REDUCTION OF CRISIS SERVICE RECIDIVISM:
ADAPTED INTERACTION MODEL

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What is Adapted Interaction?

Person-centered treatment interventions
3 years of supporting data, documenting positive changes. Reduction of crisis service recidivism.
What makes this different from any other staffing?
High Recidivists

Two or more crisis encounters within a 30 day time period
73% of the sample population had more than two crisis encounters in the last 30 days
Most crisis service utilization, may have been prevented.
Sample Population

More than 2 Crisis Encounters in 30 days

73%
Crisis Service Utilization

- Cost
- Time

Resources
Main Points

- Money
- Family
- Cracks in the Pavement
- Legal Leverage
Income
Does the client lack income?
Natural Supports

- “You must remember, family is often born of blood, but it doesn’t depend on blood. Nor is it exclusive of friendship. Family members can be your best friends, you know. And best friends, whether or not they are related to you, can be your family” - Trenton Lee Stewart, *The Mysterious Benedict Society*
Natural Supports
Who helps you?

“My Case Manager”

“No one”
Natural Supports

• Can we re-engage previously burned-out supports
  – Provide education on diagnosis
  – Provide education on boundaries
  – Help family find limited ways to re-engage in order to reduce burnout—write regular letters, Sunday dinner, attend the ART’s.
Natural Supports

- “After a good dinner one can forgive anybody, even one’s own relations”-Oscar Wilde

- “Happiness is having a large, loving, caring close-knit family in another city”-George Burns
Natural Supports

- 30 Days Prior
- 30 Days After
- 60 Days After
- 90 Days After
“Living with these behaviors on a daily basis had a profound effect on family members. Discord focused on the management of the illness; spouses often disagreed and blamed each other. Often a single family member bore the total burden... Emotional responses were high: Chronic stress, anxiety, grief, depression and unexpressed resentment” (Hatfield, 1979)
Transitions...they happen

How do we make them smoother?
Transition (inter-agency)

Recent transitions:

- New Case Manager (CM)
  - Average CM age is 26
  - Average length of employment for a CM is 3 years
70% Experienced a Case Manager Change
Transition (interagency)
Residential to outpatient treatment
Court Ordered Treatment to Independent
Loss of benefits/Income
Internal Transition

Change in treatment site (21% had changed sites in the year prior to their review)
Legal Leverage Court Ordered Treatment

- What goals might be accomplished using COT?
  - Injections
  - Case Management Appointments
  - Inpatient stabilization
  - Have they been on COT before? What were the results? What was their reaction to being on it? To coming off? Did the added structure help?
PCA: Impactful Variables:

A) Stayed out of hospital for 30 day period.
B) Kept outpatient appointments.
C) Medication Compliance
D) Abstained from substance abuse for 30 day period.
E) New willingness to attend group/treatment.
F) Stayed in recommended treatment.
G) “Pos.” = Yes.
H) “Neg.” = No.
Principal Component Analysis

Significantly positively correlated to favorable behaviors:

- Medication Compliance
- Abstinence from substances
  - Involuntary Treatment?
Main Points

- Clinical Team Dynamics
- Individualized Therapeutic Interventions
- Accountability, Monitoring, and Consequences
- Higher Levels of Care or Residential Treatment
Clinical Team Dynamics
Interpersonal Gaps
GENDER PREFERENCES
Demographic Differences

Graph showing age comparison:
- Age of CM: 26
- Age of Client: 52
Other Comparisons

Clients:
High School
Caucasian
Female

Staff:
Bachelor’s Degree
Caucasian
Female
What are the implications?

- Staff vs. client disparities
- Difficulty establishing rapport
- Staff burn-out
- Fear
Bridging the gaps

- Training, not just orientation
- How to be ‘ok’ with feeling uncomfortable
- The Rescuer (Karpman)
- Behaviors that solidify rapport
- Agency reduction or turn over
Appropriate Therapeutic Interventions

- Do you have an appropriate background and clinical profile on your client?
BE CREATIVE

- Trauma informed care
- MI
- Eclectic
- Behavior Interventions
- Paradoxical Therapy Practice
- EMDR?
DO YOUR AGENCY RESOURCES MEET THE NEEDS OF YOUR CLIENT?
You've got a problem with avoiding personal accountability.

Ya, and whose fault is that?
Accountability

- Set expectations up front during orientation
- Unified presence
- Experiential Strategies
- Positive Reward Paradigms
  - What systems do you have in place?
  - Meeting client where they are at
  - Have consequences been identified?
• Defining accountability
  – Why?
  – What does this look like?
Benefits of Confrontation

- Produce powerful steps of growth, especially at those times when the therapeutic relationship is stale
- Establishing an attainable goal
“I need a new way to get high....”
Level of Care

- Analysis of past interventions
- Succinct identification of a client’s needs
- Less restrictive levels of care
- Structure
- Complete continuum of care
  - Gaps in resources
A Fragmented Continuum

- Evaluate levels of care
- Focus on transition
- Proactive, not reactive
- Assess Subpopulations
Main Points

- Diagnostic Accuracy or Overshadowing?
  - Most Common Diagnoses
- A Reflective Multi-axial Classification
  - Assessing/Rule out Co-occurring Disorders
- Medication Review
  - Multiple factors
- Collaboration with Collaterals
  - "The Art of the ART"
“Our Family Dicho (Saying)"

“Para saber donde vas, tienes que saber de donde vienes.”

-Mama Nico

Paraphrase:

“In order to know where you are going, you must know where you’ve been.”
Diagnostic Accuracy or Overshadowing

• Is/Are current diagnosis(es) accurate or overshadowed?

- Integral piece of a 1st line review.
- Intake workers, PCP’s, therapists, agency prescribers, multiple hospital staff, etc.
- Collaborate, clarify, re-assess, and diagnosis.
- Independent assessment (i.e., consultant).
Most Common Diagnoses

- Post Traumatic Stress Disorder (PTSD)
  - Acute Stress Disorder
  - Substance Use/Dependence Disorder
- Major Depressive Disorder (MDD)
  - Recurrent- Moderate/Severe/Mild
- Opioid Dependence Disorder
- Schizoaffective Disorder
- Generalized Anxiety Disorder (GAD)
- Schizophrenia (Paranoid Type) Disorder
- Bipolar II & I Disorders
Sample Population Most Common Diagnoses

Primary Diagnosis

- SCHIZOAFFECTIVE: 26
- BIPOLAR: 16
- PTSD: 9
- SCHIZOPHRENIA; PAR TYPE: 7
- MAJOR DEPRESSIVE DIS: 7
Consider the Complexities

Co-occurring Disorders
Schizoaffective/PTSD

Schizoaffective

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<th>Condition</th>
<th>Count</th>
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<td>PTSD</td>
<td>6</td>
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<tr>
<td>Substance Abuse</td>
<td>11</td>
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A Reflective Multi-axial Classification
“Say what?”
Assess/Rule-out co-occurring disorders?

Assess/Rule-out complicated post trauma, substance abuse/dependence, traumatic brain injury (TBI), PDD, medical issues, etc.
Assess/Rule-out setting events/antecedents functions/motivations, gender, culture, etc.
“A house divided among itself, cannot stand.”

-A. Lincoln
Collaboration with Collaterals

- Invite and involve other important collaterals

- Make every attempt to including outside agencies into treatment planning or the Adult Recovery Team (ART) process.
Collaboration

- Public fiduciary
- OHR
- Payee services
- Mental Health Court
- Parole/Probation officer
- CPS/APS, Guardian, AHCCCS, ALTCS, Criminal Justice, Other CSP’s (applicable records?), etc.
Make every attempt to include outside agencies into treatment planning or the Adult Recovery Team (ART) process.
Set up a clear ART meeting agenda.

- Collaboration
  - Introductions
  - Progress Update
  - Team Treatment Planning
- Address Barriers
- Team Action Plan
Avoid Pitfalls
- Focus and reframe strengths/abilities
- Offer a new perspective
- Be realistically optimistic
- Be open and honest
- Invite impressions, etc.
Clarify strategies/interventions used.
“No hay un mal, que por un bien no venga.”

-Mama Nico

Paraphrase:

“Hope springs eternal.”
Overall Impact on Positive Behaviors

![Graph showing the relationship between Total Positive and Time Period (days). The graph indicates a positive correlation with data points scattered along a linear trend line.](image-url)
RESOURCES

- "Caring Confrontation" in Experiential Psychotherapy* 2006 Kathleen McGuire-Bouwman, Ph.D.


- American Journal of Community Psychology Vol 7 Number 5, 1979 Agnes B. Hatfield