A Holistic Approach to Care in Mental Health and Justice: Bringing service providers clients and families together

JULIE PAGLIARO, Justice And Mental Health Program Coordinator/Family Worker

IRINA SYTCHEVA, Policy And Advocacy Coordinator

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SCHIZOPHRENIA
SOCIETY OF ONTARIO
A REASON TO HOPE – THE MEANS TO COPE

Agenda

- About SSO
- Successful Community Integration
- Overview of Common Challenges
- Holistic Approach
- Promising Practices
- Working Together
- Let's Share

About SSO

Schizophrenia Society of Ontario

Mission

- We make a positive difference in the lives of people, families and communities affected by Schizophrenia and Psychotic Illnesses

Mandate

- Educate, Support, Advocate

JAMH–Justice and Mental Health Program

- **Mandate**: *To support families of people with mental illness who are in contact with the law while promoting change in mental health and justice*

- **Pillars**
  - Support
  - Education
  - Advocacy
  - Partnership

Why We Are Here

Criminalization

- Where a criminal, legal response overtakes a medical response to behaviour related to mental illness
- Looking to the justice system to help achieve what the mental health system cannot
  - Under-funded
  - Legally restricted
- A new type of revolving door
- Causal factors:
  - De-institutionalization
  - Poor access to treatment
  - Overly restrictive civil commitment laws

Successful Community Integration

What is Community Integration

- Entails helping individuals to move out of patient roles, treatment centers, segregated housing arrangements, and work enclaves, and enabling them to move toward independence, illness self-management, and "normal" adult roles in community settings
- External, concrete manifestation (viewable to the outside world) of the recovery experience

Benefits

- Intrinsic part of rehabilitation as stipulated by the correctional authorities
- Vital to mental health recovery

Factors and Dimensions

- While there is no single definition for community integration, a number of factors have been noted to promote effective CI:
  - Employment
  - Access to affordable and stable housing
  - Financial stability
  - Social/family support
  - Access to MH services and supports
  - Sense of belonging

Common Challenges

INDIVIDUALS,
FAMILIES,
SERVICE PROVIDERS

Access to Services

- Gaps in discharge planning
- Lack of service availability - system does not have capacity to meet need
- Double Stigma
  - Individuals with criminal histories labeled “high risk” and screened out of community programs and doctor’s offices
- Waiting list and intake procedures are also a barrier
  - Eligibility criteria, treatment approaches
- Transportation and challenges with getting to appointments

Communication

- Sectors work in silos
- Lack of education among different sectors and professionals – lack of common understanding
- Within each sector, services operate in silos
- Delayed , and/or partial information exchange
  - Contact info, treatment plan rarely recorded or shared
- Privacy laws
- Potential negative consequences of disclosure

(Re)Establishing Social Support Networks

- Isolated from family and friends
- Stigma and discrimination
- Unresolved family conflict
- “Fired” from services due to absence
- Difficulty navigating the mental health system
- Cut off from social supports – lose income supports and housing

Holistic Approach

What is Holistic Approach?

- Holistic Approach
  - Integration of the major systems that influence and dictate client care, well being and recovery
  - Addresses all of an individual's needs and aspirations as well as prevention, treatment and care
  - Improves client outcomes
- Care Coordination:
  - <u>Deliberate</u> integration of client care activities between <u>two or more participants</u> involved in client care to <u>facilitate appropriate delivery</u> of (health care) services (Bodenheimer, 2008). This includes multiple providers, clients and their families

Components of Holistic Approach

- Integration of all major systems involved- mental health facilities, hospitals, mental health social agencies, legal system (courts/police), the family and community
- Collaboration between health care professionals, correctional staff, clients and families
- Based on cooperation and open dialogue
- Prevention-focused

Partnerships – Pros and "Cons"

- Brings different people, agencies and values together
- Focus on shared challenges and opportunities
- Promotes holistic approach
- Incorporates different perspectives and expertise
- Builds interdisciplinary approach to care
- Fosters ability to respond quickly and efficiently
- Fosters better communication

- Time management and coordinating meeting times and dates
- Possible distraction from delivering services
- Who is accountable?
- Working in unfamiliar contexts
- Bullying decision-making and challenges with reaching consensus

Promising Models

“BEST” EVIDENCE FROM OTHER JURISDICTIONS

APIC

APIC Model - Assess, Plan, Identify, and Coordinate (APIC)

- Informs transition planning for people with co-occurring mental illness and substance use disorders, improves the chances of successful reentry, and reduce relapse and recidivism (Osher et al., 2002).
- Can be applied to the general jail population

APIC

APIC Key Components:

- **Assess** using standardized instruments, and quickly and comprehensively collect information on ind's social and clinical needs and public safety risks.
  - goal is to collect as much relevant information as possible in a short amount of time. When possible, update information and reassess needs prior to release.
- **Plan** at both the system and individual levels, plan for the treatment and services required to address identified needs
  - Know the problems and resources unique to your own community to appropriately and efficiently match needs with resources.
  - Incorporate the ind's perspective in the transition plan to make it more real for him or her.

APIC

- **Identify** community and correctional programs responsible for providing post-release services.
  - Ask who, what, when, where, and how.
  - Provide those in jail for 48 hours or less with a resource card
- **Coordinate** the transition plan to ensure that implementation occurs and gaps in the community are filled.
  - At the systems level, an oversight group must be responsible for coordinating the multidisciplinary action of all agencies involved.
  - Case management is a critical ingredient to successful transition plans, but because of limited resources, it may have to be prioritized for those most in need.

Project Link

- University-led community consortium
- Hybrid model of care that incorporates elements of three models of service delivery: assertive community treatment (ACT), the modified therapeutic community, and jail diversion.
- Functions as central locus for referral and entry
- Offers service level integration at multiple points within the criminal justice, healthcare and community support systems
- Goal: prevention of incarceration and the delivery of comprehensive MH care

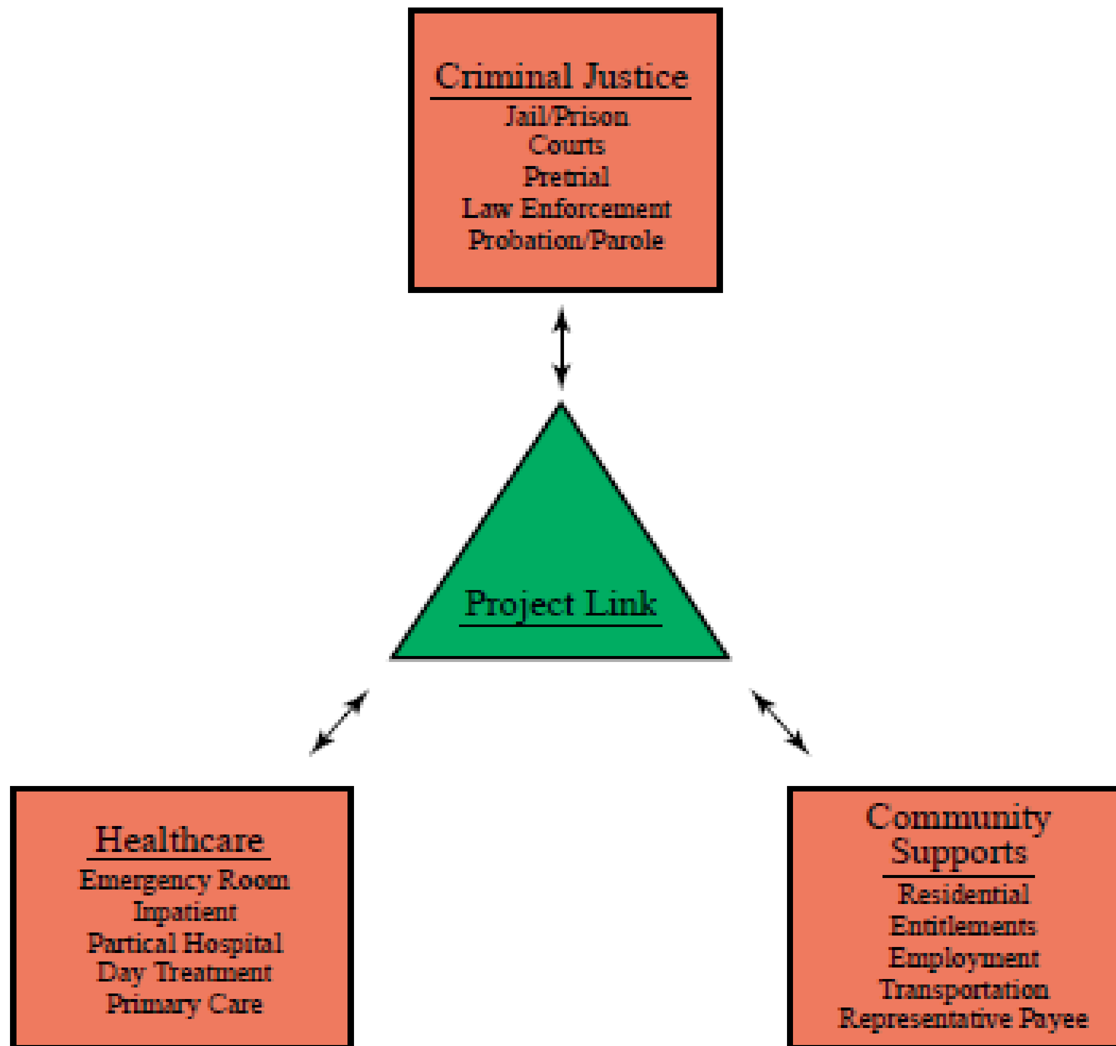

FIGURE 1. Multipoint service integration.

Source: Weisman, RL, Lamberti ,JS, & Price, N. (2004). Integrating criminal justice, community mental healthcare and support services for adults with severe mental disorders. Psychiatric Quarterly, 75(1).

Project Link

- Mobile treatment team (staffed by a forensic psychiatrist, nurse practitioner, and five bachelor’s level case advocates supervised by the team coordinator)
- Access to a concurrent disorders treatment residence
- Culturally competent staff
- And close coordination with the criminal justice system

Designated Case Management

- Montgomery County
  - Reentry collaborative case management team - group of county agencies and nonprofit organizations, probation and parole, and a consortium of faith-based groups and other post-release service providers
  - Work with inmates on release preparation and are responsible for service provision and follow-up after release
  - Meet biweekly to discuss opportunities and gaps in linkages and referrals for sentenced inmates who are within 90 days of release.

Family Engagement

Montgomery County's prerelease program

- Family engagement core element of reentry services
- Broad view of family to include not only immediate relatives but also friends and sometimes employers who are willing to take an active role in supporting an individual
- Key component - involving family early on in the development of a reentry plan
  - Within days of arrival into the program, the case manager will typically arrange for a meeting between the family member(s), the individual, and the case manager to develop a reentry plan that is formalized as a signed program contract.
  - If aspects of this contract are broken, the supporting family member, called the sponsor, will participate in a discussion about the infraction and possible courses of action

In-Reach

The Hampden County Public Health Model for Corrections :

- Bridges the gap in health care through in-reach
- Local health clinics realized that many of their patients were missing their appointments because they were incarcerated
- In response, the sheriff's department allowed health care providers to come into the jail to treat their chronically ill patients and set up community appointments after release.
- Jurisdictions around the country (US) are beginning to replicate this model

Other Models and Initiatives

Community-Oriented Correctional Health Services

- Nonprofit technical assistance and consulting organization that helps communities connect the health care provided in local correctional facilities with health care provided in the community
- Model is based on the Public Health Model for Corrections in Hampden County (Massachusetts) that brings staff from the community health center into local correctional facilities to treat inmates who will be returning to the community
- Creates a system in which correctional health care is an extension of the existing community health system
- Goal: to reduce the incidence of chronic disease and the cost of health care.
- For more information, visit the COCHS website www. cochs.org

Other Models and Initiatives

The Consensus Project

- Report (released in June 2002), as well as related projects and resources, available at http://consensusproject.org

Working Together

(TOWARD SHARED GOALS)

Individual is the Expert

- Its important to treat the client as an equal partner in their care
  - Client is the expert about their own illness, experience and needs
- Empowering people to be knowledgeable and active in managing their own illness is critical in successful recovery
- Shared decision making enhances the working relationship needed to optimize long-term outcomes
  - Increases the quality of decisions (knowledge, participation and congruence with values)

Communication Gaps Strategies

- Obtaining and sharing available resources
- Develop joint procedures together, protocols and services in MH and CJ
  - Ongoing interagency task force (leadership of MHS, local jail, court, police, probation, DA's office, and other relevant local authorities)
  - Develop interagency rules, regulations, policies
- Establish official partnerships to ensure joint goal accomplishments and accountability
- Reach out and connect with correctional service providers/connect with MH providers
- Meet with other providers involved in care of individual- engage one another in planning process/in-person meetings

Relationship-Building Strategies

- Encourage participation of informal support
    - request input from family members
- Communication among supports (formal and informal) willingness to communicate updates
- Familiarize self with roles of other service providers/community organizations and programs
- Be very clear with client about your role and the boundaries of your role, from the start of service
- Provide information to client on services needed that can not be provided directly but are offered through another agency

**Keep in mind teamwork and collaboration are central to good working relationships and best service delivery

Strategies for Working Together

- Share relevant information with community-based organizations, supervision agencies, family, criminal justice and families prior to release
- Share/obtain detention records and compile them in a reentry plan
    - Any assessments
    - Program completion or enrollment
    - Experiences during incarceration
    - Security levels
    - Past involvement with the social service system, if applicable
    - Areas of the transition process that need attention after release

Education and Training Strategies

- Cross training is of paramount importance!
  - Joint training goals and objectives
  - Collaborative, not playing the blame game
- Training for CJ service providers on signs and symptoms of MI and available services
- Training for MH service providers on CJ system and relevant laws and procedures
- Educating the community and building community awareness

Benefits of Including Families

Families play a key role in addressing issues upon release:

- Reduce anxiety, reinforce treatment (including proper use of medications)
- Decreased rates of hospitalization
- Decreased involvement with the criminal justice system
- Enhanced adherence to diversion or treatment plans
- Strong support network helps facilitate recovery
- Savings to system – don't need to rely on formal support mechanisms (housing, etc.)
- Can provide better security during bail and after discharge

How to Work with Families

- Involving families in care planning and decision making has been shown to have positive outcomes
- Principles for including families:
  - Create treatment goals in collaboration with families – these goals must be agreed upon and understood by all involved
  - Listen to families, treat them as partners – they have intimate knowledge of the client and are often de-facto caregivers on a 24/7 basis
  - Pay attention to the social as well as clinical needs of the individual
  - Encourage participation of family members, request input when considered necessary
  - Involve family in crisis planning and provide them with relevant info
  - Establish clear and simple communication ground rules

Privacy and Consent Strategies

- CJ is outside of circle of care
- Records may only be shared between MH and CJ if allowable exception:
  - Disclosure permitted to institution where person detained to assist in decisions regarding placement, detention, release, conditional release, discharge or conditional discharge.
  - Permissible to disclose that person is a patient
- But ….
  - Keep client's involved and informed and consent will come
  - Can share information (within reason)

Let's Share!

EVERYONE HERE IS AN EXPERT!!!

Questions?

Thank You!

Julie Pagliaro – jpagliaro@schizophrenia.on.ca
1-800-449-6367 ext. 249

Irina Sytcheva – isytcheva@schizophrenia.on.ca
1-800-449-6367 ext. 255