

NJ Crisis Response: C.A.R.E.S.

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Objective for Today's Workshop

- Familiarize participants with resources for crisis response and clinical stabilization for the population of individuals with intellectual and developmental disabilities and mental health or behavioral disorders
- Help participants understand how best to access and utilize CARES resources
- Discuss crisis response as a clinical activity
- Highlight key clinical issues for persons with disabilities that may make them more vulnerable to mental health and behavioral crises
- Highlight key systems issues for crisis response relevant to this target populations

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.

Crisis= Danger+Opportunity



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

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

What types of services may be needed in a crisis?

- Assessment
- Safety precautions
- Rapid tranquilization
- Inpatient hospitalization

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

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

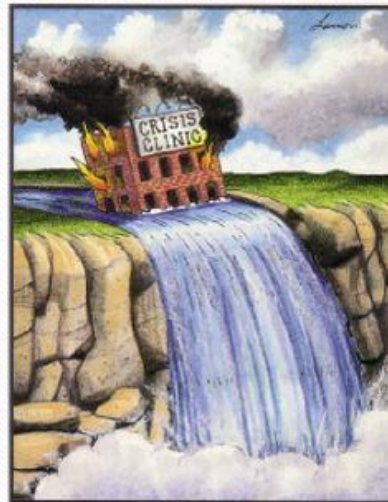
To what extent does crisis involve opportunity?

- 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

Crisis Intervention



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



Crises are in the eyes of the beholder

- Sometimes (okay, fairly frequently...) there is a difference of opinion between what families, staff and crisis responders consider to be a “crisis”
- These differences are opportunities to educate about the true nature of crisis, train on emergency protocols and to obtain feedback about crisis response services
- Please contact Ted (tcalefati@trinitas.org), Bonny (blife@trinitas.org) or Lucy (lesralew@trinitas.org) with questions about CARES .

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

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

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.)

The Emergency Room



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

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)

Adults with Intellectual and Developmental Disabilities



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
- **C**risis **A**ssessment **R**esponse and **E**nhanced **S**ervices
- 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

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



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

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

Clinical Issues

- Individuals with MI/DD represent a group with a high degree of co-occurring mental health and medical co-morbidities
- Certain developmental disorders are associated with behavioral phenotypes which make it more likely that they will present with maladaptive behavioral problems:
 - ❖ Autism spectrum and catastrophic reactions, SIB
 - ❖ Lesch-Nyan Syndrome or Cornelia de Lange associated with SIB
 - ❖ Fetal Alcohol Spectrum Disorder associated with heightened impulsivity

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

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

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 suitemates 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?

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

Diffusion of Information; Infusion of Best Practice

- 9 Regional Trainings
- Extension for Community Healthcare Outcomes
- On-site in-service training
- On-site mentoring and coaching via guided practice



Moving Knowledge Instead of People



Extension of Community Health Outcomes: ECHO

- Trinitas in affiliation with the University of New Mexico will be running learning collaboratives consisting of multi-point videoconferencing, guided practice and didactic
- Partners will be sought from DD and DMHAS provider agencies and family groups who are interested stakeholders in the learning process
- Format consists of 1.5 hour session during which de-identified cases are presented, the interprofessional team (MD, APN, Psychologist, MSW, LPC, behaviorist) provide consultation and opportunities for guided practice)

Project ECHO: A Revolution in Healthcare Education and Care Delivery

- 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?

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 providing 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



ECHO Whale



PCA Española



Baton Rouge



Pecos Valley MC



DOH Las Cruces



SBRT-First Choice South Va



Memorial HDX7000



LAS VEGAS ECFH



NEJM : 364: 23, June 9-2011, Arora S, Thornton K, Murata G

Methods

- Use Technology
- Share “best practices”
- Utilize case based learning
- Utilize web-based database to monitor outcomes

Summative Points

- Crises are a family affair
- When crises occur within agencies or facilities, they are an agency/facility affair
- Service delivery should not be at the point of crisis and more resources should be placed in stabilization services
- Train families and professional caregivers to recognize and respond to “red flags” before situations deteriorate to 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

References

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Questions?

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