

Resiliency and Disease Management for Community Mental Health

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Overall Goal

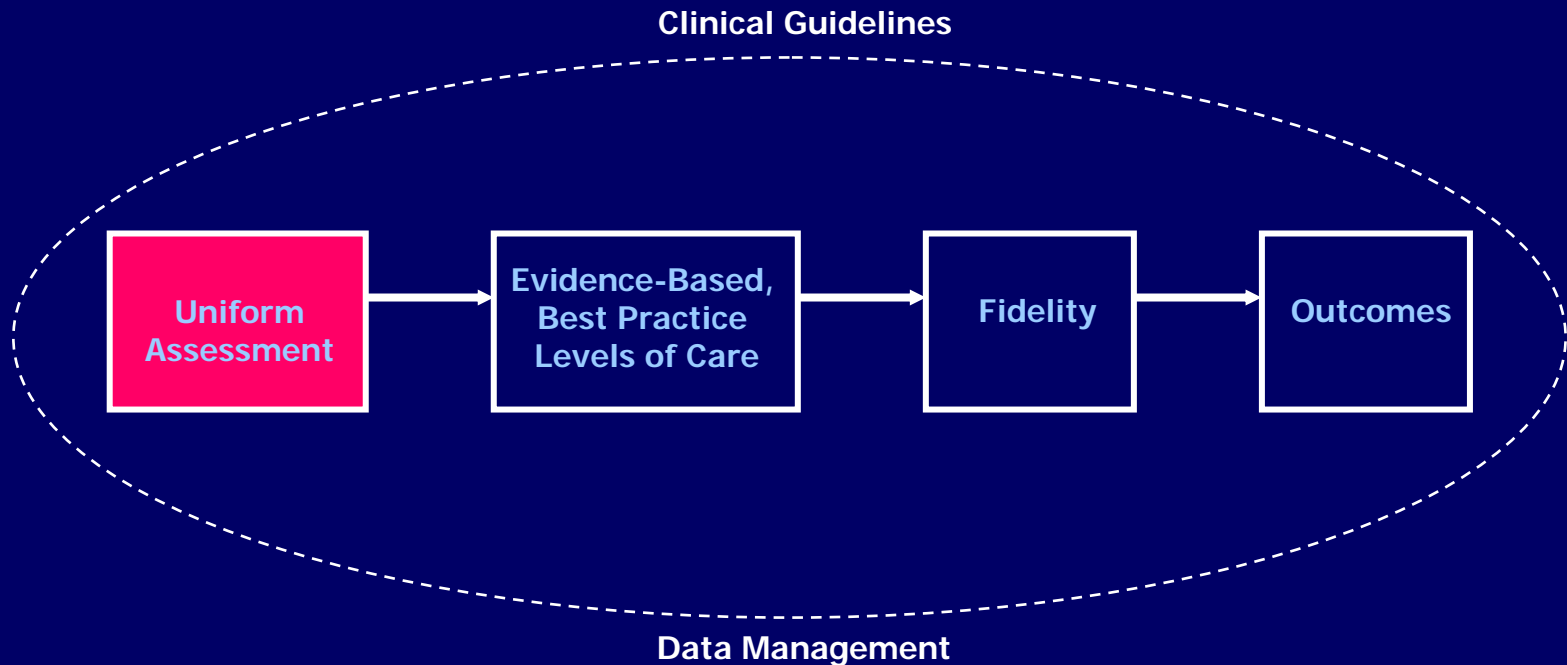
- To promote the uniform provision of services based on clinical evidence and recognized best practices to advance the recovery of adults with serious mental illness and the resilience of children with severe emotional disturbance, as defined by Texas House Bill 2292 and in accordance with the President's New Freedom Commission on Mental Health.



CHANGE

IT'S A SHORT TRIP FROM RIDING THE WAVES OF CHANGE TO
BEING TORN APART BY THE JAWS OF DEFEAT.

Resiliency and Disease Management (RDM)



TRAG

- An instrument developed to assess the service needs of adults and children face-to-face, and recommend a level of care for them in the Texas public mental health system.

Rationale for the TRAG

- To reduce inequities in care
- Existing instruments have limitations:
 - Too expensive.
 - Too complicated.
 - Not compatible with our population and geography.
 - Not suitable for adults/children with severe mental illness/emotional disturbance.
 - Poverty and related services often overlooked.

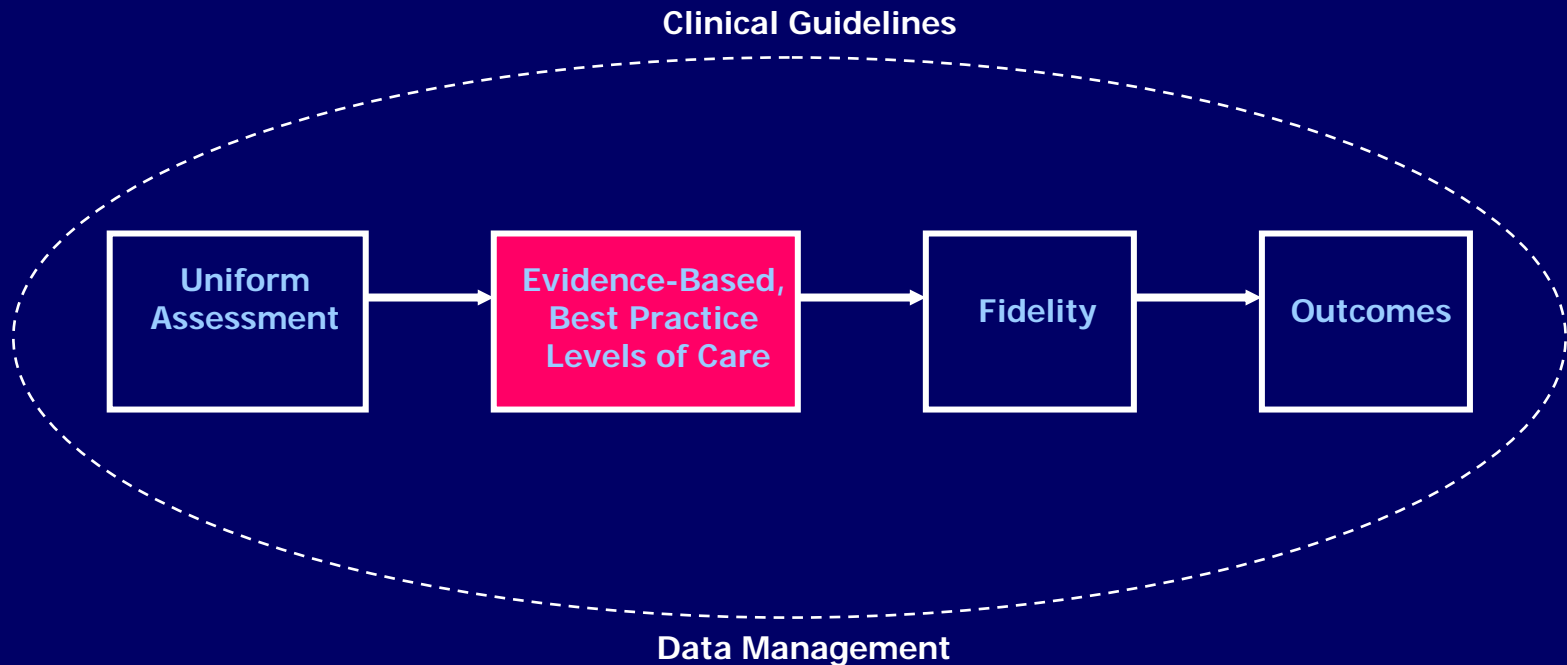
Adult-TRAG Dimensions for Assessment

- 1. Risk of Harm**
- 2. Support Needs**
- 3. Psychiatric-Related Hospitalizations**
- 4. Functional Impairment**
- 5. Employment Problems**
- 6. Housing Instability**
- 7. Co-Occurring Substance Use**
- 8. Criminal Justice Involvement**
- 9. Response to Medication Treatment (MDD Only)**

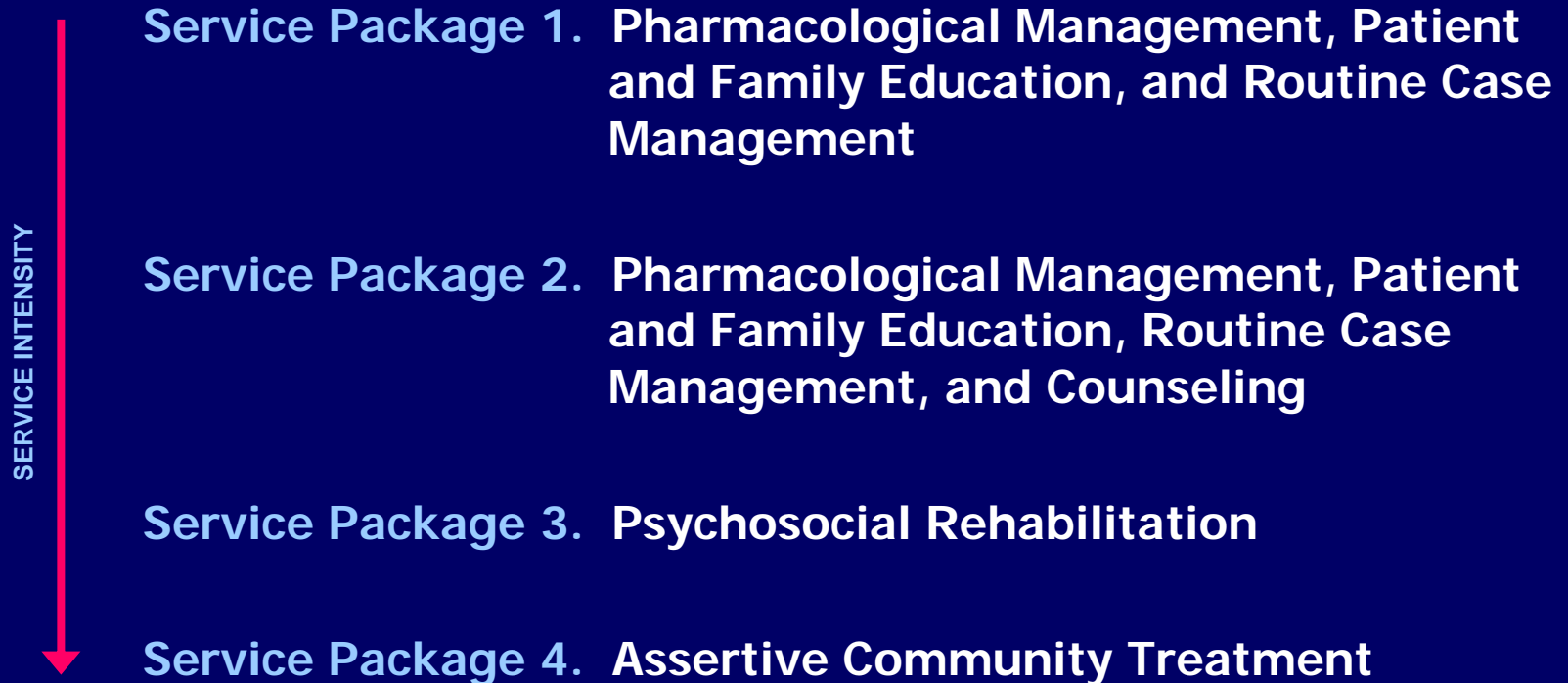
CA-TRAG Dimensions for Assessment

1. **Ohio Youth Problem Severity Scale (OYPSS)**
2. **Ohio Youth Functioning Scale (OYFS)**
3. **Risk of Self-Harm**
4. **Severe Disruptive or Aggressive Behavior**
5. **Family Resources**
6. **History of Psychiatric Treatment**
7. **Co-Occurring Substance Use**
8. **Juvenile Justice Involvement**
9. **School Behavior**
10. **Psychoactive Medication Treatment**

Resiliency and Disease Management (RDM)



Adult Levels of Care



Consensus Conference

- Facilitated by Judith A. Cook, Ph.D.
- Asked experts to review literature on psychosocial rehabilitative services.
- Come together for a two-day meeting and discuss the evidence.
- Discuss the gaps in the evidence and come to a consensus on what services should be included and how to deploy.

Questions to be addressed

- What ingredients are essential for each service?
- What level of evidence supports these ingredients?
- What evidence exists to guide implementation?
- Which consumers would benefit most?

Process

- Experts presented evidence.
- Small group of providers, consumers, and family members met with experts to discuss ingredients and came to consensus on implementation in Texas.
- Results published in *Psychiatric Rehabilitation Journal*, 27(4), 2004.

Child and Adolescent Levels of Care

Service Package 1.1 Brief Outpatient – Externalizing Disorders

Service Package 1.2 Brief Outpatient – Internalizing Disorders

Service Package 2.1 Intensive Outpatient – Externalizing Disorders – Multi-Systemic Therapy

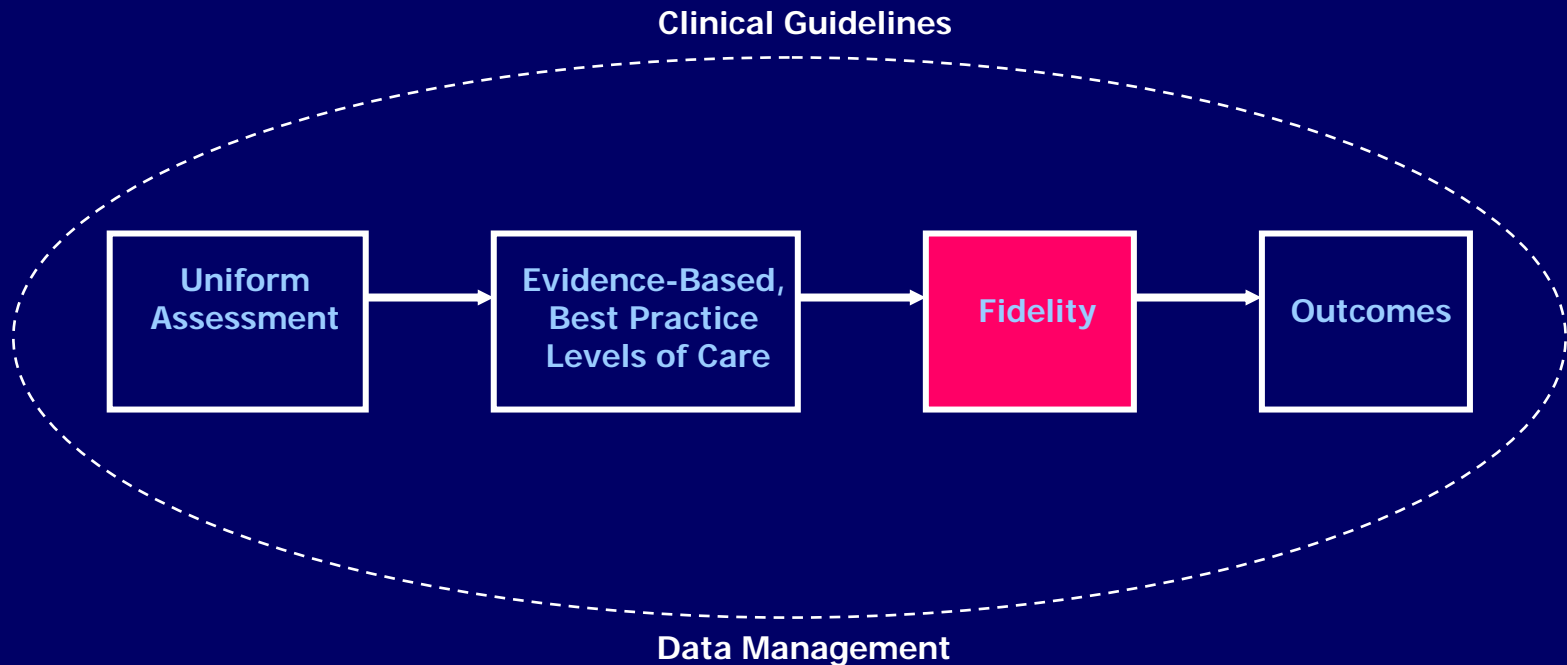
Service Package 2.2 Intensive Outpatient – Externalizing Disorders

Service Package 2.3 Intensive Outpatient – Internalizing Disorders

Service Package 2.4 Intensive Outpatient – Schizophrenia, Bipolar Disorder, Major Depressive Disorder with Psychosis, or Other Psychotic Disorders

Service Package 4 After-Care

Resiliency and Disease Management (RDM)



Use

- Communicating expectations about RDM level of care components.
- Initial training of providers in RDM service models.
- Self-monitoring and assessment of service model implementation.
- Technical assistance in service model implementation.
- External review and accountability.

Example Item for Adult Service Package 3

Definition: Effective *skills training* methods are utilized, including a) instructions; b) modeling; c) role play or rehearse; d) positive feedback and shaping; and e) repetition of role plays or rehearsal.

Rationale: To measure the degree to which effective skill training methods are utilized.

Information Sources: Progress notes

Item Scoring: 5-point rating based on the presence of the element:

1. No evidence of any skills training methods described in a - e.
2. Skill training methods as described in a - e are used in 25% - 49% of the progress notes.
3. Skill training methods as described in a - e are used in 50% - 74% of the progress notes.
4. Skill training methods as described in a - e are used in 75% - 94% of the progress notes.
5. Skill training methods as described in a - e are used in 95% or more of the progress notes.

Source: DSHS *Fidelity Toolkit for Resiliency and Disease Management*, <http://www.dshs.state.tx.us/mhprograms/IIDAdultPsychosocialRehab052505.pdf>.

Example Item for Child and Adolescent Service Packages 1.2 and 2.3

Definition: As part of *Cognitive Behavior Therapy* (CBT), children and adolescents are taught *self-monitoring* — skills to recognize and record specific experiences that affect anxiety and depression. Children and adolescents are taught to self-monitor in some or all of the following critical areas: physical sensations that occur when anxiety and depression are present; thoughts that precipitate anxiety and depression; emotions experienced; events that precipitate anxiety and depression; and actions that may follow the feelings of anxiety and depression.

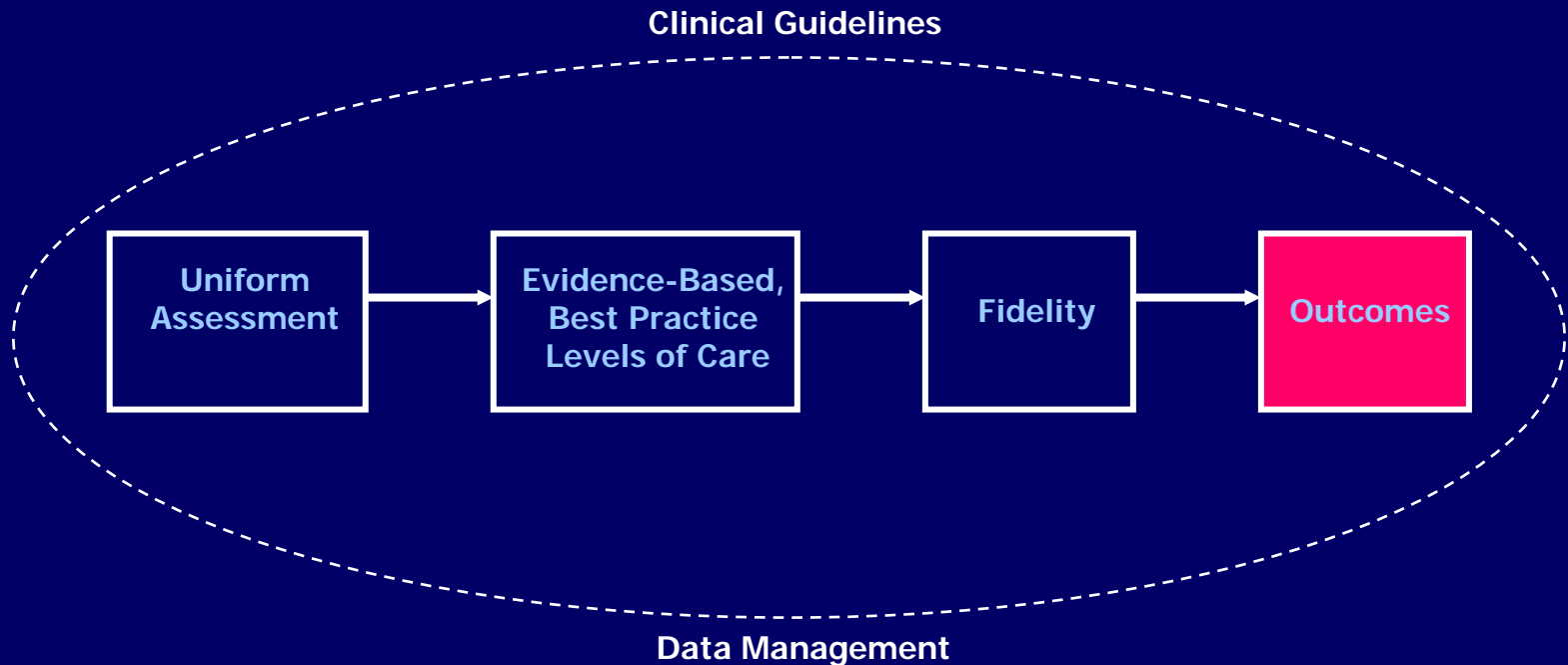
Rationale: Self-monitoring is an intervention that assists children and adolescents to become self-aware of factors that contribute to anxiety and depression, and to become self-aware of the impact of their new skills on their symptoms of anxiety and depression. Self-monitoring provides the “data” upon which interventions are based. Progress can be measured over time and children and adolescents can become aware of the strengths and skills gained to manage anxiety and depression.

Information Sources: Child record (progress notes), child interviews, supervision notes, observation, and audio or videotapes.

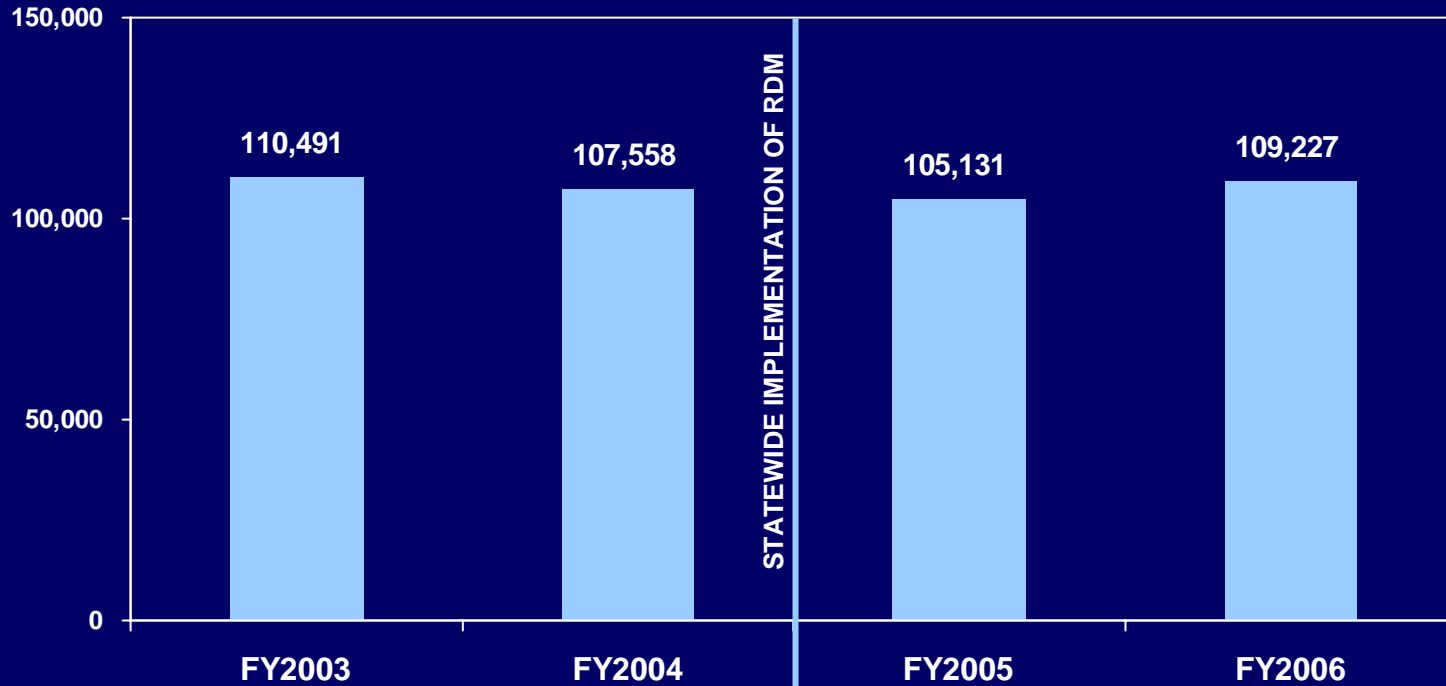
Item Scoring: This item is scored “yes” if sources demonstrate that the youth was: a) instructed in how to self-monitor their experiences of anxiety and/or depression and associated elements; and b) practiced this skill either in one or more therapy sessions or as a “homework” assignment.

Source: DSHS *Fidelity Toolkit for Resiliency and Disease Management*, <http://www.dshs.state.tx.us/mhprograms/IIICACBT090106.pdf>.

Resiliency and Disease Management (RDM)



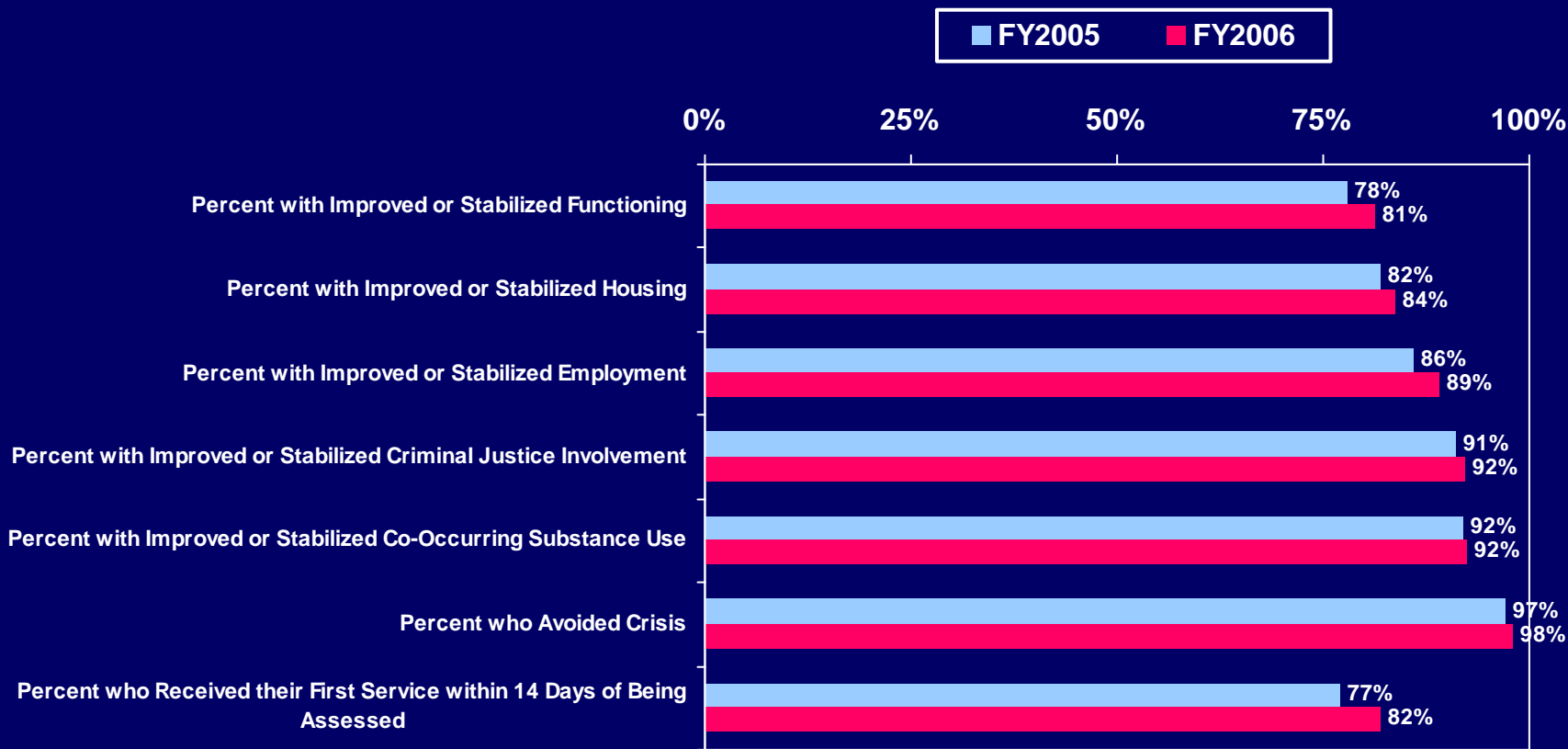
NUMBER OF ADULTS SERVED at DSHS-Funded Community Mental Health Centers



Source: FY2003 = CARE Report HC028488, *TDMHMR MH Priority Population Counts by Month for 09-01-02 through 08-31-03*, prepared on 09/20/03, total is unduplicated; FY2004 = CARE Report HC028488, *TDMHMR MH Priority Population Counts by Month for 09-01-03 through 08-31-04*, prepared on 09/18/04, total is unduplicated; FY2005 = DSHS Mental Retardation and Behavioral Health Outpatient Warehouse, Business Objects Corporate Report, *LBB RDM Served for FY2005*, 08/01/06, used for LBB reporting for number of adults receiving community mental health services per year (i.e., number who received a full RDM service package); FY2006 = DSHS Mental Retardation and Behavioral Health Outpatient Warehouse, Business Objects Corporate Report, *LBB RDM Served for FY2006*, 09/17/06, used for LBB reporting for number of adults receiving community mental health services per year (i.e., number who received a full RDM service package).

OUTCOMES

among Adults Assigned to a Full RDM Service Package at DSHS-Funded Community Mental Health Centers in FY2005 and FY2006

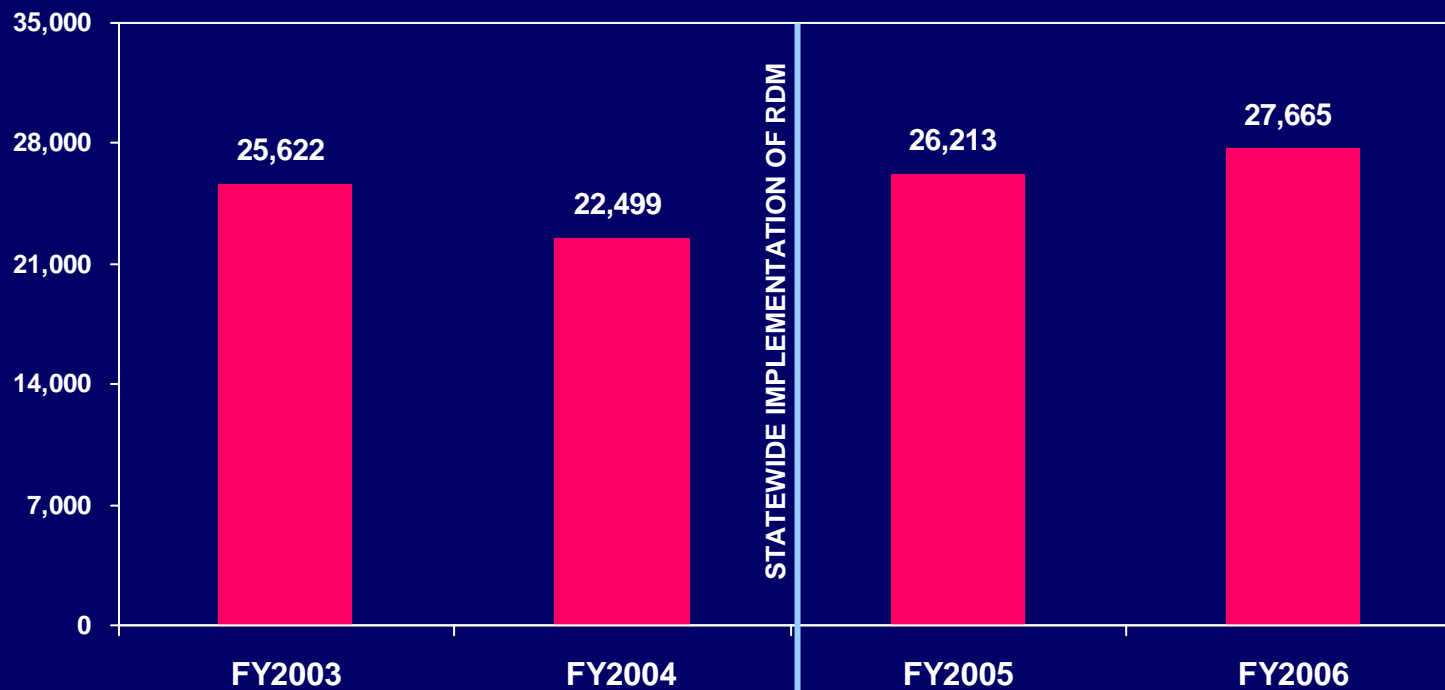


Source: FY2005 = DSHS Mental Retardation and Behavioral Health Outpatient Warehouse, Business Objects Corporate Report, *PM Adult Outcomes Report for FY2005*, 11/30/05 (*Co-Occurring Substance Use*, 08/01/06), Business Objects Corporate Report, *PM Crisis Avoidance Report for FY2005*, 12/01/05, Business Objects Corporate Report, *PM Time Between Assessment and First Service Encounter Report for FY2005*, 12/01/05; FY2006 = DSHS Mental Retardation and Behavioral Health Outpatient Warehouse, Business Objects Corporate Report, *PM Adult Outcomes Report for FY2006*, 09/17/06, Business Objects Corporate Report, *PM Crisis Avoidance Report for FY2006*, 09/17/06, Business Objects Corporate Report, *PM Time Between Assessment and First Service Encounter Report for FY2006*, 09/17/06.

FY2005 Ns = Functioning, Housing, Employment = 74,943; Criminal Justice Involvement = 10,753; Co-Occurring Substance Use = 16,172; Avoided Crisis = 105,131; Received First Service within 14 Days of Assessment = 78,782.

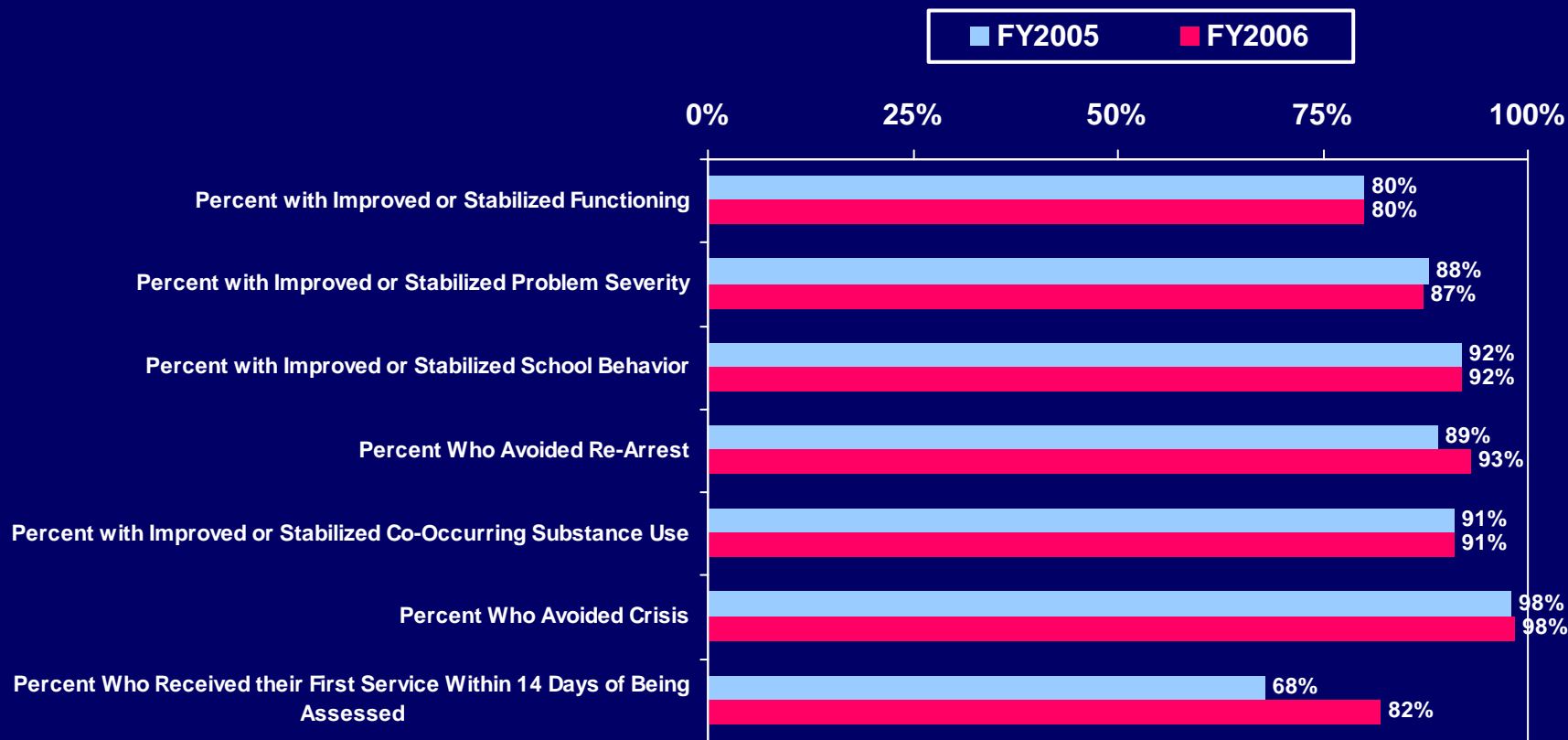
FY2006 Ns = Functioning, Housing, Employment = 84,616; Criminal Justice Involvement = 12,447; Co-Occurring Substance Use = 17,201; Avoided Crisis = 109,227; Received First Service within 14 Days of Assessment = 62,597.

NUMBER OF CHILDREN SERVED at DSHS-Funded Community Mental Health Centers



Source: FY2003 = CARE Report HC028488, *TDMHMR MH Priority Population Counts by Month for 09-01-02 through 08-31-03*, prepared on 09/20/03, total is unduplicated; FY2004 = CARE Report HC028488, *TDMHMR MH Priority Population Counts by Month for 09-01-03 through 08-31-04*, prepared on 09/18/04, total is unduplicated; FY2005 = DSHS Mental Retardation and Behavioral Health Outpatient Warehouse, Business Objects Corporate Report, *LBB RDM Served for FY2005*, 08/01/06, used for LBB reporting for number of children receiving community mental health services per year (i.e., number who received a full RDM service package); FY2006 = DSHS Mental Retardation and Behavioral Health Outpatient Warehouse, Business Objects Corporate Report, *LBB RDM Served for FY2006*, 09/17/06, used for LBB reporting for number of children receiving community mental health services per year (i.e., number who received a full RDM service package).

among Children and Adolescents Assigned to a Full RDM Service Package at DSHS-Funded Community Mental Health Centers in FY2005 and FY2006



Source: FY2005 = DSHS Mental Retardation and Behavioral Health Outpatient Warehouse, Business Objects Corporate Report, *PM Child Outcomes Report for FY2005*, 11/30/05 (*Co-Occurring Substance Use*, 08/01/06), Business Objects Corporate Report, *PM Crisis Avoidance Report for FY2005*, 12/01/05, Business Objects Corporate Report, *PM Time Between Assessment and First Service Encounter Report for FY2005*, 12/01/05; FY2006 = DSHS Mental Retardation and Behavioral Health Outpatient Warehouse, Business Objects Corporate Report, *PM Adult Outcomes Report for FY2006*, 09/17/06, Business Objects Corporate Report, *PM Crisis Avoidance Report for FY2006*, 09/17/06, Business Objects Corporate Report, *PM Time Between Assessment and First Service Encounter Report for FY2006*, 09/17/06.

First Service Encounter Report for FY2006, 09/17/06.

FY2005 *N*s: Functioning, Problem Severity = 14,767; School Behavior = 8,421; Co-Occurring Substance Use = 1,708; Avoided Crisis = 26,213; Received First Service within 14 Days of Assessment = 17,400.

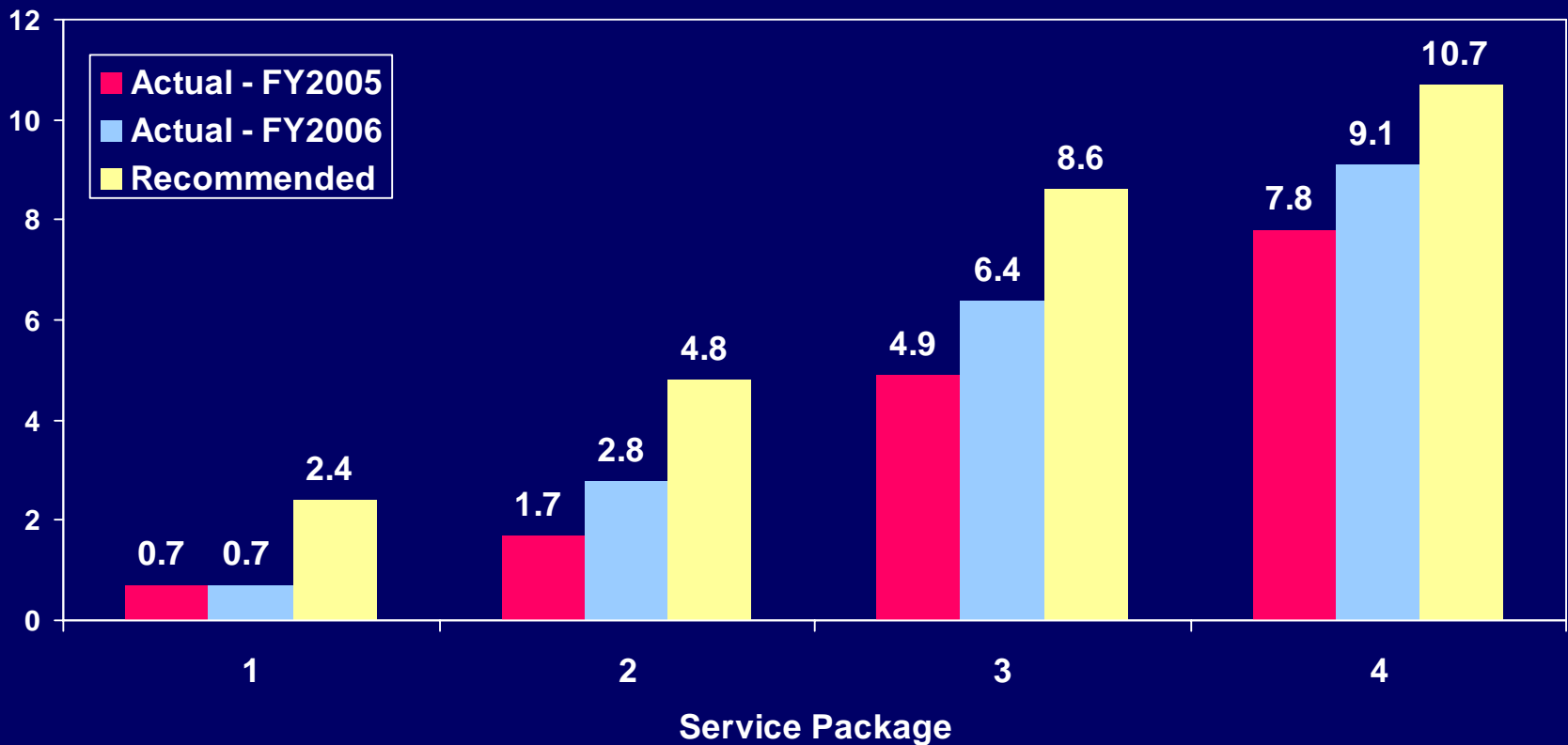
FY2006 *N*s: Functioning, Problem Severity = 16,905; School Behavior = 8,306; Co-Occurring Substance Use = 1,754; Avoided Crisis = 27,665; Received First Service within 14 Days of Assessment = 17,765.

Part 6

Challenges

ADHERENCE TO CLINICAL GUIDELINES

Recommended vs. Actual Average Monthly Service Hours per Adult in FY2005 and FY2006



Source: DSHS Mental Retardation and Behavioral Health Outpatient Warehouse, Business Objects Corporate Report, *UM Avg Client Hours by Svc Pkg*, 09/18/06.

ADHERENCE TO CLINICAL GUIDELINES

Recommended vs. Actual Average Monthly Service Hours per Child in FY2005 and FY2006



Source: DSHS Mental Retardation and Behavioral Health Outpatient Warehouse, Business Objects Corporate Report, *UM Avg Client Hours by Svc Pkg*, 09/18/06.

Key Components

- Evidence-based and consensus-based.
- Person centered – focus on outcomes.
- Continuity-of-care across levels.
- Information available on performance and outcomes.
- Utilization Management – right service, right amount.
- Flexibility.