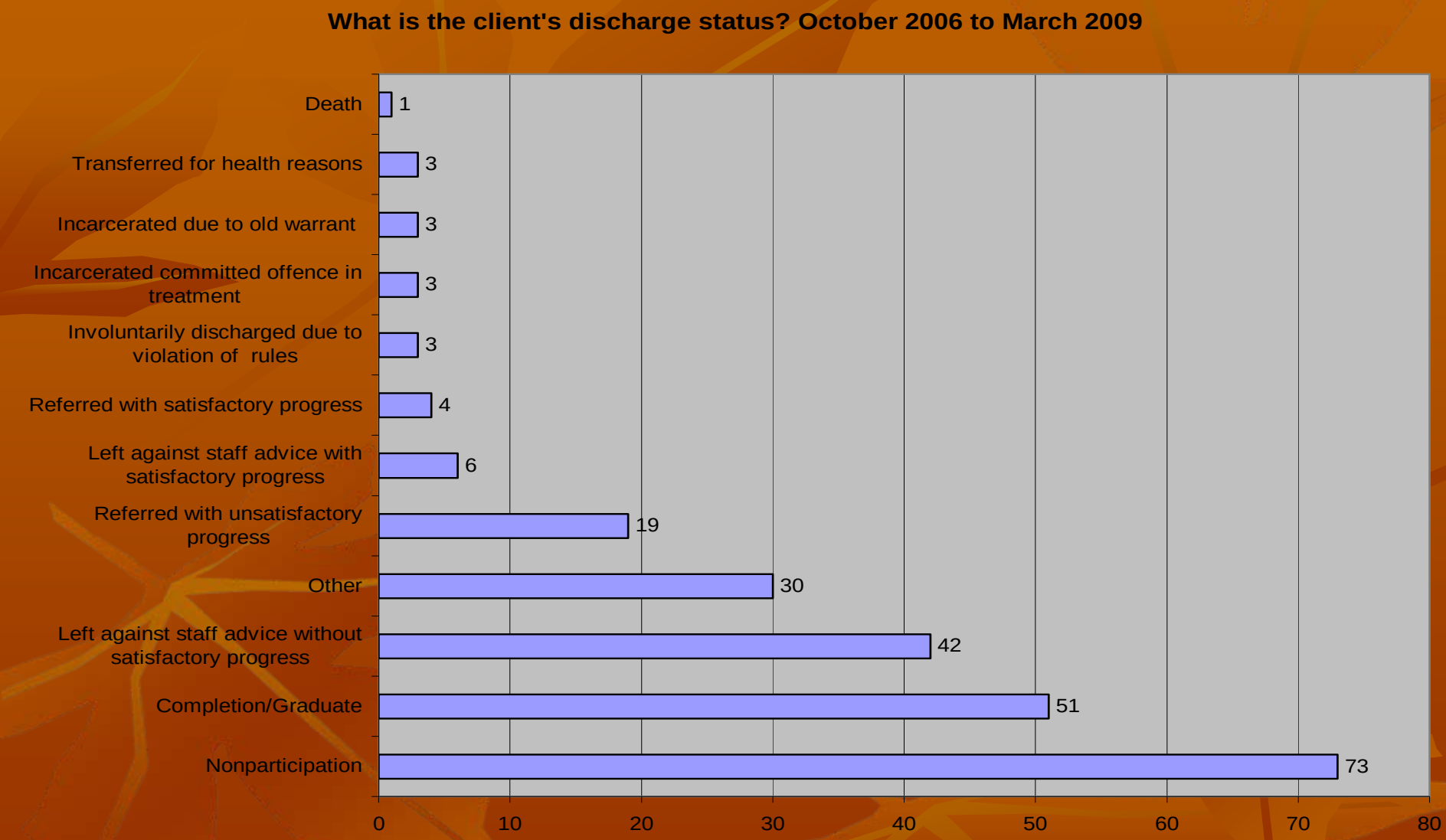
In the past 30 days, where have you been living most of the time? October 2006-March 31, 2009



	Own/rent apartment, room, or house	Someone else's apartment, room or house	Halfway house	Residential treatment	Other housed	Not Applicable
Intake	7	26	4	11	1	269
6-Month Follow-up	16	11	2	3	3	176

Intake 6-Month Follow-up

Discharge Status



Addressing trends in data

Trends in Data	27-Mar-08	5-Jun-08	31-Mar-09
Discharged from Treatment	36	87	173
Re-entered treatment after discharge	10	12	33
Intake assessment	N=99	N=118	N=326
URICA	53.20%	53.60%	62.00%
ADS/DAST-10	53.20%	54.10%	62.00%
6-Month follow-up		n=119	n=199
Mean DAST-10 Score	4.16 to 0.71	4.07 to 2.13 (n=15)	4.4 to 4.6 (n=81)
Mean ADS Score	6.33 to less than 0.71	6.18 to less than 2.07	6.65 vs. 6.2
URICA readiness to change score		9.68 to 10.54	9.90 to 10.00
Average age range (20-71)	42.56%	42.36%	42.30%
Black	48.10%	47.90%	50.20%
Hispanic	14.60%	14.60%	16.10%
White	15.10%	12.80%	10.50%
Multi-racial persons	20.50%	23.00%	20.10%
Living in shelter <= 30 days	80.60%	79.10%	78.80%
Housed <= 30 Days	12.40%	13.60%	13.80%

Successes & Challenges

Intake Data	27-Mar-08	5-Jun-08	31-Mar-09
Assessments done	N=186	N=220	N=326
Abstinent from AOD <=30 Days	42.50%	55.90%	40%
No Crime Involvement	91%	91.40%	91.10%
Employed or attending school	31.90%	33.80%	35.70%
Health or behavioral consequences	75.00%	40.00%	39.40%
Social Connectedness	75.10%	75.30%	72.50%
Permanent Housing	4	4	8
Six-Month Outcomes	N=50	N=100	N=199
Abstinent from AOD <= 30 Days	(46.8% to 58.0%)	53%	46.20%
No crime involvement	Stable	Stable	Stable
Employed or attending school	(18.0% to 40.0%)	(33.8% to 48.0%)	(31.2% to 46.0%)
Health or behavioral social consequences	Positive	Positive	Dropped from 57.7% to 44.2%
Social Connectedness	No marked changes	No marked changes	76.1% to 82.2%
Permanent Housing	4	15	37
Length of stay	14.16 weeks	18.9 weeks	19.3 weeks

Conclusions and Implications

- The findings to date suggest that New Choices is continuing to attain positive outcomes for clients in terms of substance use.
- It has reached a point of stability in terms of the characteristics and needs of the clients admitted for treatment.
- It continues to have a positive impact on clients in terms of substance use, alcohol use in particular, health status and employment/training.
- In general, New Choices seems to be attaining its stated outcome goals, while retaining clients in treatment.

ACCESS
Community Health Center

Mental and Behavioral Health Program

Christina Minerly, PhD
July 14, 2009

Program Objective

- To advance the mental health/wellness of individuals with psychological service needs through the promotion of caring, compassion, and excellence in mental health care.

Program History

- Born from the ADEPT program at AHRC
- Needs Assessment – The U.S. population age 65 and older is growing. In 2000, this group comprised 12 percent of the total population and is projected to increase to 20 percent by 2050.
- ID/DD population also living longer; availability of services must catch up with growing demand

ADEPT Program

- The ADEPT program aimed to improve medical care for elderly people by providing an efficient and accurate diagnosis and effective treatment, without the need for multiple visits to specialists.

- Individual accompanied by caretaker receives an in-depth evaluation by a team of physicians and therapists, who then devise a treatment plan, make the appropriate recommendations, and follow up with the patient at regular intervals.

Clinical Services Provided

- Medical
- Nursing
- Psychology/Mental Health
- Neuropsychology
- Physical Therapy – Occupational Therapy
- Psychiatry
- Social Work
- Neurology

Assessment in Other Domains

- Vision
- Hearing
- Nutritional risk
- Urinary incontinence
- Health behaviors (tobacco, alcohol)
- Polypharmacy
- Social assessments (elder abuse)
- Economic assessment
- Health promotion/Disease prevention
- Values history (advanced directives, end of life care)
- Depression/Mental Health

Definition of Health

- Health is not the absence of disease but rather living with complete well-being.
- Biopsychosocial model of health; ADEPT program based on multidisciplinary model of treatment.
- ADEPT team collaboration incorporates this model by assessing every aspect of the individual.
- Living with a disability is not the opposite of good health.
- *Function* is primary determinate of quality of life

Trends Observed in ADEPT Cases

- Certain diseases which are associated with aging but are not part of normal aging (such as Dementia) are thought to be occurring more frequently than they actually are
- As life expectancy increases, new circumstances arise
- Grief can be felt toward these transitions (i.e. functional and sensory loss, health status decline related to illness, independence, autonomy, living situations, changes in familial or social role)

Trends Observed in ADEPT Cases

- "Total pain" – suffering that encompasses all of a person's physical, psychological, social, spiritual, and practical struggles
- Can have mental or emotional manifestations (i.e. attention, concentration, psychomotor, mood, etc.)
- Aging can be its own stressor
- ALL stressors have a cumulative effect

Case Scenario

- A 51 year old man with Down syndrome recently began behaving differently. People were concerned it was dementia.
- Testing showed it was not dementia but he had significant symptoms of depression related to the loss of his parent, job retirement, etc.
- Incidence of dementia is actually only about 14%

A Move Toward FQHC Status

- 67,876 residents living in Wall Street area (US Census Bureau, 2000)
- Few health care resources available to local residents
- AHRC granted FQHC status in August 2008
- Mental and Behavioral Health Program a vital part of community health center services
- Projected start date for Mental and Behavioral Health services is August 2009

MABHP Scope

- In addition to extending mental and behavioral health services to our ID/DD population, we shall be available to the general public/members of our community.
- Services in the Mental and Behavioral Health Program shall be made available to all individuals regardless of race, creed, gender, sexual preference, economic status, or disability.
- Quality evidence-based therapeutic strategies shall be individualized to appropriately address the various mental health needs of the community.

A MABHP in Primary Care

- Mental and behavioral health services are seen as an integral component of the service delivery system at ACCESS Community Health Center.
- They will be available as a collaborative and/or and integrative model of behavioral health.
- They will play an important role in assisting ACCESS Community Health Center's medical providers and other professionals to formulate appropriate interventions and treatment plans for individuals, caretakers, and other persons who may be significant in the life of the individual.

Initiation of Services

- Referrals to mental and behavioral health services shall be made by the individual's medical provider as indicated after a comprehensive medical evaluation has been completed.
- Minors may be referred by parents/guardians.
- The provider shall describe the reason for the referral along with any pertinent findings that may be impacting upon the mental and behavioral health of the referred individual.

Collaboration and Cooperation

- Mental and behavioral health service providers shall collaborate with medical and other clinical staff at ACCESS Community Health Center, through case conferences (or “huddles”), and other educational/clinical activities as indicated, to ensure that relevant mental health information is incorporated in the comprehensive primary care program.

- Likewise, medical and other clinical staff at ACCESS Community Health Center shall collaborate with MABHP service providers to ensure that relevant medical or other clinical information can be considered in the development of mental and behavioral health treatment plans.

MABHP and Psychiatry

- Collaboration is crucial!
- MABHP service providers shall be familiar with psychiatric therapies being received by the individuals whom they are serving.
- A thorough understanding is needed of the psychopharmacological effects of any medications taken by an individual, including:
  - the interactive effects of polypharmacy
  - the side effects of individual medications (whether they are prescribed for psychiatric or general medical conditions).

MABHP and Other Service Providers

- MABHP service providers shall remain aware of outside treatments and services (and their interactive properties)
- Openmindedness is key!
- However - some other service providers may not be appropriate for the exchange of information. Caution should be exercised if and when communications occur between the many providers of an individual, noting the reasons for the communication and documenting all circumstances in which the individual or his or her legal guardian grants permission for communications to occur.

Structure of MABHP Services

- Initial Consultation - Comprehensive psychological evaluation, administered to all individuals who are seen at ACCESS Community Health Center for routine evaluation

- Routine Follow-Up Visits - For individuals receiving ongoing services at the MABHP.

  - Progress notes are to be recorded in the medical record on the same day of the encounter with the individual. Must be signed, timed, and dated by the psychologist with full name, title and degree.

  - Clinicians must use judgment when writing information in the progress note which refers to the content of the session.

  - Information which is clinically relevant but not appropriate for inclusion in a progress note must be maintained in a protected file for which the service provider assumes full responsibility.

Structure of MABHP Services

- Quarterly/Annual Updates – For individuals who are in a long-term therapeutic relationship with the MABHP.

  - Quarterly and annual treatment reviews (may be performed at a more frequent rate where it may be clinically advantageous to do so).

  - The purpose of these updates is to evaluate the extent of the individual's improvement over time and the need for continued treatment.

  - These may give insight as to the individual's long-term progress rather than focusing on session-to-session changes.

Structure of MABHP Services

- Termination of Treatment
  - The individual and the psychologist mutually agree that treatment outcomes have been satisfactory and that short and/or long-term goals have been met.
  - The individual may still be in need of service, but has missed too many consecutive appointments ("No Show Policy").
  - The individual is, will be, or has received in-patient psychiatric treatment or other equivalent treatment for six or more consecutive months.
  - The individual has moved from the local area or transferred care to another mental and behavioral health facility.
  - Terminations are not necessarily final; individuals who have been terminated may return for treatment (relocation to the local community, relapse in symptoms, discharge from inpatient treatment)

MABHP Service Provider Duties

- Maintain responsibility for his or her own mental health in the course of providing treatment. If any issues arise, vicarious or otherwise, a MABHP service provider is to report to his or her supervisor and/or the director immediately.

- Seek consultation and/or supervision as clinically indicated and appropriate.

- Incorporate a multidisciplinary approach into the scope of treatment practices. Service providers shall communicate effectively and collaborate with professionals from a variety of disciplines.

MABHP Service Provider Duties

- Gather the appropriate providers for multi-discipline case conferences (or “clinical huddles”) as appropriate.
- Coordinate with community resources to best fit the needs of the individual.
- Include the relationship with the individual among the treatment outcomes; listen and interpret an individual’s opinions of services and make earnest efforts to meet their requests when feasible.
- Communicate any and all aspects of treatment with the individual who presents for services; allow for open discussion and collaborative decision-making.

MABHP Service Provider Duties

- Administrative duties:

  - thorough review of all accompanying documentation (including previous evaluations) for every referred individual

  - communication with other providers when necessary to clarify information.

  - complete and thorough documentation of all services with an individual using appropriate agency forms

  - completion of referral tracking forms for neurological evaluations, social work services, nutritional assessments, physical/speech therapy services, etc.

  - participation in QI program

MABHP Services

- For children:

a) learning difficulties

b) attentional problems

c) enuresis/encopresis

d) school phobia

e) psychophysiological disorders

f) autism spectrum disorders

g) emotional problems reactive to life event(s)

h) conditions related to psychiatric difficulties, medical difficulties, developmental/intellectual disability, sleep disorders

MABHP Services

- For adolescents:

a) school dropouts

b) mood disturbance/affective disorders

c) suicidal thoughts/ideation

d) conduct disorders

e) eating disorders

f) relationship/familial issues

g) emotional problems reactive to life event(s)

h) conditions related to psychiatric difficulties, medical difficulties, developmental/intellectual disability, sleep disorders, addictive disorders

MABHP Services

- For adults:

a) occupational problems

b) mood disturbance/affective disorders

c) suicidal thoughts/ideation

d) financial problems

e) relationship/familial issues

f) emotional problems reactive to life event(s)

g) conditions related to psychiatric difficulties, medical difficulties, developmental/intellectual disability, sleep disorders, addictive disorders

MABHP Services

- For adults/geriatric:

a) occupational problems

b) mood disturbance/affective disorders

c) suicidal thoughts/ideation

d) financial problems

e) relationship/familial issues

f) emotional problems reactive to life event(s)

g) conditions related to psychiatric difficulties, medical difficulties, developmental/intellectual disability, sleep disorders, addictive disorders, end of life issues/ advanced care directives, delirium, dementia, amnesic/ cognitive disorders

Research and Education

- Returning to our ADEPT roots
- Research and education play an important role
- Special attention to trends observed in practice
- Outcome data to be collected for study (specific populations, treatment modalities, therapeutic challenges/barriers, newly developed approaches)
- Relevant findings for the professional psychological community to be presented at conferences

Thank you!!

Any questions??