Division Update for Support Coordination Agencies
June 13, 2016

**SC AGENCY PAYMENT VOUCHER SUBMISSION DEADLINE**

All SC Agency payment vouchers for services rendered through June 30 are due to Central Office by close of business on Wednesday, July 6th for processing in time for close out of state fiscal year. Late payment vouchers may not be processed or paid.

The Division is pleased to announce that effective July 1st forward, SC Agencies may begin claiming all monthly deliverables at the rate of $239.81/month. This includes Interim and any monthly deliverables via payment voucher to have one rate across all individuals served. This is an increase from the current established Interim rate of $200/month.

**TRINITAS WEBINAR SERIES FOR SCs & ADDITIONAL OPPORTUNITIES FOR ENGAGEMENT**

*Please see the end of this document for related attachments.*

**Family Crisis Handbook**
This handbook was developed to provide families with information that will help them to understand and advocate with a relative with a dual diagnosis during a mental health and/or behavior crisis.

"Main Flyer – Grant Project"

This attached document provides information about on-line surveys that Support Coordinators can take to provide input on updating the Family Crisis Handbook and to also let families know about it. The DD Council has given a multi-year grant to upgrade and expand upon the *Family Crisis Handbook (2009)* which Donna Icovino and Dr. Lucy Esralew wrote and published with the help of DDD.

**ECHO brochure**

This attached document shares information and opportunities for Support Coordinators to join a learning community focused on specialty care and addressing health disparities.
Power Point for Module 1 in Dual Diagnosis Webinar Series

Please find attached the slides from the first presentation in the Dual Diagnosis webinar series offered by Trinitas/CARES titled "Overview/Intro to the Mental Health System"

The attached Dual Diagnosis Flyer provides detailed descriptions of the webinars offered in this series. Links to register for the remaining webinars can be found below.

**Tuesday, June 21st 12pm-2pm - Dual Diagnosis of MH/DD**
Topics include: major mental health diagnoses and common co-occurring disorders, such as OCD, Bipolar, Major Depression  
**To Register:** https://attendee.gotowebinar.com/rt/186852480548995588

**Tuesday, July 19th 11am-1pm - Behavioral Aspects of Dual Diagnosis**
Topics include: behavioral supports  
**To Register:** https://attendee.gotowebinar.com/rt/3768478622680505604
An updated version of the Crisis Handbook which focuses on children, youth and adults with intellectual/developmental disability, and co-occurring mental health and/or behavioral disorders (dual diagnosis) is currently in the development phase. The handbook authors welcome your valuable input pertaining to your first hand experience addressing behavioral and psychiatric crises. Participating in focus groups and surveys are just some of the ways you will be able to lend your voice to this exciting project.

The purpose of the Crisis Handbook is to inform and empower the reader (consumers/self-advocates, families, direct care professionals, crisis response worker, and other providers) according to recommended Best Practice, so they can more effectively advocate and cope with behavioral/psychiatric crises, in order to improve the overall quality of life for people affected by dual diagnosis.

For more information or expressed interest please contact
Julie Sorrell, Behaviorist at Community Access Unlimited
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Crisis Handbook Authors
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HELP US UPDATE THE HANDBOOK BY FILLING IN THE ONLINE SURVEY:

https://www.surveymonkey.com/r/CrisisResponseWorkers
https://www.surveymonkey.com/r/ConsumerSelfAdvocate
https://www.surveymonkey.com/r/FamilyFocusGroup
https://www.surveymonkey.com/r/DirectSupportProfessionals

You can help by:

1) Filling out the appropriate survey
2) Encouraging staff, consumers and family members to fill out the relevant survey

Deadline: June 30th

Thank you!!
ECHO sessions are run for free via Zoom from iPhones, tablets, laptops, desktops.

Remaining 2016 Dates:

Fridays 1:00-2:30 p.m.

June 10, 24
July 8, 22
Aug 12, 26
Sept 9, 23
Oct 7, 21
Nov 4, 18
Dec 2, 16

Lucille Esralew, Ph.D.
Mobin Chadha, LCSW
Leone Murphy, APN
Nicole Livingston, Ph.D.
Bonny Life, MA, MPP
Phillip Caruso, LPC

Trinitas Regional Medical Center
1-888-393-3007

PRESENTING

Project ECHO®
Extension for Community Healthcare Outcomes
Moving Knowledge Instead of People
Project ECHO: A Revolution in Healthcare Education and Care Delivery

MISSION STATEMENT

Project ECHO is an educational and guided practice model that increases workforce capacity to provide best-practice specialty care and reduce health disparities. The heart of the ECHO model is its hub-and-spoke knowledge-sharing networks, led by expert teams who use multi-point videoconferencing to conduct virtual sessions with community providers. All information is HIPPA compliant and de-identified in this way, clinicians, families, and direct care providers learn to provide excellent specialty care to individuals with complex conditions in their own communities.

What is Project ECHO?

- Project ECHO is NOT Telemedicine
- The focus is on education
- It is not a billable service
- It has a multidirectional flow of knowledge
- It is a free service to partners who can access expert multidisciplinary team who provide mentoring, advice, and support.

The Hub of the ECHO Team will include a psychologist, an APN, LPC, neuro psychologist, and a LCSW.

Other community providers will be invited to be partners and to participate in regularly scheduled sessions (The sessions will last approximately 1.5 hours).

Each session will include two or three case presentations and a brief exercise or didactic on a related topic.

How ECHO Benefits our Partners

- Partners will be able to present their most challenging cases and receive immediate recommendations from the ECHO Hub Team and other partners on the video conference.
- Recommendations will be summarized and sent to the case presenters.
- CARES will provide follow up service to assist the provider in implementing the recommendations.
- Providers will have the opportunity to discuss the case again and determine if the recommendations were effective.

For more information please contact:
Mobin Chadha
mchadha@trinitas.org
or
1-888-393-3007
A Few Words About our Presenter:

Lucille Esralew, Ph.D. NADD-CC is the Clinical Administrator of CARES and S-COPE of Trinitas Regional Medical Center

**Overview and Introduction to the Mental Health System**

**June 7: 11 a.m. - 1 p.m.**

Dr. Esralew will overview different components of care within NJ’s Mental Health System, help explain the differences between mental health and behavioral health services and speak to the experience of individuals and their families in navigating systems in order to get needed services. We will review the CARES program (formerly SCCAT) and how to be a good consumer of mental health/behavioral health services on behalf of the consumer with dual diagnosis (MI/DD).

**Dual Diagnosis (MI/DD)**

**June 21: 12 p.m. - 2 p.m.**

Dr. Esralew will discuss the major mental health diagnoses seen among adults with intellectual and developmental disabilities including Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depression and severe Obsessive Compulsive Disorder

**Behavioral Aspects of Dual Diagnosis**

**July 19: 12 p.m. - 2 p.m.**

Dr. Esralew will review how to determine the behavioral support needs of adults with dual diagnosis across home, program and work settings. We will discuss the importance of a Functional Behavioral Assessment, the difference in ABA and Positive Behavior Supports, the components of an effective behavioral shaping program and how to best advocate for consumers to receive relevant and needed behavioral supports to improve consumers’ quality of life outcomes.

*Special Thanks to NJ DDD Assistant Division Director Christine James and to Administrative Assistant Kerry Filor for their assistance in arrangements for this series.*
Overview of the Mental Health System

Webinar Series for Support Coordinators
Presenter: Lucille Esrleuw, Ph.D., NADD-CC, CDP
Trinitas Regional Medical Center

Objective for Today’s Workshop

• Familiarize participants with components of the Mental Health System
• Familiarize participants with resources within Mental Health and Behavioral Health for crisis response and clinical stabilization for individuals with intellectual and developmental disabilities and mental health or behavioral disorders
• Help participants understand how best to access and utilize CARES resources
• Highlight areas of support for consumers with dual diagnosis and their families and staff
• Highlight key systems issues for crisis response relevant to this target populations
What is Dual Diagnosis (MI/DD)?

- The co-occurrence of a developmental disability and a mental health disorder
- Certain developmental disorders may have a high co-occurrence of specific psychiatric illness (Autism and OCD, Autism and Bipolar Disorder; DS and DAT, DS and depression)
- Certain developmental disorders may have a high co-occurrence of behavioral problems (behavioral phenotypes) such as self-injury (Lesch-Nyan Syndrome, Cornelia DeLange Syndrome) or impulsivity (Fragile X, Fetal Alcohol Spectrum Disorder)
- Behavioral problems can occur in the absence of psychiatric illness

What is the relationship between individuals with Dual Diagnosis and their service needs?

- Individuals with mental disorders such as Generalized Anxiety Disorder and Depression can benefit from a combination of psychoactive medication and psychosocial interventions
- Individuals with significant psychiatric illnesses such as Schizophrenia, Schizoaffective Disorder, Bipolar Disorder and severe OCD may need intensive supports both medical and non-medical (inpatient stay during episodes of dangerousness, intensive outpatient services/partial care programming, on-going medication management by psychiatrist or APN)
Mental Health versus Behavioral Health

- Although (mistakenly) used interchangeably the Mental Health System and Behavioral Health are not the same
- Mental Health Services are available through the Division of Mental Health and Addiction Services (DMAS) for the treatment of individuals with severe, persistent psychiatric illness (PESS, county and state hospitalizations, mental health group homes)
- Behavioral Health is offered through managed care, commercial insurers and within hospital and community mental health settings and can be used for health promotion (smoking or alcohol cessation, coping skills enhancement) or treatment of everyday challenges to mental health

Stabilization Services

- Counseling (individual, group, couples, family)
- Medication management
- Partial care programming
- Behavioral shaping plans
- Recreation activities
- Consistency in staffing and a positive routine
Community Based Behavioral Health Services

• Community Mental Health Centers
• Hospital outpatient services
• Private practitioners

• All the above are fee-for-service and should be covered by the consumer's managed insurance (MCO), commercial insurer or as an out-of-pocket expense

The Role of Managed Care in Behavioral Health

• Authorizes services
• Health Care Manager from MCO should have a treatment plan that justifies services
• Participating practitioners from network and Non-par agreements for out-of-network providers
What is the difference between problem behavior and a crisis?

- Problem behavior tends to be of longer term duration (the individual who has been exhibiting the same behavior for several months or years)
- Problem behavior tends to be the product of a mismatch between environment and the consumer’s needs
- Like crises, problem behavior may be the result of poor handling techniques, unaddressed mental health or medical issues
- Often attributable to delirium, pain, extreme stressors or maladaptive coping style
- Unlike crises, problem behaviors (which may be disruptive, annoying, counterproductive) are not necessarily dangerous

What is a Crisis?

- A condition, event, set of events that destabilizes the individual
- Places the individual at risk of harm to self or others
- The individual’s behaviors are rapidly escalating to an extent that outstrip his/her own and caregivers (family and/or staff’s) ability to effectively respond
- When usual management techniques/coping skills/safety precautions are not working to keep the individual and others in his/her environment safe
Mental Health and Behavioral Crises

- Although mental health crises may be experienced by anyone, individuals with developmental disabilities who also suffer from psychiatric illnesses such as Bipolar Disorder, Schizoaffective Disorder, Schizophrenia, severe Obsessive Compulsive Disorder, or Major Depression, are more likely to experience the need for acute care services.
- Behavioral crises can be experienced by individuals with or without psychiatric illness and often reflect a mismatch between the individual's behavior support needs and their current services.
Mental Health versus Behavioral Health

- Mental health services are for the treatment of significant mental health disorders
- Behavioral Health is to address challenges to everyday living on the basis of depression, anxiety, adjustment problems
- Behavioral Health may involve the consumer receiving medication but does not suggest the need for hospitalization; severity of challenges can be better managed in the community
- Behavioral Health may involve intensive outpatient services (IOS), counseling, medication management, behavioral shaping

Individuals in the community are more likely to need BH rather than MH services

- Behavioral shaping programs
- Individual, group, and or family counseling and social skills training
- Medication monitoring
- Attendance of a partial care program (may or may not be associated with the behavioral health unit of a hospital)
- Services delivered on an outpatient or in-home basis
Who Delivers What Service?

- Psychiatrists, APNs prescribe and monitor psychoactive medications
- If the consumer's medications are prescribed by a PCP (any physician can prescribe any medication) or a neurologist, it is probably wise to include consultation with a psychiatrist or APN on a regular basis
- Licensed Psychologists, Social Workers and Professional Counselors provide counseling and psychotherapy
- BCABAs and BCBAs conduct Applied Behavior Analysis
- There is no current certification for individuals who provide Positive Behavior Supports
- There are NADD-certified clinicians by the National Association for Dual Diagnosis NADD-CC

The Sy Sims Approach to Behavioral Health

- An educated consumer makes the best customer (True!)
- Ask the practitioner for her case conceptualization of what is wrong, what the practitioner can recommend to effectively address what is wrong and approximately how long the practitioner thinks it will take before you will see some positive outcomes
- If the consumer is on a treatment plan the consumer and family/staff should:
  - A) Know what is being addressed and how it is being addressed
  - B) the role of the consumer, the family and the staff
  - C) request a meeting with the practitioner to receive periodic updates about the consumer's progress
Behavioral Interventionists

• Should know how to conduct a Functional Behavior Assessment (FBA)
• Should be able to develop a Behavioral Shaping Plan
• Should educate all stakeholders on the techniques being used to shape behavior
• Plans should prioritize behaviors to be addressed on the basis of most problematic (dangerous), disruptive and interfering with quality of life
• Should reduce problematic behavior and increase adaptive skills

Positive Behavior Support

• What is Positive Behavior Support?
Positive Behavior Support (PBS) is a set of research-based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a person’s environment. Positive behavior support combines:

• Valued outcomes;
• Behavioral and biomedical science;
• Validated procedures; and
• Systems change to enhance quality of life and reduce problem behaviors.

www.apbs.org
Positive Behavior Supports

- PBS is non-coercive and is aligned with individuals’ values, interests and needs
- Individuals who live in enhanced environments that contain activities, opportunities for social connection and meaningful ways to spend time are less likely to manifest emotional or behavioral problems
- Strongly linked with person-centered care which looks to conceptualize the person and his/her needs as a total person and not merely in terms of difficult to manage behaviors

Crisis Intervention
What is crisis response?

- Determination of what is going on so that clinicians can frame intervention, consultation, intervention, training, etc.:
  - Begins with initial phone intake upon referral via a centralized toll-free number
  - Determination is made by supervisor utilizing our triage system about the timing of initial face-to-face visit; phone consultation is provided within 30 minutes
  - Clinician conducts an assessment
  - Crisis response = a cycle of iterative activity which includes assessment, formal recommendation, delivery of relevant service, documentation, evaluation and re-assessment if service has not been effective in resolving crisis situation

Statewide Clinical Consultation and Training (SCCAT) 2000-2015

- DMHAS grant with braided funding from sister Divisions within the Department of Human Services – DMHAS and DDD
- Initially funded through DMHAS in 2000 as a telephonic consultation and training program to provide technical assistance to DD and DMHAS providers supporting dually diagnosed (MI/DD) adults
- In 2007, DDD funding resulted in reorganization to include community crisis response and brief clinical follow-along for 6-8 weeks to lessen crisis acuity and refer to available longer term stabilization services
CARES: Reshaping Crisis Response

- CARES initiated January 1, 2016
- Crisis Assessment Response and Enhanced Services
- Merging of SCCAT crisis response team with ISDT clinical case management team into one service that provides both crisis assessment, stabilization services and clinical case management over a 120 day period
- Referrals will be of adults 21 and older with developmental disability and co-occurring mental health and behavioral disorders referred from screening

Whom Do You Call?

- Mobile response from local Psychiatric Screening Center
- If not imminently dangerous, call appropriate Trinitas team:
  - CARES 1-888-393-3007 for adults 21+ with IDD
Crisis Assessment Response and Enhanced Services

**Mission:**

- Reduce unnecessary admissions to state and community psychiatric hospitals
- Reduce the number of presentations to screening centers
- Reduce recidivism of high acuity individuals to screening centers and psychiatric hospital admissions
- Develop workforce, consumer and caregiver competencies across systems.

**Structure of CARES Service Delivery**

- All screening referrals will come through our 1-888-393-3007 number
- Face-to-face assessment will be provided at screening centers and as follow-ups at the clients’ homes, agencies and day programs
- Clinicians will treat clients and work with members of the clients’ valued systems for an authorized period of 120 days and create linkages to longer term stabilization services
- CARES will develop learning networks of interested stakeholders in the areas of complex case management, Positive Behavior Supports and integrated wellness approaches via ECHO
What types of services may be needed in a crisis?

- Assessment
- Safety precautions
- Rapid tranquilization
- Inpatient hospitalization

Assessment

- Mental Status Evaluation consisting of clinical observation, interview and collateral information
- Depression and anxiety scales to determine if mood problems are significant factors in the current crisis situation
- Functional behavioral assessment to determine factors associated with problem behaviors
Face-to-Face Assessment

- Clinicians will conduct a face-to-face response:
  - When the situation appears to be rapidly deteriorating and as a way of potentially averting from unnecessary ER visit or hospitalization
  - When we cannot ascertain on the basis of phone information (limited collateral or contradictory reports) what is going on so we need to “eyeball” the situation for ourselves
  - When the referral emanates from screening, families, agencies or programs that are considering hospitalization in order to make recommendations about the appropriate level of care

Phone Consultation

- Response to a call that does not require an immediate face-to-face
- Offer staff information regarding handling of a situation or provides advisement about additional information that needs to be obtained
- If offered on an evening or weekend, should be followed by another phone call to determine the effect of the consultation (did staff follow through, did the situation escalate, is there a need for a face-to-face?)
- Both phone consultation and response to consultation must be documented in our system
Crisis Response as a Clinical Activity

- Short-term intervention designed to assess and identify factors that will lessen crisis acuity
- Focus on strengths and coping
- Not intended as a replacement for longer term stabilization service
- Must involve all members of the client’s valued system. Most crisis response fails in this respect—the focus is on the individual; a crisis usually involves a person-within-system(s) destabilization
- Must work with the individual in crisis, his/her family, and staff to restore equilibrium

To what extent does a behavioral health crisis involve danger?

- Harm to self includes significant self-injury, impulsivity (e.g., eloping into traffic) and suicidality
- Harm to others includes significant aggression and property destruction
- Although verbal aggression (menacing statement, suicidal statements) indicates a high level of distress and lack of control that can escalate to dangerous behavior that must be addressed, verbal aggression (threats, cursing, etc.) in itself does not constitute a dangerous situation
To what extent does crisis involve opportunity?

- Post-crisis allows the individual and his/her valued system to re-evaluate treatments, services and supports
- A crisis situation presumes that either the person’s situation has changed and accompanying supports have not been adequately updated or that someone is missing supports that are needed in order to maintain balance and steady-state functioning
- To the extent that the crisis situation can lead to necessary changes in personal coping, caregiver skills set or knowledge base or different allocation of systems resources

What would be an effective/successful resolution in crisis situations?

- The person is stabilized in their natural setting
- The person has been referred to needed longer term stabilization services
- The person has not lost a placement because of his/her mental health crisis
- The person is receiving necessary pharmacological and non-pharmacological services and supports
- The valued system has become better equipped to recognize and respond to future challenging situations
Whose crisis or problem is it anyway?

- **Staff** - weekend coverage? Untrained with regards to behavioral disturbance? Unequipped with regard to handling individuals with severe mental illness or personality disorder?
- **Administration** - with concerns about fines, complaints from families and staff
- **Family** - which may or may not have a realistic understanding of support of relatives with behavioral and/or mental health challenges
- **Consumers** - who may have limited memory about events, limited control over impulses or poor understanding of cause-effect relationships

Stabilization versus Acute Care Services

- Acute care services are emergency, crisis response services
- The role of acute care services (CARES, mobile outreach, PESS, inpatient stay) is:
  - Short-term and time-limited
  - To reduce crisis acuity and lessen dangerousness
  - May be limited (as in inpatient stay) by authorization from the MCO
What happens when someone is referred to the ER?

- Expensive ride to Medical ER
- Wait for medical clearance
- Wait for a determination about psychiatric screening
- Will only hospitalize for dangerousness to self or others
- Determination of screening is only whether or not someone needs hospitalization; the client will generally not have treatment initiated in the ER
Types of hospitalization

- From least to most restrictive
  - Hospital-based partial care programs (day hospitals)
  - Voluntary units
  - Involuntary admissions onto Short Term Care Facility (STCF)
  - Extended stay within County Hospitals
  - State psychiatric hospitalization
  - Forensic psychiatric care

Role of inpatient psychiatric hospitalization

- Reduce dangerousness
- Rapid tranquilization
- Assessment
- Observation
- May be opportunity to trial intervention that can be continued in community
- Hand-off to community provider or (in the case of someone who does not stabilize) hand-off to higher level, longer-term care e.g. county or state hospitalization
Misunderstandings about inpatient psychiatric care

• Hospitals are not the place to address problems that arise from a mismatch between the consumer and his/her residential or day program setting
• Hospital units are not the way to resolve disposition problems
• If the family is opposed to the prescription of psychoactive medications in the treatment of the individual, that person should not be admitted to an inpatient unit
• The basis for discharge is safety (absence of dangerousness), not being symptom free from mental health disorder

Levels of Care within the Mental Health System

• Community Mental Health Centers
• Partial Care or day treatment programs
• Voluntary admission to local inpatient psychiatric units
• Involuntary admission to local Short Term Care Facility (STCF) unit
• Intermediate extended stay in a county hospital
• Admission to a state psychiatric facility (longer term inpatient treatment)
Trinitas relevant services for the MI/DD population

- 2003 initiation of a dedicated inpatient psychiatric unit within Department of Behavioral Health and Psychiatry at TRMC’s New Point Campus in Elizabeth
- Currently a 10 bed self-sustaining acute closed unit for short term stabilization of adults with intellectual disability and co-occurring psychiatric disorders; typical stay is on 7-12 days
- Trinitas also maintains 6-10 beds on its CCIS from children with MIDD ages 5-17

Specialized MI/ID Unit: Trinitas Regional Medical Center

- 2D unit at TRMC is a 10 bed acute care unit dedicated to adults who are intellectually developmentally disabled with a co-occurring mental health
- Stabilization of the acute crisis through medication management, behavioral support strategies, O.T., R.T.
- Staffed 24 hours per day by a multidisciplinary team
- Board certified psychiatrists, RNs, LCSWs, LSWs, behavioral specialist, Occupational Therapists, Recreation Therapists, mental health and medical interns
Services post-crisis

- Behavioral supports
- Counseling
- Guided practice, on-site mentoring and training
- CARES offers short-term stabilization services including providing treatment and clinical case management for up to 120 days

Challenges to Obtaining Needed Services for Adults with Dual Diagnosis (MI/DD)
Barriers

Therapeutic Erosion

- When information gets lost about the client when relayed across shifts, across disciplines or because caregivers who knew relevant information did not share with succeeding generations of staff
- Sometimes knowledge about clients known during day shift is not shared with evening, “graveyard shift” or weekend staff
- One of the areas in which our staff work with facility and agency staff involves developing suggestions for better internal communication within systems so that important information about the client is not lost
Challenges to effective crisis response

- Misdiagnoses
- Over-reliance on medication to fix psychosocial problems
- Over-reliance on ERs to handle behavioral problems that can be managed in natural settings
- Family and professional caregivers not sufficiently skilled to handle challenges posed by individuals with complex problems (medical, psychiatric, developmental, emotional, etc.)

Systems Issues

- The population is at higher risk for behavioral and psychiatric destabilization because they are medically underserved (lack of qualified psychiatrist and APNs) and psychosocially underserved (lack of qualified interventionists and social rehab programming)
- Disproportionately high presentation of this population to ED/ER around mismatch of needs with available resources
- No systematic way for determining the psychosocial and behavioral health needs of individuals and building programming around relevant service delivery
- Managed Medicaid as third party payor
- Changes in how DDD does business including January 1, 2015 shift of <21 to DCFS and change in funding for waiver services
Moving Knowledge Instead of People

What is Project ECHO?
How is it different from telemedicine?

Telemedicine:
- Focus is direct service delivery
- Usually billable
- Usually one-to-one
- Unidirectional flow of information
- Usually one-and-done, or time limited/specific
- Single expert proving opinion

ECHO:
- Focus is on education and capacity building
- Not usually billable
- One-to-many (hub and spokes)
- Multidirectional flow of knowledge
- Ongoing, based on learner’s needs
- Multidisciplinary expert team providing mentoring, advice and support
ECHO session format

- 1.5 hour ECHO Sessions
- Hub = Neuropsychologist, behaviorist, APN, social worker, licensed professional counselor
- Spokes = Provider agencies, screening centers, inpatient discharge planners
- Format: presentation of 3-4 cases of de-identified information
- Learning occurs between providers and specialists, among providers and reciprocally, from providers to specialists
- Didactic consisting of 15-20 module relevant to case presentation
- Suggestions for guided practice forwarded to all members of the session

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CASE STUDY #1

- RS is a 26 year old unmarried Caucasian female who carries the diagnoses of Mild Intellectual Disability, Borderline Personality Disorder and Bipolar Disorder. She resides in a supervised apartment in which she shares a suite with two other consumers; she receives 20 hours a week of services from a DD provider agency. She works within a sheltered workshop that is run in conjunction with a local partial care program
- RS has a history of multiple ER presentations for aggressive behavior towards suitmates and staff and multiple attempts at self-mutilation (cuts self with sharp objects)
- She demonstrates poor impulse and anger management. She has been promiscuous in her sexual relations, is suspected to use marijuana on a regular basis and has been variably compliant with her medication regimen. Last ER presentation, she destroyed property at the partial care program during an argument with staff. She is currently on suspension

CASE STUDY #2

- JM is a 22 year old African American male with autism and severe self-injury; he places within the moderate range of intellectual disability
- JM graduated from a school in which he was in a small classroom with specialized behavioral supports (ABA). He was not placed within a day program until a week prior to his presentation to the ER for significant self-injury and aggression
- He was discharged from the ER without hospitalization but referred to a community-based psychiatrist who placed him on Seroquel and Xanax. There is a question about his ability to return to the day program. His mother, who had recently returned to part-time work when JM entered day programming, has needed to stay home to care for her son until his day program placement can be resolved
Crisis Resolution involves looking at the person within context

Let’s consider RS (Case #1) and JM (Case #2):

- What does the person need?
- What do the person’s caregivers need?
- What resources are needed within each of the individual’s settings?
- What are the implications for systems change?

Summative Points

- Mental Health crises affect everyone within the consumer's natural settings (including family, staff and peers)
- Caregivers need to know the distinction between Behavioral Health and Mental Health services and the difference between acute care and stabilization services
- Caregivers need to recognize and effectively respond to “red flags” before situations deteriorate to the point of crises
- The individuals discussed in today’s workshop can benefit from counseling, behavioral shaping, targeted pharmacology, Positive Behavior Supports and best practice care in order to avert unnecessary presentations to hospital ERs or unnecessary hospitalization
Clinical Consultation and follow-along

- Work with residents to provide brief coping skills enhancement
- Work alongside staff to provide guided practice in best practice person-centered wellness and recovery principles
- Provide on-site mentoring, coaching, in-service training and psychoeducation to equip facility workforce to engage in best practice care
- Conduct 9 regional trainings per year

Non-pharmacological Intervention

- Activities programming
- Behavioral shaping
- Communication and staff handling techniques
- Counseling
- Expressive arts therapy
- Environmental modifications
Mental health Supports for Families

- CARES 1-888-393-3007
- Intensive Family Support Services www.mhanj.org/intensive-family-support-services
- MoM2MoM 1-877-914-6662 (MOM2) ubhcrutgers.edu/call-center/peer
- NAMI www.naminj.org 732-940-0991
- County Mental health Associations www.mha+county

References

Questions?
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