FINAL REPORT

for

THE SOLUTIONS BUILDING COMMUNITY COLLABORATIVE

A Demonstration Project Co-Sponsored by
San Diego Regional Center

and
San Diego County Behavioral Health Services

Submitted to:
San Diego Regional Center

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BACKGROUND

The field of Dual Diagnosis Developmental Disability – Mental Illness continues to grow as we learn more about the needs of this specialty population. Pilot projects, research and new resources are emerging that contribute to best practices in this field. The current issues for people with dual diagnosis have been dramatically influenced by the ongoing deinstitutionalization movement occurring in multiple service delivery systems.

In 1955, Congress passed the Mental Health Study Act which led to the establishment of the Joint Commission on Mental Illness and Mental Health. This led to the passage of The Community Mental Health Act (CMHA) (also known as the Community Mental Health Centers Construction Act, Mental Retardation Facilities and Construction Act, Public Law 88-164, or the Mental Retardation and Community Mental Health Centers Construction Act of 1963). This became the major impetus behind the de-Institutionalization movement which continues to this day. The ongoing success of this movement has increased the number of person with complex needs residing in their local communities. It has created opportunities for persons that heretofore, were limited in their abilities to exercise personal choice and self determination. It has also highlighted the weaknesses in our community service delivery systems when individuals with complex needs seek entitled and publicly funded supports and services. Many of these individuals require supports and services from more than one system of care. In recent years, the literature is rich with research and discussion in this regard. In particular, the critical need for collaboration among the systems when an individual requires multi-systems services.

Some of these challenges that we face today, are particularly highlighted below in an excerpt from a Supreme Court Report of 2007. While this particular report focuses primarily on persons with mental health challenges, the issues outlined and the history highlighted, follows the same path for persons with developmental disabilities and persons dually diagnosed.

“200 years ago, people with severe and disabling mental illnesses in the United States were often confined under cruel and inhumane conditions in jails. This was largely due to the fact that no alternative system of competent mental health treatment existed. During the 1800’s, a movement known as moral treatment emerged that sought to hospitalize and treat individuals with mental illnesses rather than simply incarcerating them. The first state psychiatric hospitals were opened in the United States during the 1800’s, and were intended to serve as more appropriate and compassionate alternatives to the neglect and abuse associated with incarceration. Unfortunately, overcrowding at these institutions, inadequate staff, and lack of effective treatment programs eventually resulted in facilities being able to provide little more than custodial care. Furthermore, physical and mental abuses became common and the widespread use of physical restraints such as straight-jackets and chains deprived patients of their dignity and freedom. The asylums intended to be humane refuges for the suffering had instead turned into houses of horrors.

1 http://www.nih.gov/about/almanac/organization/NIMH.htm
By the mid-1900’s, more than a half million people were housed in state psychiatric hospitals across the United States. The system was stretched beyond its limits and states desperately needed some alternative to addressing this costly and ever-expanding crisis. Around this same time, the first effective medications for treating symptoms of psychosis were being developed, lending further support to the emerging belief that people with serious mental illnesses could be treated more effectively and humanely in the community. This period marked the beginning of the community mental health movement.

In 1963, Congress passed the Community Mental Health Centers Act which was intended to create a network of community-based mental health providers that would replace failing and costly state hospitals, and integrate people with mental illnesses back into their home communities with comprehensive treatment and services. In what would be his last public bill signing, President Kennedy signed $3 billion authorization to support this movement from institutional to community-based treatment. Tragically, following President Kennedy’s assassination and the escalation of the Vietnam War, not one penny of this authorization was ever appropriated.

As more light was shed on the horrific treatment people received in state psychiatric hospitals, along with the hope offered by the availability of new and effective medications, a flurry of federal lawsuits were filed against states which ultimately resulted in the deinstitutionalization of public mental health care. Unfortunately, there was no organized or adequate network of community mental health centers to receive and absorb these newly displaced individuals.

The fact that a comprehensive network of community mental health services was never established following deinstitutionalization has resulted in a fragmented continuum of care that has failed to adequately integrate services, providers, or systems; leaving enormous gaps in treatment and disparities in access to care. Furthermore, the community mental health system that was developed was not designed to serve the needs of individuals who experience the most chronic and severe manifestations of mental illness. Lack of strategic funding and programming, and adherence to treatment guidelines that do not necessarily reflect current best practices have affected certain segments of the population in particularly devastating ways.

For many individuals unable to access care in the community, the only option to receive treatment is by accessing care through the some of the most costly and inefficient points of entry into the healthcare delivery system including emergency rooms, acute crisis services, and ultimately the juvenile and criminal justice systems.

There are two ironies in this chronology that have resulted in the fundamental failure to achieve the goals of the community mental health movement and allowed history to repeat itself in costly and unnecessary ways. First, despite enormous scientific advances, treatment for severe and persistent mental illnesses was never deinstitutionalized, but rather was transinstituionalized from state psychiatric hospitals to jails and prisons. Second, because no comprehensive and competent community mental health treatment system was ever developed, jails and prisons once again function as de facto mental health institutions for people with severe and disabling mental illnesses. In two centuries, we
have come full circle, and today our jails are once again psychiatric warehouses.”3 (Supreme Court Report 2007)

Recent research and pilot efforts have done much to mitigate this issue of transinstitutionalization and to provide quality care to persons with complex needs. This project is one of those efforts. However we can see in our own state where transinstitutionalization continues to put pressure on multiple systems including California’s Regional Centers, County Mental Health services, jails, prisons, hospitals, emergency rooms, local law enforcement, and crisis teams.

As we support the continued efforts of the deinstitutionalization movement, the numbers of individuals with serious mental illness returning to the community and working to maintain community tenure has dramatically risen in recent years. In our own state, this has been coupled with little to no increase in budget dollars for core services in the California mental health system to meet these needs.4

In discussing these issues in the field of developmental disabilities, Beadle-Brown et. al5 notes that supporting movement from institutions to community settings continues to demonstrate that outcomes are better in the community than in the institution. However, it does not bring about automatic improvement in quality of life or access to effective healthcare and treatment. These transitions clearly require proactive and thoughtful consideration with adequate support including funding from multiple systems.

As in the field of mental health, the individuals who remain in developmental centers or other institutional settings and are now re-entering the community, are often those individuals with dual diagnoses or other very complex and challenging needs. This has required proactive and innovative planning to provide quality care in community settings.

Our approach to care for these individuals with dual diagnosis historically offers services in separate and distinct systems, commonly referred to as silo’d systems. This means specific systems provide specialized expertise in treatment and services for individuals with a common designated diagnosis. However, when providing services to individuals living with complex needs, dually or triply diagnosed, these systems are pressed to provide ad hoc adaptations to their unique areas of expertise. This often results in fragmented services and sometimes minimally effective care. This is also challenging for the individual recipients of care who must make sense of individual and often disparate messages about their treatment and care from multiple systems. These challenges have often resulted in an increased need for care that results in overlapping care by multiple systems, naturally raising the overall cost of care to meet the same needs.

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A statewide needs assessment was conducted in 2005-2006\textsuperscript{6} that included providing a more detailed profile of the individuals in California who are dually diagnosed. This report also included research of current successful models serving individuals with complex needs. Each of the models cited offered a continuum of services. The continuum of services model is a strategy that requires a multi-systems approach and long-term investment and development by all allied stakeholders. These models reported developing a network or continuum of services that creates opportunities for independence, self-determination and community integration for individuals with difficult to serve needs, using existing partnerships and creating new ones where none exist.

\textsuperscript{6}http://www.mosaiclink.org/documents/SERVING_THE_DIFFICULT_TO SERVE.INITIAL_REPORT.01.12.06.pdf
The Solutions Building Community Collaborative

The Solutions Building Community Collaborative (SBCC) is a demonstration project that began in January of 2007. The demonstration portion of the project came to a close in March, 2012. This report summarizes efforts to date, along with recommendations for the Collaborative to continue using existing funding streams and agencies to provide specialty services for persons dually or triply served in San Diego County. The Collaborative has been very successful, in part due to the history of committed efforts by the local Regional Center and Mental Health System to think creatively about ways to work together to meet the needs of San Diego’s citizens. This final report summarizes the project’s work and outcomes.

PROJECT GOALS

The purpose of the project was two-fold. First, using a successful model of collaboration cited in the research, the project considered the effectiveness of specific support and treatment strategies for persons with multiple diagnosis served by more than one system of care. Second, the project evaluated what aspects of this demonstration project could be replicated on a more permanent basis by the systems of care serving persons with dual diagnosis, thus contributing to emerging best practices in this specialty field.

According to John W. Jacobson, Ph.D., BCBA, James A. Mulick, Ph.D., Steve Holburn, Ph.D., “no special needs group among people with mental retardation and developmental disabilities strains the service capacity of community and residential services to a greater extent than do people with dual diagnoses of developmental and psychiatric conditions”. This has become particularly evident with the continued success of the de-institutionalization movement. More individuals are returning to their local communities from institutional settings and many others who would previously have been referred to institutional settings, are remaining in their communities. Thus, community based supports and services in all systems, are challenged to successfully support individuals with these complex needs, to live their lives with dignity and self determination. Based upon research of successful efforts in this area, the project was developed using the model of the Dual Diagnosis Consultation and Outreach Teams in Ontario Canada. The specific objectives and strategies used in the collaborative were designed to test and measure areas of success as well as identify areas for potential replication and areas where continued research and innovative approaches are needed in community based services and supports.

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7 Dual Diagnosis Consultation and Outreach Team (DDCOT); [http://www.providencecare.ca/objects/content_revision/download.cfm/revision_id.183362/workspace_id.-4/DDCOT%20Brochure.pdf/]  
8 See ATTACHMENT L for Project Overview including Goals and Objectives  
9 [http://www.thenadd.org/pages/products/bookdetails/pm02-003b.shtml]  
10 Statewide needs assessment
The three basic strategies to meet these objectives were: Community Education, Crisis Care Coordination, and Cross Systems Planning. These strategies as well as all project work are directed by the Project Steering Committee.

PROJECT STEERING COMMITTEE

The Steering Committee is made up of representatives from key systems including the San Diego Regional Center, County Behavioral Health services, County Crisis Programs, Police Emergency Response Teams, County Hospital staff, Healthcare Management staff, a Mental Health agency and the Project Director. The strategies developed by the Steering Committee were implemented by the Support Assessment and Treatment (SAT) Team. This team was comprised of experts in multiple systems of care including the Project Director, two psychiatrists, a psychologist and behavior specialist, a mental health navigator, a forensic navigator, a substance use disorders navigator, and a developmental disabilities navigator. The project was delivered in three phases.

PHASE I

In Phase I, the focus was on treatment strategies for persons with dual diagnosis who were high frequency, high intensity users of the county’s emergency medical response systems, including police, 911, emergency rooms and psychiatric hospitalizations.

In Phase I, the first strategy of comprehensive education in dual diagnosis to all interested community stakeholders was implemented. The second strategy was to provide expert consultation and assessment for project participants using a Specialty Assessment and Treatment (SAT) team. The third strategy was to create cross systems plans including a crisis care coordination protocol. These plans were then distributed to multiple systems with regular updates.

Phase I spanned the 30 months between January, 2007 and June, 2009. In support of comprehensive community education, this project provided 83 presentations to the community including hospital emergency room personnel, hospital psychiatric inpatient and outpatient programs, residential providers, board and care operators, county and regional center staff, day programs, clubhouses, administrative committees, and regional and statewide presentations to various systems. In addition, two large conferences were held in San Diego (2008) and in Ontario (2009) with a total of over 500 attending from multiple systems of care.

The Project began taking referrals for participants in June 2007. The project has averaged about one referral a month with a total of 25 participants as of April 30, 2009. Referrals were from several community sources, including Regional Center service coordinators, county programs, the San Diego Probation Department, hospital staff, and one family member.

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11 See Attachment K for more detail
12 Attachment D
COMMUNITY REFERRALS GROW

As awareness of the project grew, ‘non participant’ consultations also occurred with various systems. These systems included local area hospitals, the probation department and regional center staff requesting assistance from the SAT team. These requests were on behalf of individuals who did not necessarily meet the initial project criteria, but were nevertheless dually diagnosed and at risk of losing certain community services or the ability to remain living in the community. The SAT team responded with consultation, training and systems navigation. These additional consultations averaged approximately one per month with 19 consultations as of April 30, 2009.

The Project continued this same rate of referrals through December 2011 with an average of approximately one project referral a month (N=67/52) and an average of one informal or ‘non participant’ consultation a month (N=55).

PHASE I STATISTICS

For the 22 months through October, 2008, the following statistics were reported:

- 86% of project participants had a diagnosis of mild intellectual disability
- 71% of participants having a diagnosis of schizoaffective/mood disorders NOS.
- 42% of all persons referred were transition age youth (16 to 24 years of age)
- 36% of all participants were triply diagnosed with additional substance abuse related disorders
- 31% diagnosed with borderline traits
- 28% have forensic involvement
- 23% have antisocial traits
- The median number of medications used per participant is 8, with the median number of psychotropic medications at 4 per person.
- Poly Pharmacy is an issue for many, with one person having 42 prescriptions due to access to many different emergency medical services at the time she joined the project.

For the 29 months from June 2007 through May 2009, these additional statistics were noted:

- 5 participants had moved into or returned to a locked setting (developmental center or jail). 3 of these individuals were transition age youth.
- At 29 months, 39% of all referred continue to be transition age youth.

OUTCOME DATA

- While sample size and project duration were too small for complete statistical analysis, comparison of participant prior histories and project participation suggests that their need for crisis services was reduced and their ability to maintain community tenure was improved. However, overall the length of stay for hospital and crisis house visits could not be clearly connected to project participation. In one example, intensive focused intervention and support reduced hospital stays to zero for one participant. Nonetheless,

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13 67 persons were referred as of December 12, 2011. Some referrals required a short consultation, typically systems navigation. 52 referrals were provided complete assessment and intervention by the team.
their high risk behavior in the community resulted in the individual being transferred to a
locked setting for longer term stabilization. On the other hand, intensive wrap around
services for another participant prevented a ‘third strike’ arrest that would have resulted in
a prison sentence. These wrap around services supported the longest period of sobriety in
her life with reports ranging from 6 to 9 months. This 48 year old woman with moderate
intellectual disability and a major Axis I disorder continues to live in the community with
intensive support from mental health, regional center and probation services.

At 59 months, (Dec 2011); 39% of persons referred to the Solutions Building Project, continue to be Transition Age Youth (ages 16-24).

NEW RESOURCES FOR DUALLY SERVED ADULTS

During Phase I, the project identified new tools and treatment strategies that are as effective in
supporting individuals with Dual Diagnoses. These are:

* Wellness Recovery Action Plan (WRAP)\(^{14}\)
* Dr. Sweetland’s Intervention Structure\(^{15}\)
* Reiss motivational profile of basic needs\(^{16}\)
*The SKILLS System- Emotion Regulation for all abilities

The WRAP has been a very successful tool in the mental health system, and with minor accommodations
for persons with developmental disabilities, this was a very useful tool for many of the project
participants. The Federal Substance Abuse Mental Health Services Administration recently has added
WRAP to the National Registry of Evidence-Based Programs and Practices after reviewing compelling
research about how WRAP is changing peoples’ lives.\(^{17}\)

The project also identified Dialectical Behavior Therapy (DBT), as a much needed support for individuals
with a dual diagnosis with emotion regulation challenges. Persons with Intellectual Disability receive
more benefit from this type of treatment strategy if adapted. Research in this area found that the Skills System\(^{18}\) had strong supporting data with very positive outcomes. This approach was piloted with great
success in Phase III.\(^{19}\)

COMMUNITY EDUCATION AND NETWORKING

\(^{14}\) http://www.copelandcenter.com

\(^{15}\) Attachment D

\(^{16}\) http://www.idspublishing.com/reiss.htm; see also Attachment F for a sample Reiss Profile used in SBCC

\(^{17}\) https://docs.google.com/present/view?id=dv7p5zx_318gjc6bdfz

\(^{18}\) www.theskillssystem.com

\(^{19}\) Attachment G Skills Pilot Summary
As a result of the comprehensive education provided in Phase I, including ongoing requests for further education, the project began development of a 30 hour **Certificate of Excellence** including 7 classes in best practice for persons with dual diagnosis. The first class in this effort was taught in December, 2009.

**At 60 months, a total of 25 face to face classes have been taught with 4 primary instructors.**

The Certificate of Excellence has been received with enthusiasm by all community partners. Along side of this education program was extensive provider training for direct care staff.

**At 60 months, a total of 19 Provider Training sessions have been offered to date with two primary instructors.**

To accommodate the steady requests for continued education, the development of Online Training in the Certificate of Excellence began in Phase III of the project.

**At 60 months, the Certificate of Excellence Online Training became available at www.solutionsbuilding.org**

In all three Phases, the project provided extensive education to various stakeholders with over 3,000 persons receiving training to date. For a detailed list of these trainings and attendance figures, please see Attachment E.  

**ADDITIONAL PROJECT OUTCOMES AND COMPELLING DATA**

In analyzing project data from January 2007 to May 2012, the outcomes support the research that Cross Systems Plans, Intervention and Collaboration enhances the abilities of individuals with complex needs to cope with day to day life stressors in meaningful and productive ways. Cross systems networking and interventions created key examples of how such coordination reduces overlapping care across systems, improves crisis care coordination and increases community tenure and of course, reduces public funding costs for all systems.

For example, a common outcome of striving for appropriate supports and services, unfortunately, is a **high rate of residential changes**, and a relatively **high number of psychiatric hospital inpatient stays** compared to the general population.

The project collected data to assess whether the strategy of using a team of experts from multiple systems would impact this particular outcome. Residential changes and psychiatric stays from all three phases compared the number of residential changes two years prior to a SAT team referral and intervention to two years after this type of treatment strategy.

**The data providing compelling support that a Support Assessment and Treatment team provided by persons from multiple systems in a closely knit approach dramatically reduces numbers of residential placements as well as numbers of inpatient hospital stays.** See below

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20 Attachment E Summary of Community Education
Most of the persons required less placements or hospitalizations after the SAT intervention than needed before the intervention. This is evidenced by a negative value for the change value, which is the vertical axis of the graphs. Furthermore, the greater the number of placements or hospitalizations before SAT intervention (horizontal axis), the greater the impact of the SAT intervention. A linear relationship was observed. In addition, the data for the Phase I group falls on the same line as the Phase II and III groups, demonstrating that a similar impact was obtained for persons in either phase with similar levels of pre-intervention placements.

PRE VS. POST DATA SUMMARY

1. In other words, when comparing pre vs. post intervention by the SAT team with regard to Psychiatric Admissions, the following was observed:

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21 These data and discussion also available in Attachment H
3 people stayed the same

1 person had 5 more admissions

7 people had a total of 60 FEWER admissions

This means there was a total of 55 fewer psychiatric hospital admissions the two years after the SAT team became involved.

(The actual total is 76 fewer admissions, but that one individual was eventually moved to a locked secure setting so this data point was removed.)

2. The number of Residential Changes was also significantly reduced.

MEDICATIONS AND POLYPHARMACY

In considering other factors that may influence community tenure for persons with dual diagnosis, data was collected regarding the number and types of medications persons with dual diagnoses were prescribed. For all Phases, this number remained fairly constant. The range of medications prescribed was from 0 to 16 concurrent medications. The average number of medications in Phase I was 8 and in Phases II and III, it was 7. The average number of psychotropic medications in all three phases was 4.

This number of medications was due in part to frequent hospital visits combined with poor self report of medications currently taken when seen during any given hospital visit. This resulted in poly pharmacy issues for many individuals. Given the high number of medications, it was at times, difficult for the medical professionals in the community to reliably assess presenting symptomatology for some individuals. Were new symptoms the result of new medications added, other medications changed or individuals reliably taking medications as prescribed given the high number of concurrent prescriptions?

The importance of caregivers assisting individuals with reporting accurate medications, and their administration practices to physicians and emergency personnel is critical to assisting medical professionals in accurately assessing symptoms and prescribing appropriate medications for treatment. This strategy was covered in all community education settings for both caregivers and medical and clinical professionals. Many caregivers do not realize that they hold critical information for the medical community that can aid in accurate diagnosis and treatment. As well, many in the medical community do not always seek out this information assuming that the individual can accurately self-report their symptoms and treatment regime. The recognition that primary caregivers and direct care staff must be considered a critical part of the treatment team continues to be a consideration for awareness.

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22 See ATTACHMENT B for detailed information on medications
CONCLUSIONS AND RECOMMENDATIONS FOR REPLICATION OF THIS MODEL

The benefit of coordinating care across systems is well documented in research regarding multiple systems of care. While this list is not all inclusive, key systems include:

- Regional Centers
- County Behavioral Health Services
- Police and Police Emergency Response Teams
- Alcohol and Drug System, Social Services
- Probation
- Public Defenders
- District and City Attorneys
- Judges
- Hospital Emergency Rooms
- Walk in Assessment Centers
- Hospital Acute Care Services
- Psychiatric Inpatient Services
- Partial Hospitalization Services
- Intensive Outpatient Programs
- Outpatient Treating Psychiatrists
- Community General Practitioners of Medicine

The three phases of the project provided extensive opportunities to examine ways to provide support, assessment and treatment to individuals with dual diagnosis.

The conclusion of The Solutions Building Project is that expertise in dual diagnosis and using key strategies can significantly impact the quality of care provided to the individual. Also, these strategies can be easily implemented, using existing funding streams in multiple systems.

These detailed findings can be best summarized as seven effective strategies in Cross Systems collaboration.

These strategies are:

1. **Engage Systems Support through Data, Research and Identified Needs and Create a Proposed Plan.** The SBCC has attempted to provide thorough data in each of the above areas. The data to date is particularly compelling when you consider the significant reduction in residential changes, and psychiatric admissions. It is also informative to note the large percentage of Transition Age Youth referrals and the challenges in medication administration and polypharmacy. The Research informed the model that the project chose for implementing project strategies.

23 See ATTACHMENT M for the powerpoint presentation that provides more detailed examples of each strategy discussed.
This strategy of using experts from multiple systems contributed significantly to the success of the project’s goals and objectives. Project implementation and careful data collection served to inform the Steering Committee of areas or identified needs for new resources. These successes could be replicated with existing funding primarily by in-kind contributions of time to serve on a once a month consultation committee focused on dually and triply served individuals that require cross systems collaboration to succeed in their communities.

This information was originally used to design the demonstration project and we can use this same strategy to discuss a proposed plan for sustainability.

2. **Steering Committee.** The decision to form a Steering Committee with representatives from key community stakeholders provided a necessary anchor for Project decisions. Having key decision makers from multiple systems engendered partnership and education regarding each system's roles and responsibilities. Administrators from key systems balanced decision making ability, systems navigation, and advocacy when considering minor adaptations to existing policies that would streamline care and reduce costs.

3. **Support Assessment and Treatment (SAT) Team.** Using this model created a knowledgeable team of experts that could not only provide assessment, training and education, but also increased access to eligible services through systems navigation.

4. **Crisis Care Coordination Across Systems.** The use of Crisis Care plans to summarize services from multiple systems, provided key contact information as well as up to date medical, psychiatric and clinical assessments that enhanced appropriate crisis care. In Phase I these plans were highlighted in the tracking system that authorized Medi-cal funded hospital stays. This was less useful than anticipated. The Plans tended to be directed toward utilization review nurses and social workers. They were not always given to the inpatient treating physician. However, the inclusion of escalation hierarchy strategies for each person contributed to reduced calls to all, hospitalizations, and ER visits.

5. **Community Education.** One of the unexpected outcomes of the project was the intense and lasting interest in receiving more training in this specialty area. Individuals with multiple challenges require expertise in more than one area. Practitioners, direct care staff and administrators all recognized the need for education in this area. The SAT Team’s expertise and training was welcomed in all relevant venues from the projects start date.

6. **Resource Development.** The benefit of cross systems support, data, research, a steering committee, and SAT team was the ability to accurately assess where resource development was needed. The Reiss profile was an important tool in assessing motivation for persons with complex behavioral expressions. The WRAP provided a reliable tool of empowerment for individuals who must report their needs, symptoms and services multiple times in many different places. This tool gave individuals an opportunity to direct some of their care by documenting effective supports when they were in a more stable place of well being. The SKILLS pilot project in Phase III was very successful in helping individuals with emotion
7. Replication and Sustainability. As mentioned earlier, a primary goal of the demonstration project was to test and measure strategies for this population that could be replicated and sustained beyond a demonstration project structure and funding. Prior to discussing replication and sustainability, the project’s challenges are presented.

a. Personal Investment. The project has seen tremendous success in the strategies used for the past five years. However, key factors in a participant’s success are their willingness to receive training and intervention offered and to try new therapies, strategies, and support services. The number of individuals unwilling to do so was very small in the project (less than 10%). Notably, most of these individuals often had a triple diagnosis with substance use related disorders and were not yet ready to be sober.

b. Changing staff. Regardless of the system, there is frequent staff turnover, especially in direct care positions. This requires commitment to provide continual education in this area. The project provided 26 Provider Trainings, with a target audience of direct care professionals in all systems. Trainings were repeated in all parts of the county over three years with new staff being trained on all occasions. Requests for this training were made from hospital staff, San Diego Probation, the Courts, the county jails, the Regional Center’s service providers, (AOD) counselors and mental health contractors. With the increasing number of individuals with complex needs seeking community based services, ongoing education in this area is essential. The Online Certificate of Excellence in Dual Diagnosis provides one sustaining source of education for changing staff.

c. Engaging Professional expertise at a Medi-Cal rate. Engaging staff to provide this specialty intensive service at a rate that is drastically below the market rate for licensed practitioners was a challenge. This can be mitigated if decision makers consider the data. Providing effective services reduces overlapping care and reduces each system’s costs. This ‘specialty consultation’ may need to be funded by individual systems but much of it can be provided by using in-kind contribution of staff time. When necessary, braiding funding is the practical solution because individuals that are difficult to serve use multiple systems. The cost of funding this type of consultation at a market rate would not exceed the cost of multiple ER triage visits, ambulance, police response to 911 calls and inpatient hospital stays. Much of the work of a SAT team can be accomplished using existing professionals from multiple systems to consult on uniquely difficult cases on a monthly basis. This was the strategy used by the SAT team, and this short amount of time in attention/consultation provided dramatic reductions in chaotic lifestyles and systems’ costs.

d. Shortage of Psychiatric Care. The nature of this specialty population requires more time for assessment and intervention and more intensive follow along care. It is strongly recommended that training in this area be part of curriculum and internships for medical and clinical professionals. If medical and other students preparing for the
health care fields do not recognize that persons with complex needs will require more intensive intervention, there will continue to be a shortage of professionals in this area.

A shortage of appropriate psychiatric care results in revolving door visits to ERs and Hospitals, as well as calls to the EMS system, where the community safety net cannot say ‘no’. As mentioned earlier, this contributes to transinstitutionalization and seeking appropriate medical and psychiatric care through some of the most costly healthcare portals in our community.

The practice of Telepsychiatry also offers an opportunity to provide these specialty services to persons with chaotic lifestyles without visiting a doctor’s office but using other frequently visiting offices such as a therapist, social worker or community based programs.

e. **Need for New Resources.** This demonstration project has provided clear evidence of the benefit of identifying needed resources and thinking creatively about ways to provide them. The cost of using the WRAP and adapting it for persons with intellectual disability is inexpensive ($10 for a WRAP book). The cost of using the Reiss Profile to inform staff about a person’s motivational sensitivities is about $6.00 for the first 25 people and then about $1.50 for ongoing protocols and online summaries and scorings. The cost of providing SKILLS training can be negotiated, but would be similar to the cost of skills training in a Regional Center budget or DBT training in a County budget and the impact represents reduced costs in accessing the Emergency Medical System (EMS).

Regarding a plan for Replication and Sustainability; the data, research, and identified needs are clear. The plan needs to be an Integrated Service Delivery model. Knowing exactly how to do that is not always clear. This demonstration project gives step by step examples of what and how to do reach this goal. Taking a last look at literature we see another step by step proposal of integrating service delivery that is consistent with project outcomes. This was provided by the Center for Law and Social Policy (CLASP) CLASP outlines 5 key elements in an integrated service delivery system.

1. **The first is a Single Point of Entry or ‘no wrong door’**. Ideally individuals should be afforded access to other supports and services in other systems regardless of the system where initially support was sought. While a consideration is that the person be eligible for those services under existing policies and procedures, the SBCC project found that in most cases, individuals were indeed eligible for services. However, due to lack of communication or misunderstanding or lack of education about dual diagnosis, access was denied to individuals who were entitled to services. Systems navigation was key in this regard. It served to provide information, training and enhanced communication across systems. Often, individuals were turned away for services

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24 CLASP; Center for Law and Social Policy; 1015 15th Street,NW, Suite 400, Washington, DC 20005 [www.clasp.org](http://www.clasp.org)
due to misunderstandings about dual diagnosis and that one system does not serve all of an individual’s needs if they have dual or triple diagnoses.

2. **The second element is Comprehensive Assessment.** Critical to making an appropriate plan with effective recommendations is a comprehensive assessment of needs and services.

3. **The third element is Joint Case Planning.** The demonstration project has provided clear evidence that cross systems plans that include a comprehensive assessment of all needs facilitates coordinated care and increases the possibility of maintaining community tenure and decreases the need for overlapping care and increased costs.

4. **The fourth element is Co-Location.** Ideally services for dually or triply served individuals could be provided in one location to eliminate extra costs associated with multiple locations. Another consideration is to have a ‘virtual’ co-location as was the case with the SAT Team who were not housed in a bricks and mortar location, rather traveled to the individual’s location or provided separate expertise and collaborated and wrote reports using electronic media.

5. **The fifth element is A Sense of Partnership.** If direct care staff and professionals in multiple systems can use a cross systems team of experts, the sense of partnership is greatly enhance as there is one ‘hub’ of communication, assessment, training and support that uses navigation to reach day to day staff. Ideally, creating a system with any or all of the elements above contributes to this sense of partnership. Another consideration is to use a Cross Systems Steering Committee similar to what was used in the demonstration project with good success.

Every local area is different with different histories among systems and differing track records of collaboration. This project has provided several key strategies including Cross Systems Planning, Crisis Care Coordination and Community Education under the direction of a cross systems Steering Committee.

Regardless of the location, community education could be replicated. One of outcomes of the SBCC project is online training in dual diagnosis. This can be accessed and used by any system with internet capabilities. If funding cuts and shortages are a consideration for any or all of the systems used by persons with a dual diagnosis, Cross Systems coordination has been demonstrated to reduce hospital stays and enhance skills in emotion regulation. Both of these outcomes represent cost savings measures. With the close of Phase III, evaluation and consideration of the project work yields the following conclusion which is the same conclusion discussed in the Phase I summary report.

“Replication of this project in other parts of the state will require Regional Centers, County Mental Health, Probation and Hospitals to be willing to work on Cross Systems Assessment, Consultation, Systems Navigation, and Cross Systems training.

Such an effort is greatly enhanced by the use of a Cross Systems Team (the SAT Team). This approach will be best served by braiding funding from multiple systems to support investment in the effort. Braiding funding is the cost effective approach. The previously held arguments that dually diagnosed individuals ‘belong’ to one system or another and thus are the sole funding responsibility of one given system, simply has not been successful. With or without a given system’s knowledge, individuals with multiple diagnoses are seeking expert help from multiple systems of care to meet their needs.
Without collaboration, multiple systems will continue to duplicate their care efforts and provide adaptations to treatment creating fragmented services to individuals. Individuals must then add to their challenges, the challenge of navigating multiple and often disparate messages about their care. This fragmented approach does not protect budget dollars, it squanders them. This fragmented approach does not provide the best care possible. The best care possible draws from the expertise of many systems and is provided in an integrated and collaborative fashion.”

---

25 Excerpt from ATTACHMENT J
# Intervention Structure

<table>
<thead>
<tr>
<th>TRIAGE</th>
<th>CRISIS STABILIZATION</th>
<th>ENRICHMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive assessment and recommendations</td>
<td>Comprehensive assessment and recommendations with follow-up</td>
<td>Monitoring and follow-up as needed</td>
</tr>
</tbody>
</table>

## Behavioral Profile

**TRIAGE**
- Recent frequent hospitalizations
- Recent unsuccessful residential experience
- Current significant depression
- Current expressions of feeling unsafe
- Recent unsafe behavioral reactions to depression or anger
- Recent police involvement
- Need for continual monitoring and support from outside person

**CRISIS STABILIZATION**
- History of successful periods without hospitalization
- History of successful residential experiences
- Current significant depression
- Current thoughts of feeling unsafe
- Is accepting of learning new ways of coping with unsafe thoughts
- Is able to seek out support and monitoring from outside person when feeling unsafe

**ENRICHMENT**
- Has not been hospitalized in past month
- History of successful residential experiences
- Currently participating in satisfying daytime activities
- Infrequent thoughts of feeling unsafe
- Is able to seek out support and monitoring from outside person when feeling unsafe

## Personal/motivational profile

**TRIAGE**
- Need for continual intervention to treat acute symptoms.

**CRISIS STABILIZATION**
- Primary desire/motivation is to live with independence
- Able to accept outpatient supports

**ENRICHMENT**
- Primary desire/motivation is to live with independence
- Has the skills to cope with stressors with support
as of 4/30/09 N = 18 **moved to a less intensive level of intervention

<table>
<thead>
<tr>
<th>TRIAGE ENTRANCE</th>
<th>HIGH RISK ENTRANCE</th>
<th>CRISIS STABALIZATION ENTRANCE</th>
<th>ENRICHMENT ENTRANCE</th>
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<tbody>
<tr>
<td>E. H*</td>
<td>A. C.*</td>
<td>B. D.</td>
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<tr>
<td>J. R</td>
<td>D. E.*</td>
<td>C. M.</td>
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</tr>
<tr>
<td>A. D*</td>
<td>C. S</td>
<td>C. Z.</td>
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<tr>
<td>L. F.</td>
<td>S. S.</td>
<td>T. T.</td>
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<tr>
<td>J. C</td>
<td>D. G</td>
<td>B. K.</td>
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</tr>
<tr>
<td></td>
<td>S. P</td>
<td>I. C.</td>
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<table>
<thead>
<tr>
<th>TRIAGE FOLLOW-UP</th>
<th>HIGH RISK FOLLOW-UP</th>
<th>CRISIS STABILIZATION FOLLOW-UP</th>
<th>ENRICHMENT FOLLOW-UP</th>
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<tr>
<td>J. R.</td>
<td>C. S</td>
<td>B. D.</td>
<td>C. M</td>
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<td>J. C.</td>
<td>S. P</td>
<td>C. Z.</td>
<td>T. T</td>
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<td>I. C.</td>
<td>D. Gr</td>
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<td>D. G.</td>
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<td></td>
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<td>B. K.</td>
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<td>L. F.</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>D. E.</td>
<td></td>
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</table>

*Lost Community Placement
*E. H. D. E --temporarily --county jail--returned to community
*A. C. B. K -- temporarily- county jail--returned to community
*A. D.
### ATTACHMENT B

<table>
<thead>
<tr>
<th>Name</th>
<th>Consultation Date</th>
<th>Medication #</th>
<th>Medication Names</th>
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<tbody>
<tr>
<td>D.B.</td>
<td>June 10th, 2009</td>
<td>4</td>
<td><em>Thorazine</em>&lt;br&gt;-Behavior&lt;br&gt;(50 mg T/D)&lt;br&gt;<em>Topamax</em>&lt;br&gt;-Behavior&lt;br&gt;(100 mg T/D)&lt;br&gt;<em>Paxil</em> (20 mg Q/D)&lt;br&gt;-Mood Stabilization&lt;br&gt;(20 mg Q/D)&lt;br&gt;&quot;Sensonal&quot;&lt;br&gt;-Regulate Menstrual Cycle&lt;br&gt;(1 tab Q/D)</td>
</tr>
<tr>
<td>M.B.</td>
<td>July 1st, 2009</td>
<td>8</td>
<td><em>Zoloft</em>&lt;br&gt;<em>Zyprexa</em>&lt;br&gt;<em>Clonazepam</em>&lt;br&gt;<em>Trileptal</em>&lt;br&gt;<em>Zonisamide</em>&lt;br&gt;<em>Loratadine</em>&lt;br&gt;<em>Abilify</em>&lt;br&gt;<em>Oxcarbazepine</em></td>
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<tr>
<td>E.B.</td>
<td>July 1st, 2009</td>
<td>Unknown</td>
<td><em>Prozac</em>&lt;br&gt;-40 mg QAM&lt;br&gt;<em>Abilify</em>&lt;br&gt;-15 mg QAM&lt;br&gt;<em>Trazadone</em>&lt;br&gt;-100 mg PRN QHS&lt;br&gt;<em>Insomnia</em></td>
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<tr>
<td>D.C.</td>
<td>April 7th, 2010</td>
<td>3</td>
<td><em>Abilify</em>&lt;br&gt;-10 mg in the AM&lt;br&gt;<em>Psychosis</em>&lt;br&gt;<em>Lexapro</em>&lt;br&gt;-10 mg in the PM&lt;br&gt;<em>Depression</em>&lt;br&gt;<em>Levothyroxine</em>&lt;br&gt;-Thyroid Condition&lt;br&gt;<em>Buspar</em>&lt;br&gt;-10 mg&lt;br&gt;<em>Anxiety</em>&lt;br&gt;<em>Klonopin</em>&lt;br&gt;-(.5 mg 2x Daily)&lt;br&gt;<em>Panic/Anxiety Attacks</em></td>
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<tr>
<td>C.C.</td>
<td>June 10th, 2009</td>
<td>5</td>
<td><em>Abilify</em>&lt;br&gt;-10 mg in the AM&lt;br&gt;<em>Psychosis</em>&lt;br&gt;<em>Lexapro</em>&lt;br&gt;-10 mg in the PM&lt;br&gt;<em>Depression</em>&lt;br&gt;<em>Levothyroxine</em>&lt;br&gt;-Thyroid Condition&lt;br&gt;<em>Buspar</em>&lt;br&gt;-10 mg&lt;br&gt;<em>Anxiety</em>&lt;br&gt;<em>Klonopin</em>&lt;br&gt;-(.5 mg 2x Daily)&lt;br&gt;<em>Panic/Anxiety Attacks</em></td>
</tr>
<tr>
<td>Name</td>
<td>Consultation Date</td>
<td>Medication #</td>
<td>Medication Names</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------</td>
<td>--------------</td>
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| I.C.      | April 6th, 2011   | 6 (As of April 2011) | IM Antipsychotic  
- Monthly  
- No pharmacy record of this  
Risperdal  
-(3mg po QAM)  
-(4 mg po QHS)  
-Psychosis and Mood  
Depakote  
-(500 mg po BID)  
-Mood Stabilizer  
Synthroid  
-(25 micrograms po QDAY)  
-Thyroid Disease  
Altace (Rampiril)  
-(10 mg po QDAY)  
-HTN  
Glucophage  
-(500 mg po BID)  
-DM |
| S.D.      | November 17th, 2010 | 2 (As of June 2009) | Abilify  
-(10 mg 2x/day)  
Trazadone  
-(50 mg PRN at bedtime)  
Seroquel  
-Hallucinations/Mood swings  
Lithium  
-Mood  
Swings/Aggression  
Depakote  
-Behaviors  
Clonidine  
-Behaviors  
Fluxetine  
-Behaviors  
Cryselle  
-Birth Control |
| J.E.      | November 17th, 2010 | 6 (As of November 2010) | |
| E.F.-P.   | March 3rd, 2010    | Unknown      | |
| L.F.      | August 8th, 2010   | 11           | Depakote |

*SBCC Psychiatrist Consult*
<table>
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<th>Medication Names</th>
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<td>F.F. *</td>
<td>August 5th, 2009</td>
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<td>(As of August 2010)</td>
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<td>Lithium Citrate Syrup</td>
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<td></td>
<td>Trileptal</td>
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<td>Risperdal</td>
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<td>Prolinix Decanoate</td>
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<td>Congentin</td>
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<td></td>
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<td>Klonopin</td>
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<td>Synthroid</td>
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<td></td>
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<td>Keppra</td>
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<td>Clonapin</td>
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<td>Synthroid</td>
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<td></td>
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<td>Aspirin</td>
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<tr>
<td>Name</td>
<td>Date</td>
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<tr>
<td>A.G.</td>
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<td>2</td>
<td>Depakote: (250 mg AM &amp; PM)</td>
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<tr>
<td></td>
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<td>- Constipation</td>
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<td>P.G.</td>
<td>September 2nd, 2009</td>
<td>18</td>
<td>Risperdal: (500 mg po BID)</td>
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<td>- (1 mg po BID)</td>
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<td>Depakote ER: (500 mg QD)</td>
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<td>- Psychosis, Schizoaffective Disorder</td>
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<td>Ativan: (1 mg PRN)</td>
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<td>- Anxiety, Catatonic</td>
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<td>- Cholesterol/ Triglycerides</td>
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<td>Prilosec: (20 mg QAM)</td>
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<td>Ecotrin (Aspirin): (81 mg QD)</td>
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# System Consults Medication List

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<td>D.G.</td>
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<td>Mellaril</td>
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### Additional Medication List

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<td>C.L.</td>
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<td>Seroquel</td>
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<td>Melatonin</td>
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*SBCC Psychiatrist Consult*
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<thead>
<tr>
<th>Patient</th>
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<td>T.M.</td>
<td>June 1st, 2011</td>
<td>3 (As of June 2010)</td>
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<tr>
<td></td>
<td></td>
<td>(10 shakes, 15 drops, take 1 rounded tsp/day)</td>
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<tr>
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<tr>
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<tr>
<td></td>
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</tbody>
</table>

- Extrapyramidal side effects
- Trazodone (200 mg po QHS)
- Detrol LA (oxybutynin) (2 mg po BID)
- Enuresis
- Nexium (20 mg po QAM)
- GERD
- Lasix (20 mg po QD)
- Hypertension, Pedal Edema
- Potassium (8 meq[?] po QD)
- Used with Lasix
- Metformin (500 mg po QD)
- Diabetes Mellitus
- Bactrim
- UTI
- Motrin PRN
- Arthritis Pain
- Advair Inhaler
- COPD? Not listed recently
- Multivitamin
- Supplement? Not listed recently
## System Consults Medication List

<table>
<thead>
<tr>
<th>Name</th>
<th>Consultation Date</th>
<th>Medication #</th>
<th>Medication Names</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td>- (100 mg po QAM and 225 mg po QHS)</td>
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<td>Trazodone</td>
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<td>Synthroid</td>
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<td>Atropine</td>
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<td>- (0.4 mg po QID)</td>
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<td>Ferrous Sulfate</td>
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<td>- (325 mg po BID)</td>
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<td>Colace</td>
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<td>- (250 mg po QD)</td>
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<td>S.R.</td>
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<td>Abilify</td>
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<td>- (10 mg QAM &amp; 20 mg QPM)</td>
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<td>Cogentin</td>
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<td>Seroquel XR</td>
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<td>- (300 mg q. 7 PM)</td>
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<thead>
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<th>Medication #</th>
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<td>- (750 mg in the AM &amp; 1000 in the PM)</td>
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<td>- Mood Stabilization</td>
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<th>Medication #</th>
<th>Medication Names</th>
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<td>Clozaril</td>
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<td>- (0.5mg NOON)</td>
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<td>Metformin</td>
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<td>- (1000mg AM; 1000mg PM)</td>
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<td>Metoprolol, Benazepril, Hydrochlorothiazide, Warfarin, Gabapentin, Advair, Metformin, Omeprazole</td>
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<td>September 7th, 2011</td>
<td>8 (As of August 2011)</td>
<td>Depakote, (500mg 4xday), Risperdal, (12mg per day), Seroquel, (300mg po qhs), Trazodone, (50 mg at bedtime)</td>
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<td>J.V.</td>
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<td>Depakote, (1000 mg daily), Seroquel, (600 mg daily), HCTZ, (25mg daily), High Blood Pressure</td>
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<td>0 (Refuses As of March 2010)</td>
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<td>A.C.</td>
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<td>9 (As of January 2008; noted in November 2008 update)</td>
<td>Lamictal, (25 mg po qd), Mood Disorder and Epilepsy, Risperdal, (2 mg po QHS), Mood Disorder and psychotic sx and IED</td>
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<td>Medication #</td>
<td>Medication Names</td>
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<td>B.D.</td>
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<td>Zyprexa (30 mg po BID)</td>
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<td>(As of 2008 Update)</td>
<td>- Psychosis</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Tegretol</td>
</tr>
</tbody>
</table>

J.C. March 26th, 2009

6 (As of February 2009)

- Neurontin
  - (300 mg po TID)
  - Seizure Disorder
- Trazodone
  - (50 mg po QHS)
  - Insomnia
- Protonix
  - (40 mg po QHS)
  - GERD
- Detrol LA
  - (4 mg po QHS)
  - Bladder Dysfunction
- Colace
  - (250 mg po QD)
  - Constipation
- Ferrous Sulfate
  - (325 mg po BID)
  - Iron Deficiency Anemia
- Dietary Supplements
  - (TID)
  - Poor Appetite

- Fluphenazine
  - (Dosage NA; Daily)
  - Schizophrenia
- Risperdal
  - (Dosage NA; Daily)
  - Schizophrenia
- Seroquel
  - (Dosage NA; Daily)
  - Schizophrenia
- Prolkin
  - (Dosage NA; Q 2 weeks)
  - Schizophrenia
- Bezotropine
  - (Dosage NA)
  - Treatment of side effects of extrapyramidal reactions
- Xopenex
  - (Dosage NA)
  - Asthma
<table>
<thead>
<tr>
<th>Name</th>
<th>Consultation Date</th>
<th>Medication #</th>
<th>Medication Names</th>
</tr>
</thead>
</table>
| A.D.      | May 2008, Completed October 2008| 10 (As of October 2008) | *(200 mg po qam & 200 mg po qhs)*  
-Mood  
**Klonopin**  
-(0.5 mg 2 tablets hs)  
-Anxiety  
**Prilosec**  
-(20 mg po qam)  
**Zestril**  
-(10 mg po qam)  
-Hypertension  
**Buspar**  
-(10 mg 2 tablets daily)  
-Anxiety  
**Inderol**  
-(10 mg 3 tablets daily)  
-Hypertension  
**Toprol XL**  
-(25 mg one tablet daily)  
-Hypertension  
**Hydrocortisone**  
-(1% 30 gm cp to affected area)  
-Feet  
**Triamcinolin**  
-(0.1% cream 80 gm cp to affected area 3x day)  
-Rectal Area  
**Lopressor**  
-(100 mg 2x daily)  
-Seroquel  
-(400 mg po BID)  
-Psychosis, Mood  
**Risperdal**  
-(3 mg po BID)  
-Psychosis, Mood  
**Artane**  
-(2mg po TID)  
-EPSE  
**Lithium Carbonate**  
-(300 mg po BID)  
-Mood  
**Propranolol**  
-(10 mg po TID)  
-Akathisia |
<table>
<thead>
<tr>
<th>Name</th>
<th>Consultation Date</th>
<th>Medication #</th>
<th>Medication Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.E.</td>
<td>May 2008</td>
<td>5</td>
<td>Norvasc</td>
</tr>
<tr>
<td></td>
<td>(Update September 2008)</td>
<td>(As of July 2008)</td>
<td>-(10 mg po qd) - HTN - Nexium - (40 mg po qd) - GERD - Ativan - (1 mg PRN) - Anxiety - Ambien - (10 mg qhs PRN) - Insomnia - Neomycin - (Drops to eyes BID)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Risperdal CONSTA - (Unknown Dose IM q2weeks) - Seroquel - (200 mg po BID) - Geodon - (60 mg po QAM and 80 mg po QHS) - Congentin - (1 mg po BID) - Dilantin - (100 mg po QHS)</td>
</tr>
<tr>
<td>L.F.</td>
<td>July 2008</td>
<td>5</td>
<td>Wellbutrin</td>
</tr>
<tr>
<td></td>
<td>(Update January 2009)</td>
<td>(As of ?)</td>
<td>Buspar - Trazodone - Abilify - Cream for psoriasis</td>
</tr>
<tr>
<td>D.G.</td>
<td>December 2008</td>
<td>3</td>
<td>Eskalith (Lithium) - (300 mg one po QAM and two po QHS) - Mood Stabilizer - Seroquel - (200 mg po BID and 400 mg po QHS) - Antipsychotic - Tenex (Guanfacine) - (1 mg po BID and two po QHS) - Antidrenergic for HTN or sometimes for agitation or ADHD</td>
</tr>
<tr>
<td></td>
<td>(As of December 2008)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Consultation Date</td>
<td>Medication #</td>
<td>Medication Names</td>
</tr>
<tr>
<td>-------</td>
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<td>---------------------------------------</td>
</tr>
<tr>
<td>E.H.</td>
<td>July 2007</td>
<td>12</td>
<td>Benadryl (-10 mg TID)</td>
</tr>
<tr>
<td></td>
<td>(Update April 2008)</td>
<td></td>
<td>Depakote (-200 mg po qhs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-Seizures and Bipolar Disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SDD (-250 mg TID)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Sinequan (-50 mg AHS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lexapro (-10 mg QD)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Naproxyn (-500 mg BID)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Zyprexa</td>
</tr>
</tbody>
</table>

Lorazepam

- (0.5 mg TID)
- Anxiety

Restoril

- (30 mg nightly)
- Insomnia

Seroquel

- (500 mg nightly)
- Mood/Anxiety

Zoloft

- (100 mg daily)
- Depression

Congentin

- (2 mg nightly)

Levothyroxin

- (0.5 mg daily)
- Thyroid

Motrin

- (400 mg BID)
- Pain

Hydroxyzine

- (50 mg TID)
- Mood/Anxiety

Calcium Carbonate

- (500 mg TID)
- Increase bone strength

Vitamin E

- (1000 units daily)

Protonix

- (40 mg daily)
- Reflux
<table>
<thead>
<tr>
<th>Patient</th>
<th>Start Date</th>
<th>Notes</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.K.</td>
<td>May 2008 (Update March 2009)</td>
<td>1 (As of January 2009)</td>
<td>Protonix (5 mg po QHS), Paranoia, mood, and poor appetite, Dilantin (200 mg QAM, QHS), Imrix, PRN Ativan (1 mg PRN), Risperdal (2mg 2 tabs each night at bedtime)</td>
</tr>
<tr>
<td>C.M.</td>
<td>November 2007 (Update September 2008: No changes)</td>
<td>12 (As of November 2007)</td>
<td>Trilafon (16 mg po BID), Psychosis, Artane (2 mg po BID), For side effects of Trilafon, Benadryl (75 mg po qhs), Insomnia and Medication Side Effects, Lamictal (200 mg po BID), Mood Stabilizer, Anti- Seizure, Seroquel (300 mg po QID), Psychosis and Mood Atenolol (12.5 mg po QAM), HTN and for akathisia, side effect of meds, Synthroid (50 micrograms po QAM), Hypothyroidism, Lipitor (10 mg po QHS), Hypercholesterolemia, Ortho Novum</td>
</tr>
</tbody>
</table>
## System Consults Medication List

<table>
<thead>
<tr>
<th>Name</th>
<th>Consultation Date</th>
<th>Medication #</th>
<th>Medication Names</th>
</tr>
</thead>
</table>
-(20 mg po QD)  
Bumex  
-(1 mg po QD)  
Zestril  
-(5 mg po QAM)  
Avandia  
-(4 mg po QD)  
Detroi LA  
-(4 mg po QD)  
Aspirin  
-(81 mg EC po QD)  
Multivitamin  
-(One daily)  
Abilify  
-(10 mg po QHS)  
Topamax  
-(100 mg po BID)  
Klonopin  
-(1 mg po BID)  
Geodon  
-(120 mg po QHS)  
Clorazol  
-(350 mg po QHS)  
Benadryl  
-(50 mg po BID) |
| J.R.  | February 11th, 2008 | 8 (As of February 2008) | Abilify  
-(20 mg po QAM)  
Lexapro  
-(20 mg po QAM)  
Depakote ER  
-(750 mg po QHS)  
Ambien  
-(10 mg po QHS)  
Seroquel  
-(100 mg as PRN as of |
<table>
<thead>
<tr>
<th>Name</th>
<th>Consultation Date</th>
<th>Medication #</th>
<th>Medication Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.S.</td>
<td>June-July 2008</td>
<td>15</td>
<td>Geodon:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- (60 mg po TiD)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Mood Lability, AH</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Ability:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- (20 mg po QHS)</td>
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<td></td>
<td></td>
<td></td>
<td>- Mood Lability, AH</td>
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<td></td>
<td></td>
<td></td>
<td>Trileptal:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- (300 mg po BID and 600 mg po QHS)</td>
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<td></td>
<td></td>
<td></td>
<td>- Mood Lability</td>
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<td></td>
<td></td>
<td></td>
<td>Benadryl:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- (25 mg po QHS)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Insomnia, EPSE</td>
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<tr>
<td></td>
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<td></td>
<td>Zoloft:</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- (100 mg po QAM)</td>
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<tr>
<td></td>
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<td></td>
<td>- Depression and Anxiety</td>
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<td></td>
<td></td>
<td></td>
<td>Lipitor:</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- (10 mg po QAM)</td>
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<td></td>
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<td></td>
<td>- Cholesterol</td>
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<td></td>
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<td></td>
<td>Zetia:</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- (10 mg po QAM)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Cholesterol</td>
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<td></td>
<td></td>
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<td>Diovon:</td>
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<td></td>
<td></td>
<td></td>
<td>- (160 mg po QAM)</td>
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<td></td>
<td>- HTN</td>
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<td></td>
<td></td>
<td></td>
<td>Claritin:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- (10 mg po QAM)</td>
</tr>
</tbody>
</table>
### System Consults Medication List

<table>
<thead>
<tr>
<th>Name</th>
<th>Consultation Date</th>
<th>Medication #</th>
<th>Medication Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>T.T.</td>
<td>April 2008 (June 2009 Update)</td>
<td>9</td>
<td>Zyprexa</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(As of June 2009)</td>
<td>(10 mg 7 am qhs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Seroquel</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(200 mg po QAM, 200 mg po q5pm, and 400 mg po q9pm)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Psychiatry, Mood</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Depakote</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>(250 mg po TID)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mood, Lability</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lexapro</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(20 mg po qhs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Depression, Anxiety</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Benadryl</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(50 mg po QHS)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Insomnia, EPSE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dalmane</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(15 mg po QHS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Insomnia</td>
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<td></td>
<td></td>
<td></td>
<td>Glucophage</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>(500 mg po BID)</td>
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<td></td>
<td></td>
<td></td>
<td>NIDDM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lotensin</td>
</tr>
<tr>
<td>Name</td>
<td>Consultation Date</td>
<td>Medication #</td>
<td>Medication Names</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------</td>
<td>--------------</td>
<td>-----------------</td>
</tr>
</tbody>
</table>
| C.Z.  | June 2008 (Update January 2009) | 8 (As of January 2009) | - (10 mg po QD)  
- HTN  
- Albuterol MDI  
- (As needed)  
- Bronchitis |

- Geodon  
- (80 mg po QAM and 160 mg po qhs)  
- Psychosis, Mood  
- Depakote ER  
- (500 mg po QAM and 1000 mg po QHS)  
- Mood Lability  
- Synthroid  
- (150 micrograms po QD)  
- Hypothyroidism  
- Os-Cal  
- (One daily)  
- Osteopenia  
- Ecotrin  
- (81 mg po QD)  
- Cardiovascular Preventative  
- Maxzide  
- (12.5 mg po QD)  
- HTN  
- DDAVP  
- (0.4 mg po QHS)  
- Enuresis  
- Colace  
- (250 mg po QD)  
- Constipation |
CONSULTATION CLINIC-- FEEDBACK/FOLLOWUP FORM

NAME: Referral Name LAST

CLINIC DATE: 08/11/10
Follow up SAT Team Consultation : 10/06/10
Extensive Systems Navigation up to 11/17/10

DOB: 01/05/91

Developmental Disability: Mild Mental Retardation

Mental Health: updated as of 11/17/10 by Dr. Colleen Connor

Axis I: Bipolar Disorder NOS; polysubstance abuse; additionally Anxiety disorder NOS
(noted on interview with Referral Name 11/16/10)
Axis II: Mild Mental retardation
Axis III: cerebellar astrocytoma with shunt placement 10 months of age and
reoccurrence of tumor with second surgery and meningitis age 2, shunt broke 2003,
jarring of shunt 2006; hernia surgery age 2; multiple injuries with broken bones mainly
2004-2006; gingivitis; headaches; possible new onset seizures 2010; head injury 2010;
mild head injury while intoxicated 2010
Axis IV: financial, legal, dependent on family for food, shelter and clothing
Axis V: 31

Medical: see under Mental Health

REFERRED BY: Service Coordinator and later by another Service Coordinator; LCSW
both Service Coordinators of San Diego Regional Center
CONTACT EMAIL: sc@sdrc.org
CONTACT PHONE: 619-596-1000

SBCC PRELIMINARY FINAL REPORT  PEGGIE WEBB, M.A.  DECEMBER 7, 2012
REASON(S) FOR REFERRAL:  Referral Name recently out of Jail was arrested for probation violation. Currently on probation for possession of drugs. Is supposed to be attending AA/NA meetings once a week. At time of referral was attending McCallister P31000 program. Referral Name has had a shunt since early childhood, is dually diagnosed and is in need of counseling and services to help him with substance abuse, education, training and employment.
10/06/10: follow up consultation... Referral Name still having difficulty with day to day life stressors, another arrest, in jail at the time of this consultation.

CLINIC ATTENDEES: Peggie Webb, M.A., Darlene Sweetland, Ph.D., Colleen M. Connor, M.D., Alain Azcona, Tamara Stark, M.S., SC- SDRC Service Coordinator
10/06/10: add SC, new SDRC SC, Kevin Ferrar; SDRC Vendor, Mary Hubbard, CADC-II, CAS-II, M-RAS, CSC.

FEEDBACK: QUESTIONS AND RECOMMENDATIONS

Discussion and questions about his substance use, conditions of release/probation/medical and psychiatric history, current living arrangement and current level of motivation on Referral Name’s part to receive treatment.

10/06/10: Questions and discussion about most recent arrest with arraignment next day. Inquired of legal status; still very unclear with little clarity provided at the consultation. Recommendations include Dr. Connor and Mary Hubbard send letters to Public Defenders office for the next day arraignment. Recommend Tamara assist with clarifying status of arrest and discussion with jail staff. Substance Abuse appears to be ongoing if not increasing issues for Referral Name. Mary will assist with recommendations for appropriate treatment opportunities should Referral Name agree to use them. Referral Name’s motivation for treatment still unclear.
<table>
<thead>
<tr>
<th>FOLLOW UP-ACTION ITEMS</th>
<th>WHO'S RESPONSIBLE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recommend follow up information be secured regarding exact nature of criminal justice involvement.</td>
<td>SC to inquire of SDRC vendor; Kevin Ferrar (client advocate) regarding his legal circumstances. Tamara Stark to receive information to include with recommendations by team</td>
<td>Completed. Follow up consultation in September, October and November by Tamara Stark; SAT Team Forensic Navigator (See recommendations by Navigator attached.)</td>
</tr>
<tr>
<td>2. Recommend assessment/evaluation to establish comprehensive medical and psychiatric history and current conditions with recommendations for opportunities for</td>
<td>Colleen Connor, M.D.</td>
<td>Began assessment in August, 2010. Several attempts made to complete evaluation; difficulty catching up with Referral Name in/out of jail settings. Completed 11/16/10. During Referral Name’s most recent incarceration (See attached recommendations).</td>
</tr>
<tr>
<td>3. Recommendation for Psychologist/Behavior Specialist to provide recommendations to support Referral Name and his support staff with clinical/behavioral tools in residential setting once an appropriate setting is located and Referral Name agrees to live in that setting.</td>
<td>Darlene Sweetland, Ph.D.</td>
<td>Pending; status will remain pending until Referral Name moves to a residential setting that is not considered transitory in nature (often returns to family home for transitions between residential placements).</td>
</tr>
</tbody>
</table>
| 4. 10/06/10: Recommend Substance Use Disorders Navigator explore potential drug and alcohol treatment programs appropriate for Referral Name and his current substance use challenges. This will be opportunities for Referral Name to take advantage of, only if he is willing. No court ordered treatment at this time. | Mary Hubbard, CADC-II, CAS-II, MRAS, CSC and SC to share information Mary finds with Referral Name. | Completed. SC contacted Mary a Friday evening and Mary was able to facilitate an immediate entrance into McCallister Detox program. Other initial recommendations made (See letter sent to courts 10/07/10) 11/16/10 Current: Mary investigating current treatment options, will provide SC, SC with this information. If possible, Mary will meet with Referral Name to
| facilitate her investigation of appropriate treatment options |
10/4/10

To Superior Court Judge, County of San Diego

RE: [Redacted], CASI #: CT34971

Your Honor,

I am a member of the SAT team who is working with the above referenced case. SAT is part of the Solutions Building Community Collaborative and is comprised of experts in the field from multiple systems. This Collaborative is a demonstration project that provides specialty consultation for individuals with dual (MI-DC) diagnoses who have complex needs such as substance abuse related disorders and may also be known to the criminal justice system. It is funded by the State Department of Developmental Services and co-sponsored by San Diego Regional Center and San Diego County Mental Health services. Members of the SAT team have reviewed the case and are trying to meet with Mr. Halanych while in jail.

My role on SAT is that of a certified drug and alcohol consultant. My understanding is that [Redacted] has failed a previous attempt at treatment. I have contacted a short term residential program in the hopes that he can be referred to a residential treatment center. Jeanne McAllister of McAllister Institute Detox has agreed to give him a bed when he is released. The detox will then work with Steven on a long term residential, if the court deems it so.

Thank you and if you have any questions, please feel free to contact me at 619-890-6758 (cell) or work 858-573-2600 x 1709

Sincerely,

[Signature]

Mary Hubbard, CADC II, CCS, M-RAS
Mental Health Systems, Inc.
MARTE Consulting
E: mhubbard@mhsinc.org
9/16/10

To Superior Court Judge, County of San Diego
Your Honor,

I am consulting on the case of Referral Name LAST as part of Solutions Building Project which is a group that reviews the most difficult dually diagnosed mentally ill and developmentally disabled adult clients of San Diego Regional Center in order to make recommendations that might improve their functioning and reduce recidivism in the legal and hospital systems.

Referral Name has a mood disorder clearly documented as bipolar disorder by a child psychiatrist since about age 9. There is a family history of bipolar disorder. By testing he is also mentally retarded with full scale IQ of 62 with verbal IQ 66 and performance IQ 63. He has been diagnosed with a mixed learning disability and ADHD. Some of these problems may be related to the cerebellar brain tumor he suffered at 10 months old requiring shunt placement and tumor removal and then at age 2 tumor removal again after recurrence and a bout of meningitis. He later suffered rupture of the shunt and a few years later he suffered jarring of the shunt with head injury in a motor vehicle accident (he was a passenger and hit by a drunk driver). There was a significant increase in behavioral problems after each of these incidents.

Referral Name does not have the outward appearance of someone, for example, with mental retardation due to cerebral palsy who might have clear articulation and motor problems. So he may appear "normal" except for the immature demeanor and speech. This makes him vulnerable on the street to be taken advantage of because of his immaturity, low intelligence and poor judgment.

Referral Name has in the last few years developed the additional diagnosis of multiple substance dependence which has now escalated to heroin possession. There have been multiple attempts at outpatient rehab. I strongly believe he requires residential detox and rehabilitation or his chances for success are slim.

Sincerely,

Colleen M. Connor, M.D.
Diplomate, American Board of Psychiatry and Neurology

(619)379-0914

SBCC PRELIMINARY FINAL REPORT  PE Gregg WEBB, M.A.  DECEMBER 7, 2012
Referral Name LAST is a 19 year old single Caucasian male born on 1/5/91 in San Diego, CA second born child to a 28 year old mother Teri from Torrance, CA and a 30 year old father Tim from Oregon. Siblings include brother Brian who was first born (DOB 4/10/89) and two younger brothers, Brandon (DOB 8/20/94) and Christopher (DOB 10/30/97). He lives in Santee with his family.

Referral Name was born full term at Kaiser Hospital by NSVD with normal birth weight and Apgar scores. Umbilical cord was around his neck but there were no apparent complications. There were no problems in the newborn period and early milestones were normal. At 10 months of age he was diagnosed with hydrocephalus secondary to a cerebellar astrocytoma. He underwent a shunt placement operation 11/12/91 and then tumor removal 11/16/91. In 1992 the tumor reoccurred requiring a second surgery. He also suffered meningitis at that time.

In 2003 the shunt broke and he developed severe behavioral problems and in 2006 the shunt was jarred in a motor vehicle accident and family noted similar behavioral problems as in 2003.

Current problems: Mood lability, aggressive behavior, noncompliance with treatment, substance dependence and legal troubles

Psychiatric History:
In February 1997 at age 6, Referral Name was evaluated at Kaiser Center for School Problems. He had difficulty with attention, notably the "conscious redirection of attention" and developmental language delay. There were no problems with executive functioning. In 1997 he was first involved in special education classes.

Referral Name saw Dr. PHYSICIAN a child psychiatrist since about 2000 and a letter by him stated that he took medication until May 2001 when he was taken off medications for a neurology assessment and when medications were restarted Depakote was not restarted. He was reevaluated at Kaiser Center for School Problems in July 2001 and it was noted he had begun to experience fluctuations in behavioral control, anger management problems, memory problems and decreased capacity for sustained attention. Language delay had improved but there were now deficits in executive functions including rapid loss of cognitive set, cognitive sequencing, and verbal memory. There were continued deficits in conscious redirection of attention and this was worse on a long task.

He saw a psychiatrist in 2003 for cognitive and neurologic problems. He later described being depressed in 2003. Shunt had broken in 2003 and behavioral problems escalated.
including pointing to knives and saying he wants to hurt dad. In addition he would call 911. Depression noted by family.
He was also seeing a therapist at Kaiser in 2003 and in February 2003 she noted that he was taking Ritalin and Paxil and Depakote. He was in a special day class with severely delayed kids. He had pulled a knife on father and police were called but father chose not to have him removed. He was described as a "troublemaker, impulsive and distractible". He wanted to leave the appointment the entire time and was "tired of docs". He said he was embarrassed by the shunt scars. Mom was "sweet and cheerful". The therapist noted consumption of wine 2-3 times per week. The maternal grandfather had died of pneumonia after being paralyzed for several years but it was noted that this had no significant effect on patient per family.
A letter dated 3/6/03 from Dr. PHYSICIAN summarized his treatment of Referral Name for at least the prior several years. He was treated for impulsivity, hyperactivity, poor frustration tolerance, and mood instability. There was periodic deterioration of mood and behavior in the late winter months over the three years prior. This was manifested by dysphoric mood, increased impulsivity, anger and aggression. There was deterioration of cognitive function at those times. Dr. PHYSICIAN described that over the last few months (early 2003) there had been a deterioration of mood and behavior. The parents were reluctant to resume mood stabilizing medication despite "prior evidence of success". He said that medication was discontinued in May 2001 prior to a complete neurological assessment and Depakote was not reinstated. Dr. PHYSICIAN diagnosed Bipolar Disorder NOS, ADHD, impulsive reactive type, Learning Disability, mixed, and postoperative cerebellar astrocytoma.
A 3/17/03 therapy note stated paramedics were called because Referral Name had increased pulse and pounding heart and seemed confused (forgot what mom looked like, forgot cousin's name) while camping. He was taken off Ritalin and Paxil then by neurology. The therapy note described regression academically to a second grade level, temper outbursts once per day, unhappy most of the time and "nothing to live for" and he said aunt took three razor blades from him. Also it stated that mom said father minimizes the neurologic part of his illness and is critical of Referral Name. The therapist met with father 3/25/03 and described him as pleasant and high energy and he admitted that he loses patience with Referral Name.
On 3/26/03 the therapist noted that Referral Name told mom he hears voices.
An April 2003 child and adolescent psychiatry evaluation at Kaiser, at 12 years old and 6th grade, revealed a significant memory and functional decline in the past few months. He dropped from a 6th grade level to a second grade level across the board. There was an emergency IEP meeting the week before. It was noted that he had done better at Sycamore Canyon school (K-4th grade). He was irritable and complained of headaches and electric shock sensation. He was depressed and had suicidal thoughts (a few weeks prior but no plan or intent) and auditory hallucinations. Sleep and appetite were okay. Also, "he feels stuck with kids who are severely delayed". He was becoming aggressive with mother and brothers. He had been restarted on Depakote 3 days earlier. Mother was concerned about something neurologically wrong and she said "the neurologist does not take me seriously" since there had been similar symptoms two years earlier and all tests were negative. He had been on and off psych medications. Mom "is not convinced the problem is psychiatric". Mom wanted a second opinion by a different
psychiatrist which was the reason for the Kaiser psychiatry visit. Recommendations were referral for psychological testing, obtain EEG results that were pending, obtain neuropsychological testing results which were pending, follow up with neurosurgery, continue Depakote and check labs.

He also had a psychological evaluation at Kaiser in April 2003 at 12 years and 3 months and grade 6. It noted poor athletic ability and general difficulty with coordination. Also oppositional behavior, inattention, difficulty in group activities at school and related better to younger peers. He appeared younger than stated age and was reluctant to engage. His mood switched from cheerful to frustrated rapidly and he "spoke quickly often" with normal articulation. He stared into space and appeared like he was having petit mal seizure. There was a continued "deficit in conscious redirection of attention". Full scale IQ was 62 with verbal IQ of 66 and performance IQ 63. In a motor task with a pegboard he was severely deficient with both dominant and non dominant hands. On a developmental test of visual-motor skills Referral Name was mildly deficient. Language production and verbal reasoning were below age expectations and vocabulary and verbal reasoning were in the moderately deficient range. Language processing skills were intact. He had difficulty recalling information over time; this was below average even with cues. He had impairment in information processing for both verbal and visuospacial information marked by adequate initial recall and decreased capacity to recall over time. There were difficulties with encoding, consolidation and retrieval of information. This was worse with increased volume of material. There was difficulty focusing, shifting and sustaining attention. A measure of attention and hyperactivity by mom was in 10th percentile and by teacher was in 8th percentile. There was a problem maintaining arousal and sustaining attention. There was significant impairment in executive function skills consistent with IQ. The only executive function not impaired was planning ability.

The April 2003 psychological evaluation was also significant for psychosis and mood issues. He received a positive predictive score for mood and disruptive behavior disorders. There were signs of potential psychotic and attention disorders on a psychotic disorder screening instrument. He did not meet criteria for mania and he was in the clinical depression range. Referral Name described to the examiner hearing voices sometimes. He described two voices, a boy and girl, outside his head, that scare and bother him. They sometimes give commands and they occur regardless of emotional state. The AH started a few months prior and decreased when he resumed medication. On Rorschach April 2003 he "is at risk for periods of anxiety, tension, and irritability. He lacks the psychological resources to cope with the demands placed on him and has poor frustration tolerance. He is prone to decompensate even in more structured situations, though he will function better in structured settings due to poor tolerance of ambiguity". There was substantial impairment in reality testing and his profile was similar to others with psychotic illness. It was noted that he is likely to misperceive events and meanings of others' actions. He may display poor judgment. At times he can think logically and coherently. He has low self esteem and compares himself negatively to others. He has poor social skills. Diagnoses were ADHD, depression NOS, psychosis NOS, and no diagnosis on Axis II (though he scored on IQ testing as having mild mental retardation). Recommendations included targeting the low self esteem and low self confidence in treatment and reevaluate in one or two years.
An April 2003 therapy note said that Referral Name's brother thinks it is "unfair how mom caves in" to Referral Name's demands.

On 5/13/03 Referral Name had a speech and language evaluation through Santee School District at 12 years and 4 months in 6th grade. The conclusions were "significant receptive and expressive delays" and "it is unusual for there to be such a drastic regression in one's speech and language skills without a possible medical or emotional component". Peabody Picture Vocabulary Test was at an 8 year old level, expressive vocabulary test was at 8 years and two months, and Expressive One Word Picture Vocabulary Test was at 7 years and 8 months. He had difficulty recognizing and identifying common pictures from his environment. He had word finding and vocabulary difficulties. He was obsessional about when the testing would end.

On 5/28/03 Referral Name was very hyperactive and bit his mother with his fist as she was ignoring his tantrum. He later yelled at his therapist at Kaiser about not wanting a tutor. He was transferred to a male therapist after that.

In a 5/29/03 note by Dr. PHYSICIAN he points out a pattern in the last few years of 3-5 months of calm behavior followed by severe decompensation and declines in mood, behavior, learning, and cognition. He states that 2 years ago Depakote was prescribed following negative neurological work up and Referral Name a good response but mother removed all medications and pulled him out of treatment. She had the belief he was cured. He noted the diagnosis as Bipolar Disorder with comorbid attention deficits.

In September 2003 Referral Name said his memory was better and he was making progress in the seventh grade.

In October 2003, Dr. PHYSICIAN said there was significant improvement in school performance, impulse control, and mood stabilization on Depakote, Wellbutrin, and low dose Seroquel, Ritalin and Tenex. It was noted that Ritalin targeted his task completion and attention span. He had switched to Dr. PHYSICIAN with secondary insurance and then later returned to Kaiser and saw Dr. Velasquez. There were apparently no major medication changes between fall 2003 and sometime in February 2006 when he was not fully compliant with medications.

An evaluation by Dr. Velasquez on 6/6/05 at Kaiser at age 14 and eighth grade. He was to attend high school ISP class and mainstreamed for physical education and woodshop. He was returning to Kaiser for psychiatric care as there was no longer any alternate insurance coverage. Diagnoses were Bipolar Mood Disorder, mixed, Learning Disability NOS, rule out ADHD, combined type, and rule out borderline IQ (this was later clarified as mild mental retardation), and history of cerebellar astrocytoma. He appeared younger than stated age and was immature in demeanor and language skills. There was no current SI. Sleep and appetite were fine and there was no psychosis. Dr. Velasquez noted that he had improved academically and memory and functioning were better. Academic achievement was at a 6-8th grade level. He was with more high functioning peers. He had anxiety about starting high school and planned summer school at the high school and an advocate.


January 2006 shunt jarred in MVA (as a passenger in a car with friends hit from behind by a drunk driver on a Sunday night at 11pm) and after that mom noted behavioral problems similar to three years prior. He was irritable, impatient, and having problems at school.
February 2006 mom was hospitalized and older brother as well, so Referral Name stayed with relatives and did not have medications with him. He had been having conflict with father and insomnia. On 2/23/06 he pulled a steak knife on father and was fighting with 8 year old brother. He refused to work at a school cafeteria job and he was walking out of class and calling a peer a homosexual slur. He was very irritable. Diagnosis was bipolar, mixed phase.

On 3/6/06 he was "out of control" and he had been having difficulty since the MVA. He was suspended from school after he threatened to shoot a peer with a BB gun. He was staying with aunt. There was an episode of alcohol abuse. He also called a peer to get cannabis but did not use it. He was refusing appointments.

On 3/8/06 things were slightly better. Referral Name had met with the sheriff at the school as part of a return to school plan. Mother declined in office follow up at Kaiser due to the copay and she will call as needed. 3/15/06 he was having academic problems at school and ran away.

On initial application to San Diego Regional Center on 3/24/06, mother described "temper tantrums, learning problems, difficult to discipline, aggressive". Also she described "trouble getting along with other children sometimes, causes disruption, fights, argues with siblings and father, defiant, argumentative, hard to handle when out of control". She stated that Referral Name "seems depressed at times when peers pick on him at school". Also he is "very difficult with his behavior, defiance and emotional outbursts. He has difficulty with his peers and respecting authorities. Very hard time learning due to the traumatic brain injury". Also, "socially he is very aware of his surroundings, therefore he is bothered greatly when he is with peers who are extremely lower than he, yet he has many learning disabilities himself. He wants to be a 'regular' kid and he thinks he belongs with regular education, however processing material is very difficult for him.

On 3/27/06 he had "weaned self off pills" (Depakote, Wellbutrin and Seroquel) because he was "doing really well at home and school". He had spent 2 weeks with each aunt and then restarted the medications.

On the initial interviews by Regional Center April and May 2006, Referral Name was 15 years old and living with family. He was argumentative and appeared agitated. He was wearing baggy jeans which were his dad's pants. Per mom he picked out inappropriate clothes and mom has to put his clothes out for him. He used his fingers to eat. He could only use a digital clock, could not make change for purchases, was only able to print his name not write in cursive. He was needing reminders to shower and groom and often refused to brush his teeth leading to gingivitis. He was okay with fastening buttons and zippers and rode skateboard and bikes. He had significant receptive and expressive language delays and had speech therapy but it ended since the teacher was falling asleep but was not rescheduled. He was confused by a calculator and he had difficulty with the concept of time. Per mom, he was sensitive to being different from his peers. Mom said "he takes defense to things not directed at him". "He calls his peers names often. He is an instigator and then perseverates on the situation. He is argumentative and often takes things personally that don't relate to him." Also, "he does not play often with his brothers who are into sports. He has difficulty with sports. He is better around kids and adults." Mom said "this school year has been a 'wash'. He does not fit into any other classes they have for him. The school does not know how to deal
with Referral Name and some of his behaviors". Mom also complained that his teachers
had not read his IEP. An IEP was upcoming on 6/1/06.
In April 2006 he mentioned past suicidal thinking and "I was suicidal at one point". He
had been on several medications. Diagnosis was Bipolar Disorder NOS.
In May 2006, mother requested a psychological report to assess cognitive ability at age
15 years and 4 months (grade 9 with special education and peer tutor and behavioral
support plan) through Grossmont Union High School District. Wechsler Intelligence
scale revealed full scale index of 54 with verbal comprehension 63, perceptual
reasoning 69, working memory 62, and processing speed 50. He was aware of being
timed and had difficulty with timed tasks. When he lost focus he tapped his fingers or
made mouth noises or yawned. He often complained of it being too hard. It was noted
that expressive vocabulary, immediate auditory memory and "hands on activities"
are his areas of strength. He was poor at learning new tasks and he had difficulty
understanding directions and some responses appeared random. On Peabody Picture
Vocabulary test he scored in 5th percentile with age equivalence of 9yrs 6mo. On
Conner's Parent Rating Scale mother said he is oppositional, inattentive, and at risk for
ADHD. He was easily distracted, had short attention span, needed close supervision to
do assignments, only attends if something is very interesting, distractibility and attention
span problems, trouble concentrating in class, and gets distracted when getting
instructions. On Wide Range Achievement Test he was at the 4th grade level in
reading, 5th grade in spelling, and 3rd grade in math. He read mainly one syllable
words, printed legibly, and attempted all words presented. He was inconsistent in math.
Cognitive ability was assessed at the extremely low range. He did better in expressive
vocabulary, receptive vocabulary and immediate auditory rote memory. Strengths
were in spelling and rote reading. He preferred hands on tasks like blocks or pictures.
He had many characteristics of kids with ADHD. He needs frequent breaks and
immediate rewards. He had difficulty learning new material especially if timed.
Recommendations included to continue the short school day, summer school, avoid
many verbal instructions and timed tasks, utilize computer and hands on activities,
and positive interventions like checklists and rewards, and use quiet area for
learning.
May 2006 school transcripts ranked him 550 out of 587 students.
In June 2006 a teacher commented that he has limited range and coordination and is stiff
in movements (physical education instructor). Also he likes computers and cars, has nice
handwriting, likes art projects and mimics peers.
January 2007 Regional Center assessment documented verbal abuse and threats to
family and tantrums at least once per month. He was on Seroquel, Wellbutrin and
Depakote. He complained of headaches. He also was having school problems and was
transferred to a different high school. He was washing cars and mowing lawns for
money. Parents were building an addition to their home and he will have his own room.
3/21/07 through 3/27/07 Mesa Vista hospitalization for suicide thoughts (possibly on
Abilify and trazodone as of this hospitalization)
6/13/07 through 6/18/07 Mesa Vista Hospitalization for attempted suicide
9/10/07 through 9/14/07 5150 Mesa Vista Hospital for suicide attempt; he overdosed
on pills and father discovered him. In record it states something about he was angry
about going to school and overdosed. Mom was out of town.
A school assessment in November 2007 noted that he was withdrawn and guarded and irritable, easily distracted, often annoyed by peers, and was receiving individual counseling at school.

On January 2008 SDRC summary it was noted that Referral Name had switched high schools twice. Also, Mom wanted to focus more on life skills. He had been hospitalized multiple times. "He was progressing with teachers but not with family or peers." He was doing usual activities like biking and skateboarding and going to the desert with family to ride motorcycle and enjoyed the computer.

March 2008 assessment noted recent injuries from falls, and physically aggressive less then once per month, major property damage once in 12 months, running away or wandering off less than once per month, emotional outbursts at least once per week.

In May 2008 he was in court for a substance related charge. Requirements of probation were to be individual psychotherapy at least once per week related to anger and theft issues, 40 hours community service, substance abuse treatment and testing, and curfew 6pm till 6am. A review hearing was set for November 2008 and May 2009.

6/21/08 through 6/25/08 Mesa Vista Hospital for suicidal ideation
A September 2008 Regional Center note mentions a stay at a drug and alcohol treatment center.

In October 2008 a behavioral consultation assessment was requested for Referral Name to address challenging behaviors of abusing drugs and aggression toward parents. He was enrolled at West Hills High School in special needs class and had difficulty expressing anger and other emotions. Mother did not allow the evaluation. She said she was cancelling the behavioral service because client's behaviors were "typical teenage stuff and it will be a waste of the therapists time" and mother "did not think his behaviors could be changed".

In December 2008 he tried to stab father with a knife and mom was accidentally stabbed trying to intervene. Also in December 2008 he stole from his parents to buy liquor and he was in juvenile hall end of December 2008 through 3/3/09 and then on house arrest with probation for one year.

A San Diego Regional Center behavioral assessment January 2009 revealed some physical aggression more than once in 12 months, major property damage more than once in 12 months, running or wandering (actual or attempted) at least once per week.

In March 2009 he was in ROP through Grossmont Union High School transitional program. It was noted in a SDRC assessment that he trusts the wrong people, has a strained relationship with father, and he has hit and spit at parents when very agitated and usually intoxicated. He AWOLs in middle of the night and yells and screams at times. He refuses school most of the time (Grossmont ROP) and does not consider himself disabled.

May 2009 Referral Name was being prescribed Abilify and trazodone (possibly since about March 2007 but probably variably compliant as mom says she would not allow the medication if he was using street drugs) and being followed by Dr. Velasquez at Kaiser. Temper tantrums were 2-3 times per day for 10-15 minutes each. He was better on a one to one basis. He had been to rehab for alcohol. He was at ROP in restaurant preparation. He enjoyed cooking class and said he may want to do a chef program. He also still liked building things. He was studying for his driver license. It was noted he hangs out with the wrong crowd.
September 2009 arrested with drug paraphernalia and jailed until December 2009. A San Diego Regional Center assessment January 2010 revealed physical aggression resulting in injury more than once in 12 months, outbursts at least once per week and usually requiring intervention. He was having friction with his parents and he wanted his own apartment but he was not going to school or working except he was mowing lawns for small amounts of cash. He was demanding and argumentative. It was noted that he had been released from jail December 2009 and was to be on house arrest for three months. He was drinking alcohol underage and was once arrested with a potentially lethal alcohol level. He was looking into a medical marijuana card. He had insurance via parents at Scripps but he was on no medications and apparently not seeing a psychiatrist or therapist.

A March 2010 CLS assessment described goals of "locate apartment by August 2010 and gain employment by July 2010". Mom was appealing SSI. There was cannabis use and misdemeanor conviction and he was working with Kevin Farrar, forensic advocacy specialist. He was on informal probation for possession of drug paraphernalia. He was to do 30 NA/AA meetings for charges to be dropped but he was unmotivated. He even procured a medical marijuana card. He had had several run ins with police and some time in jail for assault with a deadly weapon and his minor record was not sealed as he did not complete probation requirements. He "forgets to take his medications". Also he had no ability to budget and he was taken advantage of by "friends" who encouraged him to buy $2500 worth of items in one day (when he briefly had access to some money from the motor vehicle accident he was involved in) and then to give all the items to the friend so he had nothing left. Past methamphetamine and LSD use was mentioned and he drank alcohol on occasion. It was noted that family does not restrict his activities. He does not drive but he skateboards sometimes in traffic. He has a cell phone.

On 5/10/10, Referral Name was upset on a Monday morning. Mom called the sheriff as he was out of control and aggressive. He appeared under the influence. Unfortunately the officer became overly aggressive and hit him with an open hand to the head and then apologized profusely. Ankle was also sore after the incident.

At 8/11/10 Solutions Building Project meeting Referral Name's case manager reports a probation violation. He was in a car with someone with drugs. He has argued at court, "you can't tell me what to do". She says he "looks normal" and does not like being around people with obvious disabilities. She reports that he received 40K related to injury suffered in a car accident in 2006. Parents are using it for his legal troubles.

Recently he got access to the account and spent 14K in one month. This was related to the above incident on 5/10/10. She describes LSD use a year ago, heavy alcohol use (once blood level was five times the legal limit) and possession of heroin and cocaine times one. She reports seizures, petit mal and grand mal. She says three other kids are in the house (brothers 21, 16 and near 13 years old) and Referral Name sometimes sleeps in a truck. Mom has health issues and dad is alcoholic and antagonizes Referral Name. Placement elsewhere was cancelled twice by parents. Case Manager also describes two suicide attempts and during one the mom was out of town and dad called 911 (these were described above). Referral Name has an ILS worker but this is "hit or miss" as he is variable cooperative. He says he wants to work and he has been connected with Job...
Options but either does not go or is in court. At the time of the meeting he had been sober two weeks.

As of 8/24/10, he has a new service coordinator at SDRC, SC, M.S. (619)596-1057.

I discussed Referral Name with his mom on 9/16/10. She says his "brain does not process right" and that it is obvious. She says he is childlike. He is agitated and has a short temper. He is on no medications and he is not seeing a psychiatrist. Mom says she did not want him mixing psychiatric meds with street drugs which now include heroin. She says Abilify seemed helpful in the past. He has a court date tomorrow and will attend with Kevin Farrar the Forensic Services Advocate from SDRC. He was ordered to do a three month class and he failed it the first week. The court has not ordered inpatient treatment. Mom mentions Restoration Ranch, a Christian rehab in Ramona but she has not looked into the cost. She has not checked into Scripps resources. She says Referral Name will have a second chance at outpatient rehab and if he fails he returns to jail. She said a friend set up a visit to a prison for Referral Name to see what it would be like. She says he has only done 5 days at a county jail and no prison time.

I set up appointment to see Referral Name 9/23/10 but I had car trouble and by early the next week he was in jail after stealing a Wii game from a store along with other charges. On the jail web site these are listed as felony burglary, theft and under the influence of a controlled substance.

Psychiatric Medication History:

May 2001 "medications stopped prior to neurological assessment and Depakote not reinstated"; not known what other medications were being used then

2/12/03 Paxil and Ritalin
2/21/03 Paxil, Ritalin, and Depakote per a therapy note
3/17/03 Taken off Paxil and Ritalin by neurologist

4/8/03 Restarted on Depakote

4/25/03 Depakote and Seroquel; it was noted that Referral Name had a negative reaction to past SSRI medications with increased aggression and manic like symptoms

In 2003 shunt broke; sometime in 2003 possibly around May there was noncompliance with medication and he punched mom

October 2003 Back on meds Depakote, Wellbutrin, low dose Seroquel, Ritalin and Tenex and Dr. PHYSICIAN noted that he was doing very well then

8/4/04 Depakote, Seroquel and Wellbutrin noted on ER medical visit

6/6/05 Per Dr. Velasquez: Depakote (1000mg per day), Tenex (1mg BID), Seroquel 12.5mg po qhs, and Wellbutrin SR 150mg po BID. He was transferred back to Kaiser from Dr. PHYSICIAN. It was noted that higher doses of Tenex and Seroquel during the day caused sedation and past Ritalin caused severe agitation and Paxil caused irritability. There had been a trial of Adderall as well but no other information on this.

2/2/06 Seroquel dose increase to 25mg po qhs (January 2006 had been the shunt jarring)

2/6/06 Tenex added and other medications continued.

2/23/06 Extra Seroquel dose in am was tried but discontinued due to sedation. This was when he pulled a steak knife on Father. Compliance with meds is questionable February through March 2006.

3/24/06 Depakote (total 1000mg po qd), Tenex (guanfacine, 0.5mg po qam and 1mg po qpm), Wellbutrin SR 150mg po BID and Seroquel 25 mg po qhs

12/07 Abilify and PRN trazadone (possibly started at Mesa Vista Hospital)
ATTACHMENT C

7/08 Abilify and trazodone
12/08 Abilify and trazodone per Dr. Velasquez
3/16/09 Abilify 20mg po qd, trazodone 50mg po qhs
May 2009 same
1/14/10 no meds; looking into medical marijuana card
April 2010 noted in CLS report that he was prescribed Levetiracetam 500mg po BID for new onset of seizures; drowsiness on it

Family History:
Father has difficulty with spelling
Father possibly alcoholic
Paternal grandmother and great grandmother bipolar disorder
Cousin Brittany was on probation in 2006 and attended court ordered anger management classes
Maternal grandfather had limb girdle muscular dystrophy
migraines
cardiac problems both sides

Social History:
Referral Name lives in Santee with his family. Father is an assistant manager at Vons grocery store and mother was a deli clerk and now is a checker at Vons.
Referral Name enjoyed building with wood and riding his bike as a child. It was noted that he liked sports at age 12. At 15 years old he said he liked cars and was interested in mechanics. He also liked tracking the weather in different cities on computer. He said he would like his own apartment and to work after high school. Another time he said he likes poker, energy drinks, "working on wood building stuff, skateboarding, jumping on my bike, and going on My Space". He hated math and did not like all the reading in social studies.
As a teen he liked to put things together such as birdhouses, he was noted to be tender to children and animals, and he liked to mow the lawn and listen to music.
May 2009 while doing courses at ROP in restaurant preparation he said he may want to be a chef but attendance and performance were poor.
In January 2010 it was noted that he likes Xbox videos, music, and skateboarding, scooter, and motorcycle.
Friends were Cody and Andrew. He had his own bedroom at home and a dog and two cats at home. He was described as having a sense of humor and a good heart and that he is a good worker but not working (with the exception of lawn mowing for cash) or going to school at that time.

Past Medical History:
Brain tumor (cerebellar astrocytoma) with resultant hydrocephalus and ventriculoperitoneal shunt placement (posterior temporal) 11/12/91 followed by surgery to remove the tumor 11/16/91. Reoccurrence of the tumor and surgery and a bout of meningitis at age 2 (October 1993).
Surgery for double hernia 1993 at Kaiser
2003 shunt broke and severe behavioral problems noted
EEG 4/7/03 due to "change in cognition and behavior"; normal in wakefulness, drowsiness, and sleep
Labs 4/22/03 with normal LFTs, TSH, and CBC and normal Depakote level 109.5
Head MRI May 2003 apparently normal

SBCC PRELIMINARY FINAL REPORT  PEGGIE WEBB, M.A.  DECEMBER 7, 2012
ATTACHMENT C

Jan 2004 broke right wrist skateboarding
April 2004 fell when his motorcycle hit train track, right knee injury
August 2004 left arm injury after fall off scooter
December 2004 fell off electric scooter and landed on hand; left wrist fracture
February 2005 he was diagnosed with a healing fracture of left wrist
March 2005 slightly low RBC and hemoglobin; Depakote level 85.6, normal liver function tests
June 2005 fungal infection of feet
July 2005 spider bite right leg while camping
October 2005 bout of infectious mono; low hemoglobin and RBC
November 2005 evaluated for foot fungus; culture negative
January 2006 shunt jarred and left sided bruises arm and leg in a serious motor vehicle accident (hit from behind by a drunk driver on a Sunday night at 11pm) with similar behavioral problems as in 2003 afterwards. C-spine films showed "shunt disconnection, a break in the silastic tubing distal to the connector behind the right ear". There was normal lateral and third ventricle size and slightly large fourth ventricle. Assessment in ER was "old shunt separation; shunt very likely separated years ago". No symptoms indicating acute shunt failure.
He later in January 2006 had abdominal films to assess distal shunt which "courses subcutaneous in right lower chest and abdominal wall and enters the peritoneal cavity at the level of L3-4".
February 2006 he had a CT of head without contrast; stable head CT with VP shunt in place; intraventricular shunt catheter entering the right posterior parietal region
February 2006 he had abdominal plain films rule out rectal foreign body
February 2006 Depakote level 85.9, LFTs normal, lipids normal, CBC with mildly low hemoglobin and RBC but improved from October 2005
No history of seizures noted in 2006
March 2006 frequent headaches, and good appetite, but very picky and "only soft or junior foods"
March 2006 MRI of brain with and without contrast showed no recurrent tumor and no evidence of acute infarct
March 2006 right shoulder injury after trauma; broken collar bone
April 2006 refusal to brush teeth; had been diagnosed with gingivitis
Use of energy drinks May 2006
May 2006 vision and hearing normal
January 2007 complained of headaches
Dental visit December 2007 and none in two years noted January 2010
Noted in CLS assessment April 2010, he was prescribed Levetiracetam 500mg po BID for new onset of seizures. Also case manager reported seizures (petit mal and grand mal) at team meeting SBP August 2010, so possible new onset seizure disorder (could be substance related with risk factor of past head trauma)
Sexually active and uses condoms per April 2010 note
Hit on head with open hand by police May 2010
Per case manager 2010 out all night for four nights, injured self on scooter while drunk; hit someone's car and cut head and knocked front teeth
Cigarette smoker and use of energy drinks
NKDA; lactose intolerant? (hates milk)

Substance history:
"Consumption of wine 2-3 times per week" noted by a therapist 2/21/03 (this would have been at age 12 and no other comments about it were made in that note by the therapist)
March 2006 (age 15) episode of alcohol abuse and an episode of trying to get cannabis from a peer while staying with an aunt
Had May 2008 court for drug related charge
December 2008 stole from parents for money for alcohol
One arrest with potentially lethal alcohol level. Per case manager he gets drunk to the point of passing out on a neighbor's lawn. One past rehab program for alcohol noted in May 2009. Occasional alcohol use noted April 2010.
September 2009 arrested with drug paraphernalia.
Known to use cannabis and acquired a medical marijuana card by March 2010
Past methamphetamine and LSD (case manager says LSD one year ago) and heroin and cocaine possession times one per case manager but recent heroin charge and frequent use and this week charged with burglary and under the influence of a controlled substance
Mental Status Exam on 11/16/10: Referral Name was seen by myself and Tamara Stark at the jail. Referral Name is a right handed, thin male with disheveled grooming who appears younger than stated age. He is fully alert and oriented and cooperative with evaluation. He appears anxious and mildly antsy. Otherwise there are no abnormal movements. His posture and demeanor are timid and passive. His thought pattern is normal and he seems to understand most questions and, if he does not understand, he is able to ask for clarification. Referral Name admits to depression and his main complaint is anxiety. He says this is longstanding and it is helped at home by smoking cigarettes. Affect is constricted and near tearful at times. Thought content is without SI or HI. He denies any thoughts of not wanting to live or any suicidal intent. There is no evidence of psychosis. He is able to do simple calculations. He signed a release of information for me to speak with the therapist at the jail.
Assessment:
Axis I: Bipolar Disorder NOS; polysubstance abuse; additionally Anxiety disorder NOS (noted on interview with Referral Name 11/16/10)
Axis II: Mild Mental retardation
Axis III: cerebellar astrocytoma with shunt placement 10 months of age and reoccurrence of tumor with second surgery and meningitis age 2, shunt broke 2003, jarring of shunt 2006; hernia surgery age 2; multiple injuries with broken bones mainly 2004-2006; gingivitis; headaches; possible new onset seizures 2010; head injury 2010; mild head injury while intoxicated 2010
Axis IV: financial, legal, dependent on family for food, shelter and clothing
Axis V: 31
Recommendations:
This is a challenging case and Referral Name is deteriorating as the substance problem worsens. Referral Name is undisciplined, has no boundaries or rules, and dad has unfortunately taken a backseat. There have been insufficient rules and expectations for years. Even as far back as the January 2006 motor vehicle accident he was, at age 15, out with friends on a Sunday night, a school night, at 11pm when the accident occurred.
Also there was the note from Kaiser which mentions consumption of wine two to three times per week at age 12 (need to confirm the validity of this). The older brother complained about mom’s lack of limit setting at a Kaiser therapy session. It sounds like dad came on strong initially but has since backed off to the point of uninvolved. I really do not like to point blame at family members when they are dealing with very difficult circumstances, however in this particular case there has been a clear pattern of mother sabotaging treatment and other interventions.

Mother has refused help when Referral Name and the family most need it. This is probably related to something in her early background which makes her create a scenario in which she is fully responsible for someone and noone is helping and she is resentful that noone is helping but she will not allow the help. This would have to be very delicately explored with her. She may have been forced into a caregiver role at a young age for example and is recreating this with Referral Name.

Examples of the problem over the years include the interference with Dr. PHYSICIAN's treatment by taking him off medications which worked, complaints about the school system not accommodating Referral Name and not even caring (per her complaint they did not even read his IEP report), refusal of Kaiser sessions just when most needed with the excuse of having to pay the copay, refusal of a psychological evaluation recommended by San Diego Regional Center stating that it was just "teenage behavior" and the assessment "will not help", refusal of placement in alternate housing by San Diego Regional Center three times, refusal to initiate psychiatric care at Scripps when their insurance changed determining on her own that he should not have psychiatric medications if he is using street drugs. And then taking on the problem herself by planning to set up a visit for him to see a prison so he would see what it is like and stop using drugs.

Even with me she set up a very narrow range of time in which I could see him and so it was impossible to go there later in the day after my car was repaired even though it was her day off, as she had other appointments in the afternoon which took priority. She wanted to be there when I saw him. When she knew of my cancellation she said she might try to call and cancel SC (SDRC case manager) and Kevin Farrar (forensic specialist) as well (they were coming at the same time as me).

Some of these are subtle examples and could be rationalized and explained away, but the big picture reveals a larger problem and the recent outcome for Referral Name supports this.

There is also a persistent focus by mom on the remote brain surgery and later head injury as the cause of his problems which places the psychiatric illness as secondary and gives Referral Name an "out" in regard to his bad behavior. The childhood bout of meningitis could be more significant in regard to the intellectual disability than the cerebellar tumor as the cerebellar tumor would more likely effect coordination and balance. He did have an increase in falls and injuries after the 2006 shunt jarring. Also, the psychological and behavioral issues which mom prefers to attribute to the brain surgery and later shunt problems is more likely a manifestation of the bipolar illness which runs in the family on dad's side and which was diagnosed by a child psychiatrist at a young age due to clear mood cycling. Also auditory hallucinations began in early adolescence.
ATTACHMENT C

The discouragement of medication use by mother along with the substance abuse by Referral Name are fueling the fire of the bipolar illness. It will be harder to treat if left untreated. Priorities in the recent past should have been substance treatment and psychiatric treatment and therapy, but these have not been pursued. Referral Name was allowed to continue living at the home despite the repeated bouts of intoxication and violence toward mother earlier this year.

Recommendations depend on the legal outcome of the current charges, which are serious. If he returns home, discussion with mom about the above issues will be critical. Getting her on board with the treatment plan will be important. Family therapy is recommended with the therapist being aware of the information in this report. Also communicating with Referral Name directly and increasing his autonomy will be important.

Getting Referral Name back in psychiatric care is the first priority. Inpatient or residential rehab will probably be needed possibly through their Scripps insurance. A restrictive sober living situation would be ideal. TLM in Oceanside might be a good choice as there is 30 day restriction of activities and one to one supervision after that if necessary. They have done a lot of good for some very long term substance abusing and treatment resistant ACT clients some of whom have borderline intellectual functioning. SSI could be reapplied for to help pay for that, as he has a clearly documented Axis I diagnosis (Bipolar Disorder Type I) diagnosed way before the substance problem. A very limited number of medications have been tried for the Bipolar illness with variable compliance. Once psychiatric treatment is reinitiated at Scripps, Referral Name's psychiatrist might consider either a monthly Invega shot or Risperdal shot every 2 weeks.

His use of energy drinks should be assessed and basic labs including chemistry panel, CBC, thyroid labs and basic urinalysis will be helpful. The legal system will probably be checking toxicology screens.

Use of condoms with every sexual contact should be confirmed. Also if he is using dirty needles there is a need to check HIV status now and 6 months out from use.

Also there were apparently some recent seizures which were treated and then treatment was stopped. I do not know if treatment was stopped by his physician or on his own. He needs follow up on the new onset seizures which are probably related to the substance use, with the risk factor of past head injury.

He needs dental follow up. It was noted that he only eats soft foods and I do not know if this is related to dental or other issues.

Input from Dr. Sweetland will be helpful about ways to structure his time and create more responsibility and ideas about healthy activities. This will help his self esteem, because running loose on the streets provides immediate gratification but I am sure he is sinking deeper and deeper in his self-regard.

I am not certain that neuropsychological testing is needed at this point. He has been tested several times in the past and strengths have been documented as expressive vocabulary, immediate auditory memory and "hands on activities" like computer use. This information could be utilized once he is ready to work. Testing might be repeated once he is secure in his sobriety.

I had no access to Mesa Vista Hospital records, or the Kaiser outpatient records after the March 2006 ones. These would be helpful.
Lastly there are two minors in the home and assessment of the effect of all this on them should be addressed. It is important to question about substance use by siblings for example and possibly necessary to involve CPS if this is occurring.

Thank you,
Colleen M. Connor, M.D.
cell (619)379-0914

Addendum: I spoke with Referral Name on 11/16/10 at the jail. He described the events leading up to the arrest. He says he was in the parking lot of the trolley station and a car approached him and his friend. The man first spoke to the friend and then Referral Name thought it was okay to speak with him. He says the man told him that if he stole about thirty dog toys from the pet store he would get 100 dollars. Referral Name stole the toys by stuffing them in a backpack and then he left the store stealing the items without getting caught. While riding his bike home he saw a police man and feared the policeman would stop him and find #5 Xanax he had on him from a friend. He took out the Xanax and threw them into a bush drawing attention to himself. Police then stopped after seeing him do this and they asked to search his bag and found the toys. He says the officer told him if he tells the truth he will not get in trouble or be arrested. Then the officer arrested him when he had no receipt for the toys. It is not clear why he was charged with burglary and not shoplifting.

Referral Name says he did it as he had no money. He says he would not feel the need to steal if he had $40 in his pocket. He says he would stretch this out over several days if he had it. He says there was money he had from the MVA injury but he spent it all.

We asked about the prior incident of stealing and he says he also stole in order to trade the item for money then.

Referral Name says he has been using marijuana and smoking heroin (no IV use as a cousin died from IV use). He was high on the day he stole the dog toys.

Referral Name's main concern is getting out of jail and going home. He would like to be on house arrest and then go to rehab. He is upset because family will go on a motor cross trip on the weekend and he wants to go with them.

Referral Name said he was put on Zoloft in jail and had a seizure on it. His roommate witnessed a full seizure. (There was past agitation on SSRI meds.) Referral Name did not mention his history of seizures or bipolar illness (and treatment with Depakote and Seroquel) to the doc who prescribed the Zoloft. He is currently on trazodone for sleep.

Referral Name was resistant to the possibility of living anywhere other than home. It seems that home is comfortable and safe and there are no restrictions or structure at home so it is where he can feel least anxious. It seems that the anxiety escalates at the thought of a group home or rehab facility. This is consistent with his failure at rehab after one week and there is also information that he had a conflict with roommate at the prison he was at recently.

The thought of living away from home seems almost foreign to him. It may be partly related to the fact that the older brother has not left the home either even though he works full time and attends school. It seems to be a tightly knit family that does a lot of motor sport activities together.

For the reasons stated in the evaluation above a return home is not ideal and very problematic. A structured setting in which he is monitored 24 hours per day would be ideal. Tamara mentioned the possibility of a traumatic brain injury group home where
there are a lot of normal appearing but impaired residents similar to Referral Name. We would have to get mom and the family on board with this. The alternative is very aggressive family therapy with an experienced family therapist informed about the case to address the family issues I outlined above.

Colleen M. Connor, M.D.
cell (619)379-0914
ATTACHMENT C

ATTACHMENT D

FORENSIC NAVIGATOR – Tamara Stark

Note: multiple calls and contacts with jail, probation and team members. Some listed below.

08/11/10: Initial Consult, Navigator followed up with Probation for clarity on legal status

10/04/10: Attempts to schedule visit with Referral Name at Jail unsuccessful

10/06/10: Facilitated contact information for letters to be sent to Karen Hirr; Referral Name’s public defender by Mary and Colleen

10/21/10: Call from Kevin Ferrar, regarding Referral Name. Referral Name interested in Freedom Ranch rehab.

11/08/10: Calls to Jail, calls to Kevin Ferrar to inform of legal status, currently in jail

11/14/10: Contact with Kevin Ferrar, SDRC Vendor, who states Referral Name will go to court 11/18/10.

11/16/10: Interview synopsis with Referral Name in County Jail:

Per the jail clinician, SD saw jail psychiatrist on Nov. 6th and was prescribed 50mg Zoloft am and 100 mg trazadone at bedtime. SD reported to clinician that he had a seizure Saturday morning 11/13 and he would stop his Zoloft for this reason. He said his cellmate saw him having a seizure while sleeping. He refused Zoloft 11/4 and 11/15 but resumed taking it 11/16/10. Jail reported that they are also in contact with his mother. She reported to them that Referral Name has had some seizures in the past. She did not give additional information regarding past medical care or medications. The clinician also reminded me that the jail has very limited oversight to ensure that inmates don’t cheat medications so although they are passed to the individual, they are never sure about compliance.

I passed on the information to Jail Clinician shared by Dr. Connor, that he has been on Depakote in the past. They would like to receive any of your reports or other SAT Team reports, that we feel could assist them with his care. Please fax atta. David Fleming at 619 615-2440 if you feel it is appropriate. David is our Downtown jail clinical contact and very open to working with the team to facilitate care for any SAT team participants.

David also told me that all Regional Center clients in jail are to be in protective custody which means they will be housed solo in a cell or in a cell with another Regional Center consumer (good to know but not sure why this is necessarily safer than with another inmate). Because of this, Referral Name was transferred down to George Bailey last week to share a cell with 2 two other RC consumers. He and his cellmate engaged in an altercation of some type (no details). Referral Name now back at Downtown jail in cell alone.

Referral Name shared with me and Dr. Connor that he wants to go to rehab to get out of jail and to get clean to he will stop "messing up my life". Referral Name said that he could talk to his attorney and judge he would ask to be put on house arrest or stay in jail until he can get a bed in a rehab. He said he wants to try. He would skip detox and go straight to rehab that Mary can find. He also expressed how much he wants to work, earn money and feel useful. He said he has never received job support from SDRC and is open to that as a future goal. He also agreed that RC should be his payee.

Systems Navigation discovers a Traumatic Brain Injury program in Escondido. Other persons receiving RC services participate there. Recommend SDRC investigate as possible residential placement for SD.

SBCC PRELIMINARY FINAL REPORT  PEGGIE WEBB, M.A.  DECEMBER 7, 2012
ATTACHMENT E

Substance Use Disorders Navigator: Mary Hubbard

10/06/10: calls to McCallister Institute to assess bed availability for Referral Name.
10/06/10: Letter to Judge for 10/08/10 arraignment.
10/15/10: call from SC Friday evening; facilitated open bed at McCallister for Saturday a.m. 10/16/10.

Calls and contact between several programs in San Diego that may be viable opportunities for Referral Name for rehab/recovery should he choose to take advantage of them.
Several calls and contact with team members about these opportunities.

10/16/10- 10/20/10: follow up calls with program that Referral Name left about nature of the exit. Training provided to program about accommodations for persons with dual diagnosis.

11/17/10: investigating other resources for Referral Name. Appropriate placement/opportunities for treatment dependent upon outcome of 11/18/10 arraignment.
CROSS SYSTEMS INFORMATION

Referred to Project: June 2, 2008  Plan Completed: June 30, 2008  Updated: 09.30.2008

I. Name: Candy Striper

II. ID other:
   Date of Birth: 07/23/77
   UCI # (SDRC): 9999999
   Insyst #: 000-0000

III. Address: 856 Candy Apple Ln., San Diego, CA (ILF) Phone: 555-555-5555

IV. SDRC Service Coordinator: Joe Biden  Contact Number: 1-858-576-2996

VI. CLINICAL SERVICES:
   - Outpatient Treating Psychiatrist: Sarah Palin, D.O.

VII. INSURANCE: Medi-Cal

VIII. 2008 HOSPITALIZATIONS/VISITS; extensive; see insyst report for hx;
      recent
      Bond’s Hospital: 08/20/08 - 8/22/08
      Hope Mercy: 08/05/08-08/08/08
      Ideal Memorial: 07/23/08-07/28/08

IX. CRISIS HOUSE VISITS; recent; 0 visits

DETAILED MEDICAL HISTORY AND OVERVIEW – ATTACHMENT A pg. 2
DETAILED BEHAVIORAL-CLINICAL IMPRESSIONS – ATTACHMENT B pg 9
CURRENT SUPPORTS/SERVICES THROUGH SDRC - ATTACHMENT C pg 12

CRISIS SERVICES PROTOCOL (for the Emergency Medical System)
1. INFORM: If contacted by community medical staff, UBH staff will
   fax current plan as is, to medical personnel to facilitate crisis care
   coordination.
   2. CONTACT
      i. Emergency Contact: Joe Biden; 858-576-2996
   3. REFER: If patient requires specialty mental health services other than
      acute care hospitalization, refer to appropriate community based
      resources.
   4. FOLLOW UP: SC will notify Team of hospital visits/incidents to
      update plan. Team is available for consultation and training if
      requested.
ATTACHMENT D

ATTACHMENT A MEDICAL INFORMATION –

Completed by Colleen M. Connor, M.D., Solutions Building Consulting Psychiatrist
Phone: 333-333-3333

06/2008

Candy Striper is a 31 y.o. female of with dual diagnosis of intellectual disability and mental illness.

She was born at a normal birth weight to a mother who was age 22 and a slow learner and a father who was age 24 and also a slow learner with poor coordination. The labor and delivery appeared normal.

NOTE: Extensive medical including family history has been removed from this document. The history is detailed beginning with infancy, and significant medical/familial/legal/bereavement/residential/vocational events noted at age 1, 14 months, 3 years, 5 years, 10 years, 12 years, 14 years, 20 years, 21 years, and every year thereafter up to the present.

This section is several pages as Candy has had numerous hospitalizations, for unstable, high risk substance abuse, suicidal or self injurious behavior. Frequent contact with law enforcement also occurs.

Her housing has been unstable, sometimes staying with family, motels, independent living facilities, board and care facilities, crisis houses at various times, and periodically homeless.

Past Medical History

Frequent colds and bronchitis as a child
Ear infection 1984
Bilateral hip dysplasia (unstable/dislocatable hips) diagnosed at age 17 mo.
Unknown congenital syndrome with blue sclerae as an infant, high pitched cry as an infant, underdeveloped thoracic creases, double parietal hair whorls (uncommon and possibly an indicator of altered size and/or shape of the brain prior to 12 weeks of gestation), loose ligaments with B/L congenital hip dysplasia, B/L clinodactyly of fifth digits, small hands and feet with tapering digits, Hx microcephaly and plagiocephaly as an infant, dev delay and learning disabilities, obesity and short stature. Some of features were noted to be c/w Prader-Willi phenotype. A connective tissue disease such as Osteogenesis imperfecta or Ehler-Danlos syndrome were considered. Normal chromosomal analysis (46,XX).
Large flat hemangioma left buttocks and posterior thigh in infancy
Mild lumbar kyphosis (structural anomaly in the spine)
Obesity since late teens
Chronic knee dislocation problem with falls; she was to have surgery. In 1994 wore a knee brace. In 1999 she was supposed to wear braces but refused.
High foot arches and painful calluses noted in 1995
Degenerative joint disease (a cane was recommended)
Hypothyroidism in 1999- treated? (TSH 21.43); in 2006 TSH 5.37 and was treated
Hypertension treated w/Lotensin in 2001, Diovan in 2008
Hx asthma? Received Combivent MDI in 2005
Smoker ½ PPD
Diabetes Mellitus Type II, treated with glyburide and glucophage in 2001, glyburide in
2005. Avandia and Lantus insulin in 2006
Increased LD and total cholesterol in 1994
Hx UTI 10/06, mildly reduced TP, Albumin, and calcium in 10/06, decreased HDL
cholesterol of 38 then as well.
Frequent bowel or bladder incontinence (noted in 9/01 to occur in the day and not at
night). No organic etiology found. Vasopressin not helpful. She wears Depends.
Past birth control pill use to regulate periods.
Record states she may have had a tubal ligation
GERD diagnosed 4/07
Miid mitral regurgitation 11/06

Family History
8 notations; family medical history extensive

Substance History
Crystal meth and THC use noted in 1999 and 10/06
She denies overuse of the pain medications ever.

Current Medications: possible changes see Dr. Palia for update
Geodon 60mg po TID (mood lability, AH)
Abilify 20mg po qhs (mood lability, AH)
Trileptal 300mg po BiD and 600mg po qhs (mood lability)
Benadryl 25 mg po qhs (insomnia, EPSSE)
Zoloft 100mg po qam (depression and anxiety)
Lipitor 10mg po qam (cholesterol)
Zetia 10mg po qam (cholesterol)
Diovan 160mg po qam (HTN)
Claritin 10mg po qam (Allergies)
Glucophage 1000mg po BiD (DM)
Synthroid 50 micrograms po qam (thyroid disease)
Detrol LA 4mg po qam (bladder incontinence) and wears Depends
Flonase PRN (asthma)
Propoxyphene HCL 65mg po q6hours as needed for pain
Darvocet-N 100 one po q6 hours as needed for pain

Allergies: penicillin, Tylenol, beestings, pollen, strawberries, peanut butter

Past medication trials
past Prozac “not helpful” in 1999
One dose of IM Prolixin received in the past per Dr. X.

**Diagnoses**

**Axis I:** Schizoaffective disorder, Bipolar type
- Polysubstance Abuse, in remission
- Nicotine dependence
- Complicated bereavement

**Axis II:** Mental retardation, mild
- Personality Disorder NOS (mixed features- borderline, dependent, antisocial)

**Axis III:** Congenital abnormalities as described including connective tissue disease, hip dysplasia, Type II diabetes mellitus, HTN, thyroid disease, GERD, asthma,

**Axis IV:** primary support group, housing, medical issues

**Axis V:** 35, highest not known

**Recommendations**

Candy complains of severe mood swings on a day to day basis. Every day she thinks, “am I going to be in a good mood or a bad mood today.” She is not compliant with medications.

I discussed with patient the variable medication compliance and the risk of worsening of the course of the illness due to this. I suggested IM Risperdal Consta. She at first resisted the idea but then she stated that she is interested in it. I gave her an information pamphlet to take to her next psychiatric appointment with her new psychiatrist. She has tolerated oral Risperdal in the past.

Consistent treatment of the psychiatric illness with IM medication would allow for easier placement.

She denies any recent bloodwork. I did not have any recent labs for review. She may need updated bloodwork.

Regarding the enuresis and encopresis, she denies any problems with toilet training and completed it at 4 yo. The problems began after … remove notes.....relative died.. “It took me 3 months to go back to school.” She started to urinate inappropriately at school and was suspended. She describes it as “attention seeking behavior”.

Remove notes; second family dies..
Remove notes; friend dies ; the patient attempted suicide.

There seem to be a lot of unresolved grief issues and Candy may benefit from specific grief therapy techniques in individual psychotherapy.
ATTACHMENT D

Dialectical Behavioral Therapy would benefit patient. I think it is a very critical part of the treatment plan. She will need extra guidance due to the intellectual disability, but on exam she is very talkative and engaging.

Assistance in finding a day program or clubhouse program would also be helpful.
ATTACHMENT B

Review of Clinical Issues and Behavioral Recommendations
completed by Darlene Sweetland Ph.D.

NAME: Candy Striper
AGE: 31 years old
RESIDENCE: Candy Apple Lane
TYPE OF RESIDENCE: Board and Care

Candy is a 31-year-old woman who is diagnosed with Mild Mental Retardation. There is also record of a diagnosis of “paranoid schizophrenia”. In addition, an evaluator for the B Regional Project at X Developmental Center wrote in her report “if not per her report, I’d say Personality Disorder, maybe Borderline or Hysterical Personality Disorder.” She also suffers from various medical conditions (please see the medical section). She walks with a gait and reports she “cannot do stairs” which has impacted past living situations.

Candy is a very friendly and social woman who expresses herself well using a well-developed and fluent vocabulary. She has a bright smile and enjoys it when people visit her. She is liked by others and currently has a boyfriend of two months. She speaks of spending time with him as one of her favorite activities. She said her main goal is to live independently with the support of a staff person to help her with some daily living skills. She said she also wants a job in the community so that she can earn money to support herself.

Candy has lived in various board and care homes as well as Level 2 and Level 3 Regional Center group homes. Her stays have been brief because she has a history of frequent hospitalizations following suicidal ideation or plans. She was hospitalized several times per month over the summer and seven times since October. Her most recent hospitalization occurred last week following an overdose on her medication. She said that she did it because she was mad, but that “it wasn’t worth it.” Behavioral challenges that have interfered with her living situations are suicidal ideation, incontinence, and high-risk sexualized behavior.

Candy said that she really wants to live independently and that a group home with behavioral support would not work. She said that while she would like staff to assist her, she wants her freedom. She said that rules at group homes don’t work for her. Candy has had long-standing struggles with completing ILS (hygiene, taking medication, getting up in the morning, attending day program). She said she understands she must do these things to get the things she wants but that she just “can’t”. She attends day program less than two days per week and her day program staff have tried reward programs, natural consequences (she can’t get a job in the community if she is not reliable), and support with no success. Positively, in the past few months Candy has been more open to discussing the issues that are preventing her from reaching her goals. She understands that not going to day program prevents them from finding her a community-based job.
She also reported she is “a habitual liar”, which she has been reluctant to admit. She is also able to identify some of her behavioral responses as what she call “behavior seeking”, which upon explanation was attention seeking.

Candy has been most successful when she has continual support from others to complete her ILS, take her medication, and talk to her when she is angry or sad. The director of the program providing ILS hours for her, Betsey Ross, reported her staff try to make themselves available to her when she needs emotional support. Ms. Ross said that consistent, unconditional support and an immediate person to talk to when she is angry or sad has really helped.

Candy is described as a woman who desires affection and unconditional caring. She is very social and sensitive. At the same time she has had a lot of difficulty establishing long-term relationships. **Removed notes.** She has the desires and goals of many women her age. Records indicate her cognitive level is in the mild range of mental retardation, she expresses herself very well, and appears to possess the skills to care for herself. However, her emotional regulation and coping skills are very immature. She said at times she uses incontinence as a way to express anger, doesn’t take medication because she “doesn’t feel like it”, took an overdose on medication because she was mad and doesn’t like to get up for day program because she is tired. These are very primitive ways of coping. At the same time, they are successfully keeping people around her to support her.

Candy often lets people know when she is upset and needing support. Therefore, she may really benefit from having a list of people she can call for support:

**Step 1:** Talk to staff at the residence
**Step 2:** Call family member or friend
**Step 3:** Call ILS worker
**Step 4:** Call the crisis hotline or “warmlines”
**Step 5:** Call the crisis team

**BEHAVIORAL CONSIDERATIONS:**

- Candy repeatedly talks about wanting independent living. However, she described the desire to have a person available to her regularly to help her get going in the morning.
- Candy would really benefit from having access to someone who could
  1. wake her up in the morning
  2. help her with hygiene
  3. help her make a healthy breakfast
  4. help her with medication and talk to her about the purpose of it
  5. assist her in getting to day program
- Candy acknowledged that one reason she doesn’t do things for herself is because she enjoys the support she gets from others, therefore, it is very important not to take the support away as she gains skills. She has long-term and engrained habits that are likely to return if the support is taken too quickly.
• It will be very important to provide Candy with a lot of support and positive attention when she is doing well. This will help to change her pattern of engaging in unsafe behavior to gain that attention, what she calls “behavior seeking”.

• Always be aware of secondary gain with Candy’s behavioral patterns. For example, she said one reason she does not want to overdose again is because the charcoal tasted bad and the hospital stay was too short. She said it was “not worth it”.

• It appears that she automatically responds to emotional discomfort (anger, depression, anxiety) with acting out to bring people to her. She does not feel she has the skills to cope on her own. It will be important to offer her the support that she desires without her acting out. Reinforce the pro-active and safe ways of letting people know how she feels.

For example, if she responds to feeling angry by calling someone on her support list it would really reinforce this if someone came by the next day to take her to lunch and check on her. This may be a program that can be set up with her ILS workers since they are seeing her most days anyway.

• Candy has shown that she may act on a statement that she will hurt herself, therefore, any threats of self-harm must be taken very seriously.

The SAT Team behavioral specialist can offer the following services:
1. Training and consultation to any staff working with Candy
2. Collaboration in developing a behavioral program with Candy and a staff person.
ATTACHMENT D

ATTACHMENT C – San Diego Regional Center Services
Coordinated by Joe Biden; 858-576-2996

- SDRC provides coordination of services, including monitoring of health and safety.
- SDRC is rep. payee for SSI for C.S.; and facilitates securing appropriate residential care and payment for residential care using these funds.
- SDRC funds Independent Living Support Services from *Independence Plus*:
  Contact: Betsey Ross; 444-444-4444.
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Note: A small percentage of individuals referenced for community education have participated in more than one presentation, making the total number of individuals receiving training slightly smaller.

- Certificate of Excellence in Dual Diagnosis
- Provider Trainings to Direct Care Professionals/Staff in multiple systems
- Statewide Conferences
- General Presentations to multiple audiences
- Mental Health Resource Fairs and special topics
- Grand Rounds Target Audience - Physicians
- Scheduled training with estimated numbers
ATTACHMENT F

Fundamental Goals and Motivation Sensitivities
based on the Reiss Profile (2001)

NAME: Dan
AGE: 26 years old
GENDER: Male
RATERS: Raggedy Ann – residence support person
        Andy Stanford – residence support person

Here is a rank ordering, from most to least important, of basic desires and values that Dan finds important:

- Romance
- Independence
- Physical Activity
- Frustration
- Curiosity

The following motivations were considered neutral to Dan:
- Attention
- Order
- Social Contact
- Acceptance
- Anxiety
- Pain

The following motivations were considered unimportant to Dan:
- Eating

Profile Description
According to raters, Dan has a strong desire for sex, which he is likely to seek frequently (romance). He is likely to spend more time and energy on this aspect of his life than would his peers. He also shows a strong desire for independence. Individuals with high independence scores have a desire for self-reliance. They are reluctant to ask for help and show a high desire for independent decision-making.

According to raters, Dan tends to be irritable, angry and impatient (Frustration). At the same time, he has the desire to be free of that anger (Tranquility II-TQ2).

Dan’s profile also indicates he has a strong desire for physical activity. People with these ratings want to be fit and exercise regularly. They also tend to want to participate in vigorous activity that challenges their stamina or strength. His profile also showed a person with a low interest in eating. These individuals tend to have weak appetites and rarely think about eating.
ATTACHMENT F

According to raters, Dan also has a high curiosity and desire to learn. People with this rating are highly motivated to explore new places and manipulate novel objects. They enjoy observing what is going on in their environment. They are happiest in environments that offer the opportunity to explore and learn.

Environmental Profile

Given the results of this profile, Dan may be most successful in a home and occupational environment that offers:

* support people who provide coaching in frustration tolerance and anger management
* exercise and physical activities can be a great coping skill when feeling the agitation of anger or frustration
* regular outlets and opportunities to participate in exercise, this should be part of his every day routine
* eating and mealtimes set up as part of his routine; with a low interest in eating it will be important that his support staff monitor his blood sugar and food intake (particularly with an exercise routine)
* support people who are open to discussing and assisting him in identifying safe modes of expressing his sexual interest
* intellectual stimulation
* opportunities for learning new things
* an occupation that allows him to feel independent and valued
* new activities offered frequently
* independence is very important to him, so keeping him involved in setting his goals will be very important
* goals moving toward increased independence are likely to be the most motivating for him
* unstructured or down-time is likely to be a high risk time, so a structured schedule of activities offered will be important
ATTACHMENT G
SBCC PHASE III
SKILLS SYSTEM PILOT SUMMARY

The Skills System pilot was launched in Phase III after work was completed and analyzed in Phase I. In Phase I, it became apparent that many individuals with high frequency, high intensity needs would benefit from emotion regulation therapy. Given the unique nature of their disabilities, including a developmental disability, many individuals in need of this therapy, required adaptation to the typical Dialectical Behavior Therapy approach offered in the community. In researching possible options in this regard, the Skills System provided the parameters and structure that seemed to meet this need perfectly.

The project collaborated with The Center for Personal Growth to pilot this therapy approach for persons with a dual diagnosis. The architect and author of this approach, Julie Brown, LICSW provided initial intensive training to all therapists, the Project Director and the SAT Team Psychologist. Julie then provided ongoing consultation to the therapists throughout the pilot. The pilot began in January, 2011.

Individual and Group Therapy was provided for each pilot participant for 6 months. Group therapy only was provided for the next 6 months. Ideally, individual and group therapy should be provided throughout. However, due to budget constraints of the pilot, the individual therapy component was provided only for the first 6 months. In addition to this therapy, the SAT Team Psychologist also provided monthly training and support in the Skills System to identified care givers and support persons. This adjunct training and coaching was to support the participant’s use of SKILLS in their day to day environments. The support persons were able to support individual and group learning in this regard. They were able to encourage persons to use their Skills when circumstances arose where these tools would aid in emotion regulation.

The total number of persons referred to the Pilot as of Dec. 1, 2011 was 31. The pilot initially provided two groups (one adult and one transition age youth (TAY) . In April 2011, the pilot combined groups due to the smaller number of referrals for the TAY group. As of December, the group enrollment remained steady at 9 persons with average of 75%-100% attendance in later months. In general, the group’s attendance was very high, averaging in the 80% range.

Attendance the support persons group was less consistent with one or two supports persons consistently absent from this monthly group. Nonetheless, caregiver responses to a pilot survey were very positive.

The pilot participants and their support persons completed both a Reiss profile and the Supports Intensity Scale (SIS) prior to participation. The Reiss profile was very useful to both therapists and staff in looking at motivational sensitivities and how these impact emotion regulation. It is not surprising that for many individuals referred for the Skills System, the Reiss Profile suggests an anxiety disorder or obsessive compulsive disorder be considered. The SIS was conducted at the 6 month mark as well in order to evaluate any areas of change. See Table below
### Change in SIS Score, Before vs. After Six Months Therapy

<table>
<thead>
<tr>
<th>Person</th>
<th>A</th>
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<td>1</td>
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<td>C. Change in Lifelong Learning</td>
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<td>E. Change in Health &amp; Safety</td>
<td>1</td>
<td>7</td>
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<td>F. Change in Social</td>
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The SIS Support Needs Scale was successfully administered to eight people before and after 6 months of individual and group therapy. The change in the composite scores in this test are summarized in the table above. The composite scores are reported by SIS to have 95% confidence limits of about +/- 3. Differences in the composite scores were generally less than that, and therefore were too small to demonstrate change with this particular test. One possibility is that the duration of therapy (six months) was too short to effect a change which could be measured with this test. In research by Brown and Brown\(^1\), their study showed improvement in the first year with continued gradual improvement over the first three years.

However, the lead therapist for the pilot also developed a satisfaction survey which was completed and returned by 6 of the participants and 5 of the support persons. The specific results of this survey are included at the end of this attachment. The responses highlight the results of this pilot in a very positive way. All individuals provided very positive feedback throughout the project to caregivers, service coordinators and family members. One service coordinator provided a detailed summary of how learning and using this tool made a significant impact upon one participant including a 40 pound weight loss, securing a $15/hr employment doing house cleaning, improved relationship care with significant others and a feeling of accomplishment and well being. In the words of this service coordinator, the success of the pilot for this participant has 'reinforced my belief that with the right support and tools people can change."

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\(^1\) In press; Brown, Julie, Brown, Milton, DiBiasio, Paige- Justice Resource Institute-Effectiveness of Dialectical Behavior Individual Therapy and the Skills System for Individuals with Intellectual Disabilities.
Survey Responses

INDIVIDUAL PARTICIPANTS: 3 returned surveys to date (10/10/11), 3 additions (10/25/11)

1. What was your favorite part of the Skills System Group?
   
   Response 1: “The games that were played during class.”
   
   Response 2: “I like learning how to have better relationships.”
   
   Response 3: “Learning different skills and how to rate my feelings.”
   
   Response 4: “Therapy with Kathleen. Participating in group.”
   
   Response 5: “Talking to People: Snack”
   
   Response 6: “Going to Group”

2. What would you change about the Skills system Group?
   
   Response 1: “Have a longer counseling time.”
   
   Response 2: “Nothing I like it like it is”
   
   Response 3: “No Changes”
   
   Response 4: “Continue to have therapy with Kathleen.”
   
   Response 5: no reply
   
   Response 6: no reply

3. Since you started receiving individual therapy and began attending the Skills system Group, do you feel you are in better control of your emotions?
   □ [ ] Yes □ [ ] No
   a. If yes, please tell us why you feel more in control.
   
   Response 1: “I use my skills when I need them. I have learned what to use when I am angry.”
   
   Response 2: “I don’t feel so depressed. I feel more in control. Because I’m learning more about thing. I need to know. I know how to made my life more happier with new me activities.”
   
   Response 3: “I’m learning to control my emotions by going through the skills list. That helps me think things through instead of striking out in anger. This class has helped keep my emotions in control so that I don’t wind up back in the hospital.”
   
   Response 4: “I use SKILLS to calm myself down. I don’t have a lot of outbursts like before.”
   
   Response 5: “I don’t listen to what the voices tell me to do. I tell them to stop.”
   
   Response 6: “I talk more about what I want and don’t want to do.”
   
   b. If not please tell us why you don’t feel more in control.
4. If you have any additional suggestions that can make these services better, please list them below.

Response 1: “I have learned how to use different skills when angry, upset, or when I have nothing to do. (new me activities)”

Response 2: “I hope the group continues because it helps all of us learn – we need and keep learning.”

Response 3: “no suggestions”

Response 4: “Sugar free Snacks”

Response 5: no reply

Response 6: no reply
Survey Responses

Support Person Satisfaction Survey

SUPPORT PERSONS: 3 RETURNED SURVEYS TO DATE (10/10/11) 2 ADDITIONAL REC’D 10/25/11.

1. Did you feel the monthly support person meetings facilitated by Dr. Darlene Sweetland are helpful? □ Yes □ No
   a. If yes, please tell us how you feel they have been helpful.

   **Response A:** “Explained how skills are used – helpful to have others to discuss their experiences as well.”

   **Response B:** “Yes – it helped me to better understand the skills system. It’s nice to hear from other providers how they’ve supported their clients with these skills.”

   **Response C:** “Because she helps us better understand the skills system steps and program.”

   b. If no, please tell us why you feel they have not been helpful.

   **Response D:** “helps being able to communicate with other support persons how SKILLS System is working for their participant. Darlene is able to answer questions we may have about implementing SKILLS sys in daily life.”

   **Response E:** “Having the SKILLS steps explained as well as having this is really a tool for life change rather than something to simply use when crisis arises was key to understanding this system.”

2. Are the following Support Person Meeting logistics convenient for you?

   **Time:** 4:00 – 5:00 p.m. □ Yes □ No

   **Location (San Diego Regional Center)** □ Yes □ No

   **Recurring Date (first Wed. of every month):** □ Yes □ No

   **Response A:** Yes to first one, second two left blank

   **Response B:** Yes to all.

   **Response C:** Yes to all. “Great Class”

   **Response D:** Yes to all. “Support Persons should also be provided similar packets/binder that participant has so support person can review references to help better understand the SKILLS system.”
Response E: Yes to all.

3. What additional topics (if any) would you like covered in the Support Persons Meeting?

Response A: My consumer enjoys the subject of relationship. Could possibly discuss more on skills used and help make good choices in relationship.

Response B: left blank

Response C: “None”

Response D: “Focusing on SKILLS 1-5 we believe is important because those are the SKILLS used most by our participants.”

Response E: “It’s hard to say since I don’t see Jerome as often as I used to. I can explain more in person.”

4. Are the following skills system Group logistics convenient for you?

   Time: 6:30 p.m. to 7:30 p.m. □ Yes □ No
   Location (The Center for Personal Growth): □ Yes □ No
   Recurring Date (Thursdays): □ Yes □ No

Response A: Yes to all

Response B: Yes to all

Response C: Yes to all “Her participation in this program has made such a huge difference in Debra.”

Response D: No for time and yes to Location and Recurring date. Would prefer if SKILLS group started at 6 p.m. but 6:30 is okay.

Response E: Yes to all.

5. Do you have any suggestions that you feel can improve the services being provide to the person you are supporting? □ Yes □ No

Please provide any additional comments or suggestions:
Response A: checked “no”

Response B: “Suggestion: The support people should have had their own workbooks to use since the first day of class. I was completely lost my first two months because my clients wouldn’t share his book with me.”

Response C: checked “no”

Response D: Yes. Ongoing individual therapy and DVD for staff/support person training purpose.

Response E: checked No. I see Jerome benefitting from this SKILLS group in his level of communication and self advocacy.

6. Do you feel your participation is important to the success of the person you are supporting?
   □ Yes □ No
   a. If yes, please tell us why you feel your participation is important.

Response A: checked “yes” - “Can use repetition of the skills to problems that come up in daily life.

Response B: My participation is important because I’m able to help David during a crisis and walk him through the steps to calm himself down. If I didn’t know these skills, I wouldn’t have been able to help reinforce them with him.”

Response C: “Her participation is important, because Debra has changed so much from being a part of this skills system.”

Response D: “Participation and understanding how to use SKILLS system with participant helps improve emotional regulation. Understanding SKILLS helps us better support the participant so he/she can have a sense of emotional well being and control over their own lives.”

Response E: “If I weren’t familiar/knowledgeable about the SKILLS System, Jerome would get inconsistent support.”

b. If No, please tell us why you feel your participation is not important.

7. Since Starting the Skills System Group, have you noticed any improvements for the person you are supporting in any of the following areas:
   a. Psychiatric hospitalizations □ Yes □ No
   b. Emotional Regulation □ Yes □ No

Response A: left a. blank, checked “Yes” to b.
Response B: Yes to both, “David is doing much better emotionally. He enjoys being able to understand his emotions and how to rate his emotions so he can 'stay out of trouble'”.

Response C: Yes to b., a. left blank

Response D: Yes to all. We have noticed a reduction in verbal and emotional outbursts. No psychiatric hospitalizations. Some participants can identify 'strong feelings' and with some verbal prompting can bring down the 'strong feelings' to a safe/lower lever instead of losing control of emotions.

Response E: Psych. Hospitalizations – not applicable, emotion regulation – yes. With the exception of what's happened since August, Jerome has been more emotionally stable since regularly attending SKILLS group and one on one therapy.

Please provide any additional comments or suggestions:
Most of the persons required less placements or hospitalizations after the SAT intervention than needed before the intervention. This is evidenced by a negative value for the change value, which is the vertical axis of the graph. Furthermore, the greater the number of placements or hospitalizations before SAT intervention (horizontal axis), the greater the impact of the SAT intervention. A linear relationship was observed.

In addition, the data for the Phase one group falls on the same line as the Phase II and III groups, evidencing that a similar impact was obtained for persons in either phase with similar levels of pre-intervention placements.
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<td>1</td>
<td>Name</td>
<td>DOB</td>
<td>Clinic Date</td>
<td>Reason for Referral</td>
<td>Diagnosis DD</td>
<td>Diagnosis other</td>
<td>Number of medications</td>
<td>residential pre-2yrs</td>
<td>residential post 2yrs</td>
<td>Current Location</td>
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<td>Ashleigh Cope</td>
<td>11/17/1983</td>
<td>November 5th, 2007 (Updated November 7th 2008)</td>
<td>Crisis Care Coordinaton</td>
<td>Mental Retardation, Mild to Moderate and hx possible autism diagnosis</td>
<td>Dually Diagnosed with an intellectual disability and a mood disorder. She has a long history of depression and mood swings and past psychosis and a suicide attempt with multiple hospital admissions.</td>
<td>9 (As of January 2008, noted in update)</td>
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<td>Developmenal Center: February 2009</td>
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<td>Fair View Developmental Center: 10/6/2010-Present</td>
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<td>Joshua Cordova</td>
<td>5/19/1984</td>
<td>March 26th, 2009</td>
<td>317 Mild Mental Retardation</td>
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<td>Hepatitis B, Vision Impairment</td>
<td>6 (As of February 2009)</td>
<td>12</td>
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<td>4</td>
<td>Bruce Davis</td>
<td>5/14/1955</td>
<td>Sep-07</td>
<td>Crisis Care Coordinaton</td>
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<td>Schizoaffective Disorder, Bipolar type; Intermittent Explosive Disorder</td>
<td>Hypertension, GERD, speech deficit (articulation problem), strabismus, mild oral-lingual tardive dyskinesia, possible mild hearing deficit, hx hypothyroidism, hx enuresis</td>
<td>11 (As of 2008 Update)</td>
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<td>6</td>
<td>Danita</td>
<td>1/20/1960</td>
<td>May 2008, Update November 2008</td>
<td>Crisis Care Coordination</td>
<td>Mild Mental Retardation</td>
<td>Visual Impairment, overweight, epilepsy, HTN, asthma, urinary incontinence, hx anemia, GERD, hiatal hernia, sleep apnea, osteoarthritis ----</td>
<td>PSYCHIATRIC/RECOMMENDATIONS: Medication regimen beneficial, consider antidepressant, monitor diet and weight, blood glucose and triglycerides, Consider smoking cessation products, Primary care follow-up is important, Healthy sexuality with use of birth control and condoms should be encouraged, recommend very structured daily schedule with day program or other activities</td>
<td>5 (As of July 2008)</td>
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<td>Leigh</td>
<td>7/9/1982</td>
<td>July 2008, Update January 23rd, 2009</td>
<td>Crisis Care Coordination</td>
<td>Mild Mental Retardation, ADHD by history, R/O Dependent and borderline personality traits</td>
<td>DM Type II, Obesity, myotonic dystrophy, psoriasis, chronic lower back pain ----</td>
<td>PSYCHIATRIC/RECOMMENDATIONS: Regular Discussions about safe sex should occur and regular follow-ups with a gynecologist for STD evaluation and PAP smears, If abilify is not effective then another mood stabilizer might be considered, Psychotherapy for healthy &amp; safe dating, address possible emotional factors that accompany her relationships</td>
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<td>David Gaston</td>
<td>7/31/1984</td>
<td>Dec-08</td>
<td>Crisis Care Coordination</td>
<td>Moderate Mental Retardation, Childhood Onset ADHD, possible autism</td>
<td>Schizo-affective Disorder</td>
<td>Epilepsy, history of elevated lipids</td>
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<td>Deborah Gray</td>
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<td>Elizabeth Herzog</td>
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<td>July 2007, Update</td>
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<td>Schizoaffective Disorder, Bipolar type, Mood Disorder NOS with multiple contributing etiologies, Anxiety Disorder NOS (w/o features of GAD and Panic Disorder), hx of eating disorder NOS, hx of conversion disorder, overweight, menometorrhagia, migraine headaches, GERD</td>
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<td>Schizoaffective Disorder by history, Cannabis abuse</td>
<td>Cerebral Palsy, acne</td>
<td>1 (as of January 2009)</td>
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<td>Cayenne Martinez</td>
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<td>Sep-07</td>
<td>Crisis Care Coordinatio n</td>
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<td>(15) 8 SAILS: 7/7/2010 - Present</td>
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<td>Jan-09</td>
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<td>Nicotine Dependence, Mitral valve prolapse, diabetes mellitus, hypertension, GERD</td>
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<td>Jennifer Rice</td>
<td>2/3/1987</td>
<td>January 2008, Updated June 2008</td>
<td>Crisis Care Coordination</td>
<td>Mild Mental Retardation R/O ADHD features and R/O Borderline personality features, complicated by overlap with mood disorder and anxiety symptoms</td>
<td>Schizoaffective Disorder, Bipolar type, Polysubstance Dependence (Cannabis, Amphetamine, Cocaine), in full sustained remission, R/O additional Anxiety Disorder NOS</td>
<td>Mild Asthma, Smoker, Occasional back pain, needs visual correction and dental care</td>
<td>8 (As of February 2008)</td>
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<td>16</td>
<td>Christina Saenz</td>
<td>4/27/1977</td>
<td>June-July 2008</td>
<td>Crisis Care Coordination</td>
<td>Mild Mental Retardation, Personality Disorder NOS</td>
<td>Schizoaffective Disorder, Bipolar Type, Polysubstance Abuse in Remission, Nicotine Dependence, Complicated Bereavement</td>
<td>Congenital abnormalities as described including connective tissue disease, hip dysplasia, Type II diabetes mellitus, HTN, thyroid disease, GERD, asthma</td>
<td>15 (As of July 2008)</td>
<td><em>N</em></td>
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<tr>
<td>17</td>
<td>Timothy Taylor</td>
<td>10/29/1957</td>
<td>Apr-08</td>
<td>Crisis Care Coordination</td>
<td>Mild Mental Retardation</td>
<td>Schizophrenia, Paranoid type, Intermittent Explosive Disorder, Nicotine Dependence, R/O additional anxiety disorder</td>
<td>Hypoxia at birth, multiple middle ear infections as a child with 25 myringotomies (to lance the ear drum) and 2 mastoid surgeries at age 6, bronchitis and pneumonia, degenerative joint disease both knees and left knee arthroscopy 2000, NIDDM, HTN, hypercholesterolemia, overweight (but no longer morbidly obese)</td>
<td>9 (as of June 2008)</td>
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<td>28(k)</td>
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<td>18</td>
<td>Constanc Zafis</td>
<td>June 2008, Updated January 2009</td>
<td>Crisis Care Coordination</td>
<td>Mild Mental Retardation</td>
<td>Schizoaffective Disorder, bipolar type (Past diagnoses were paranoid vs. undifferentiated schizophrenia) hx &quot;mild cerebral palsy&quot;</td>
<td>8 (As of January 2009)</td>
<td>15 (lo)</td>
<td>16 (lo)</td>
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<td>Name</td>
<td>DOB</td>
<td>Clinic Date</td>
<td>Reason for Referral: Increase in risk behavior including verbal and physical aggression. At risk of eviction from current apt. Receives ILS.</td>
<td>Diagnosis DD: Mild Mental Retardation</td>
<td>Diagnosis MH: Early childhood diga of ADHD other deferred</td>
<td>Diagnosis other: Diabetes</td>
<td>Number of medications: 4</td>
<td>residential post 2 yrs: 2</td>
<td>2 August 2009</td>
<td>Own home: 2</td>
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<td>2</td>
<td>Dorothy Barbar</td>
<td>6/27/1971</td>
<td>6/10/2009</td>
<td>(0)</td>
<td>(1)</td>
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<td>3</td>
<td>Michelle Beck</td>
<td>12/3/1976</td>
<td>7/1/2009</td>
<td>(1)</td>
<td>(0)</td>
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<td>Lives independently, has severe mood swings, very high anxiety, manic behavior, numerous calls each hour to SC, suspicious of others, not monitored well on medication</td>
<td>Mild Mental Retardation with borderline to severely impaired adaptive skills</td>
<td>Axis I deferred, Axis I UCMS; Bipolar Disorder; rule out shizoaffective disorder</td>
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<td>Recommend for releases for team/navigator to talk with Tri Cities to inquire of why Cari did not follow through, or do well at Tri Cities? SC will secure releases and/or inform from Tri Cities. Tamara will assist if needed in possible re entry into Tri Cities behavioral health</td>
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<td>7/1/2011</td>
<td>Recommend behavioral assessment including goal guided heirarchy</td>
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<td>6</td>
<td>Desire</td>
<td>Cisneros</td>
<td>6/29/1992</td>
<td>4/7/2010</td>
<td>314.01 Attention Deficit Hyperactivity disorder, combined type by history 96.80 bipolar disorder NOS by history 309.81 PTSD by history Axis III 799.90 Axis IV support group problems interacting with legal system/criminal justice Axis V GAF: 40 (current)</td>
<td>(2)</td>
<td>(0)</td>
<td>Parent's Home:</td>
<td>3</td>
<td>10</td>
<td>4 9/2010</td>
<td>TBL referral pending, Recommend a higher level of care to form a treatment plan to meet her needs; strengths of program</td>
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<td>7</td>
<td>Israel Cortez</td>
<td>3/28/1978</td>
<td>4/6/2011</td>
<td>frequent anxiety attacks that ends up in the hospital, has had numerous hospitalizations and cute care hospitalizations</td>
<td>Mild Intellectual Disability</td>
<td>Schizoaffective Disorder</td>
<td>Axis III: NIDDN, HTN, Obesity, GERT, thyroid disease, hx leg fracture, HX asthma</td>
<td>Axis IV: financial, legal Axis V: 35 highest not known</td>
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<td>(26)</td>
<td>Doesn't last long in outpatient programs...therapy may need to be provided in home setting, Israel has a new ILS worker and still expresses a desire to get a job. Sai mobile crisis team paid for by SDRC, attends</td>
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<td>(3)</td>
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<td>With Roommate San Diego:</td>
<td>9 9/26/2011</td>
<td>program</td>
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<td>Mild MR NOS (not RC eligible per record), Developmental Delay NOS (not RC eligible per record)</td>
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<td>9</td>
<td>1</td>
<td>Luis Franca</td>
<td>1/17/1970</td>
<td>August 8th, 2010</td>
<td>Not able to be maintained and safe in the community</td>
<td>Paranoid Schizophrenia</td>
<td>Hypothyroidism NOS</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
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<td>Requires 1:1 supervision at present which is not typical for this setting, does not seem to be responding to internal stimuli</td>
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<td>10</td>
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<td>Jameela Eloum</td>
<td>7/2/1988</td>
<td>11/17/2010</td>
<td>unclear-possibly to support current care provider for aggression</td>
<td>Cerebral Palsy, Seizure Disorder, Mild Mental Retardation</td>
<td>11</td>
<td></td>
<td>(1) (1)</td>
<td>L-3 ARF</td>
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<td>Secure releases from Jameela</td>
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<td>Peggie speak to D. Cook regarding possible eligibility for medicare under fathers social, speak with MHS to alert regarding ernestos's interest in TBS, discussed benefits of completing a WRAP plan, Warren speak with intake, send fuller collateral info to intake</td>
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<tr>
<td>Ernesto Fernandez-Perez</td>
<td>6/20/1990</td>
<td>3/3/2010</td>
<td>298.9</td>
<td>Psychotic Disorder NOS; R/O Schizophrenia; R/O Schizoaffective Disorder; specific phobia, animal type</td>
<td>Axis IV: Psychosocial and environmental problems; acts childlike lacks social support and independent living skills</td>
<td>GAF 40</td>
<td>Unknown</td>
<td>N/A</td>
<td>N/A</td>
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<td>12</td>
<td>Florinda Filo</td>
<td>7/4/1973</td>
<td>August 5th, 2009</td>
<td>residential placement transitory; looking for a new home. Notice from previous homes due to daily falling; questions regarding origin</td>
<td>Moderate Mental Retardation</td>
<td>Some records indicate Bipolar Disorder with psychotic features</td>
<td>Unclear; possible seizure disorder; possible other undiagnosed medical</td>
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eval and EEG, including a sleep-deprived EEG to rule out focal or traumatic brain seizures or partial complex seizure disorder, blood work, regular monitoring of Tegretol levels and CBC w/diff to watch for possible bone marrow suppression, Consider separation anxiety disorder symptoms, Address family/s concerns with
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<td></td>
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<td>Phillip Green</td>
<td>6/11/1947</td>
<td>September 2nd, 2009</td>
<td>SC looking for assistance with how to avoid frequent hospitalizations, strategies to ensure stability</td>
<td>Mild Mental Retardation</td>
<td>Schizoaffective Disorder/Bipolar Disorder</td>
<td>18</td>
<td>Secure names of psych liaison for PET teams at both Palomar and Tri Cities...provide feedback form and other info including effective behavioral interventions, New home secured; new provider concerns about transitions</td>
<td>Recommend delay in transition to new home to maximize positive move, recommend Behavioral strategies be developed and staff training prior to the move.</td>
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<td>14</td>
<td>Skylar Groom</td>
<td>5/18/1993 2011</td>
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<td></td>
<td>need for additional behavioral input/strategies with recommendations, need for training staff in dual services/dual diagnosis/cross systems collaboration, consultation needs</td>
<td>V71.09, other records, v6289 Borderline Intellectual Functioning, Mild MR, other records - deferred 799.9</td>
<td>296.90 Mood Disorder NOS 313.81 Oppositional Defiant Disorder 305.20 Cannabis abuse, unspecified</td>
<td>Physical disorders/conditions; hearing and vision Axis IV: V6289 Psychosocial and Environmental Problems: Educational, social, and primary support</td>
<td>(0) (0)</td>
<td>Independent Living House: 3/9/2011 9:15</td>
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- TAY was referred to east county TAY, should be referred, referral to Catalyst given unpredictable lifestyle and residences. TAY services would benefit greatly. Forensic MH Navigator offered to inquire. Interested in work; given a certificate instead of a diploma when file indicates he was "diploma bound"; unclear why. Recommend referral to USD that provides free advocacy and advice. Motivation may be an issue.
- Independent living house: spend 2 days in Cool Beds, 1 day in Oz house, substance use by Dr. Connor.
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<td>Frequent hospitalizations and frequent periods of living with mom, although this cannot be a permanent arrangement due to her Section &amp; contract. Looking for recommendations to assist Alfredo to remain stable in the community. Hx of med noncompliance. Currently unpredictable living arrangement.</td>
<td></td>
<td>Mild Mental Retardation</td>
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<td>reconnect with Heartland clinic after this recent discharge from Bayview to follow up with meds. Catalyst and Oasis or other TAY programs may provide additional supports outside of chaotic family life. Presently lives on and off in board and care homes, but not completely med compliant. RC is already looking into St. Madeline's as Alfredo states he likes this program, as well as Adult Foster Home Care as he previously lived in a level 2 but ran away to TJ and was not</td>
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<td>16</td>
<td>Roberto Guitierrez</td>
<td>1/9/1974</td>
<td>April 6th, 2011</td>
<td>diagnostic questions</td>
<td>cerebral palsy, severe mental retardation,</td>
<td>references to impulse control disorder, no formal diagnosis</td>
<td>Epilepsy</td>
<td>Unknown</td>
<td>(0)</td>
<td>(0)</td>
<td>Own Home 2/2019</td>
<td>medical/psychiatric history and overview requested</td>
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<td>rec MH services if needed be addressed post psychiatric/medical/psychological/behavioral assessments and consultation. Currently in process of beginning a community based program with a new vendor, Steve Prystach operator.</td>
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<td>17</td>
<td>Chris Hill</td>
<td>May 6th, 2009</td>
<td>concerns about recent escalation in extreme anger, screaming, verbal abuse several times per week. Apparent inability to discern reality from fantasy... example is assuming he is to girlfriend on a specific day with no other apparent supporting evidence (no plans, girlfriend uninformed, etc.). Behaviors occur mainly at home, day program able to redirect.</td>
<td>Cerebral Palsy, Epilepsy</td>
<td>Takes Lexipro for Anxiety from GP, other MH diagnosis unclear.</td>
<td>4</td>
<td>0</td>
<td>(0)</td>
<td>(0)</td>
<td>Current day program stable...chris wants a future job and is a possible future clubhouse participant</td>
<td>Recommend evaluation/referral for Dr. Ott</td>
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<td>18</td>
<td>Matthew Kay</td>
<td>6/21/1991</td>
<td>June 10th, 2009</td>
<td>Autistic Disorder</td>
<td>Autism</td>
<td>6</td>
<td>0</td>
<td>(0)</td>
<td>(0)</td>
<td>Casa Del Sol, Fallbrook: Clinic sought for medication review</td>
<td>Early childhood diagnosis of ADHD... Followup? Unclear</td>
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<td>19</td>
<td>Crystal</td>
<td>Bright</td>
<td>6/15/1986 – 11/25/2010</td>
<td>Lighten</td>
<td>06/21/1986 – 04/25/2010</td>
<td>Crystal has had several</td>
<td>Mild? Mental Retardation, Microcephaly</td>
<td>Psychosis, Depression given at API on 4/10/10 discharge</td>
<td>Collateral indicates that family has had numerous medical issues</td>
<td>(3)</td>
<td>(0)</td>
<td></td>
<td>Mom has mental health issues, Crystal has had a lot of medication changes. Discharge summaries for the past year would be helpful to determine what assessments, evaluations, and recommendations have been made by her acute care professionals. Further eval and collaboration with the level 4 behavioral specialists for this program may provide additional info about best fit for residential needs.</td>
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<td>21</td>
<td>William McMillian</td>
<td>3/17/1956</td>
<td>January 5th, 2011</td>
<td>requesting assistance with a plan to secure appropriate services</td>
<td>Mental Retardation</td>
<td>Axis I: Anxiety Disorder, NOS, Anxiety Secondary to benzodiazepine withdrawal, resolved, Mood Disorder NOS</td>
<td>Axis III: Gastroesophageal reflux disease, back pain</td>
<td>3</td>
<td>9</td>
<td>12</td>
<td>Own Home:</td>
<td>August 2011</td>
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<tr>
<td>22</td>
<td>Troy McDonald</td>
<td>3/3/1965</td>
<td>June/July 2009</td>
<td>Pattern of frequent hospitalizations for medical complaints, hearing voices, suicidal ideation and aggression when his request to go to the hospital is not granted.</td>
<td>Mild Mental Retardation</td>
<td>Borderline Personality Disorder and Schizoaffective Disorder</td>
<td></td>
<td></td>
<td>(5)</td>
<td>(22)</td>
<td>L-4</td>
<td>A-RF</td>
<td>5/01/11</td>
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RC has already begun looking for a different type of support then 24/7 supervision and higher level of care including all of her medical services.
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<td>24</td>
<td>Marisol</td>
<td>Moreno</td>
<td>4/6/1978-7/1/2009</td>
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<td>Recommend regular liver function tests and monthly blood draws to check levels of seizure meds.</td>
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<td>Available for medication and then 30 minutes after.</td>
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<td>Available for further consult if requested.</td>
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<td>1</td>
<td>Jerome</td>
<td>Palmer</td>
<td>11/7/1962</td>
<td>December 1st, 2010</td>
<td>Requesting further assessment, recommendations, and consultation with current home and staff</td>
<td>Cerebral Palsy, Moderate Mental Retardation</td>
<td>Anorexia Nervosa; purging type</td>
<td>Liver Hemangiomas, Mitral Valve Replacement, Disphagia with G-Tube, Rectal Prolapse, Congestive Heart Failure with Systolic Dysfunction</td>
<td>9 (as of March 2010)</td>
<td>3</td>
<td>Eating disorder support group recommended assessment by Dr. Connor, consultation, and training by Dr. Sweetland</td>
<td>Utopia Home, San Diego CA: Receiving RC services</td>
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<td>26</td>
<td>Alicia Pastore</td>
<td>4/19/1994</td>
<td>8/19/2010</td>
<td>Severe hospitalized at UCSD CAPS, CAPS requesting assistance with discharge planning specifically for residential placement. SDRC residential placement typically addresses issues/training related to developmental delay, collaborating with mental health experts for mental health issues. Alicia's current profile suggests serious Mild Mental Retardation; rule out borderline intellectual functioning.</td>
<td>Severe Diagnoses: early onset of schizophrenia? Dissociative disorder due to family abuse, Axis I: 312.9 Disruptive Behavior Disorder NOS, severe cutting, fire setting Patrick Henry High started 9th grade, placed at juv. Hall for 2 months, reduced to probation..</td>
<td>(2)</td>
<td>(1)</td>
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<td>Recommend a meeting with UCSD DSS requesting collaboration on best treatment options including residential placement for Alicia, no return calls to date... SDRC Level 4 I homes declined due to diagnosis..</td>
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<td>27</td>
<td>Thomas Pignataro</td>
<td>2/23/1984</td>
<td>November 17th, 2010</td>
<td>last year hospitalized twice for methamphetamine use and went into a fatal coma and they kept him 4 weeks the first time and 1 week the second time, he left against medical advice, He makes dangerous decisions, has chronic pain and claims the only thing that helps is marijuana, poorly controlled diabetes and a visual impairment.</td>
<td>Mixed Dev. Disorder, atypical bipolar with periodic tourette's syndrome, methamphetamine addiction</td>
<td>Schizoaffective disorder</td>
<td>2 (as of February 2009)</td>
<td>(2)</td>
<td>(0)</td>
<td>Unlicensed Board &amp; Care:</td>
<td>8</td>
<td>1 5/1/2011</td>
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<td>Suggested service was a level 3: Sue Raymond (Behavior Specialist) suggests team review services. At Best Residential #2 - Caregivers need feedback on reducing behaviors including aggression toward others, property destruction, diabetes monitored by a consultant in the home... looking for assistance with medication review and understanding.</td>
<td>Impulse Control Disorder? Reactive attachment disorder? Diabetes, Medical only</td>
<td>6 (As of June 2009)</td>
<td>18</td>
<td>(8)</td>
<td>(0)</td>
<td>Best Residential #2: 5/11/2010 - evaluation for further services pending completion of medical/psychiatric and behavioral/clinical assessments/recommendations</td>
<td>Recommend medication review</td>
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<td>29</td>
<td>Donna Riley</td>
<td>6/29/1961</td>
<td>April 7th, 2010 (updated April 28th, 2010)</td>
<td>due to escalation in behaviors with fire setting elopement and property destruction increase in auditory hallucination prompting her to make fires; voices new within the last few days</td>
<td>Schizophrenia Paranoid Type</td>
<td>heart murmur, Chronic obstructive pulmonary disease, Constipation, Diabetes, (on record, but note of conflicting medical reports)</td>
<td>16 (As of March 2010)</td>
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<td>Canyon Springs Psych Hospital: 3 5/4/2011</td>
<td>Medication review and case history review</td>
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<td>(6)</td>
<td>(2)</td>
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<td>Who is therapist? Ask RC to consider alternative placement where follow through may occur more reliably and offer Donna a new start with new behavioral strategies. Pam has requested and Donna approved for a deflection home; no female beds at present. Pam continues also, a statewide search.</td>
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<tr>
<td></td>
<td>Name</td>
<td>Age</td>
<td>Diagnosis and Past History</td>
<td>SCHizophrenia, Parano</td>
<td>Intermittent explosive</td>
<td>Hypothyroidism, moderate</td>
<td>Consider re-engaging SAT</td>
<td>AB2726. If not, recommend</td>
<td>Medical History, overview</td>
<td>Own Home 11/22/11</td>
<td>Own Home 11/22/11</td>
<td>Own Home 11/22/11</td>
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<td>Tianna Roberts</td>
<td>30</td>
<td>had several psychiatric hospitalizations recently and is current at a hospital. At this time, there is not a placement for her as several of the residential homes have declined service due to aggression. She has been referred for Family Home Agency (Adult Foster Care) but no placements in this area either. The Deflection Team of SDRC recommends Supported NOS.</td>
<td>Mild Mental Retardation, Learning Disorder</td>
<td>Oppositional Defiant Disorder</td>
<td>obesity, history of mild anemia, psoriasis, intrauterine cocaine and syphilis exposure, near-sightedness</td>
<td>team after assessment, stabilization to consider possible MH supports for TAY. Recommend alternative to Stein education be considered. Recommend RC inquire of Stein to see if Tianna receives</td>
<td>team explore mental health navigation to assist with consideration of this funding source that may open up additional educational/behavioral opportunities for Tianna.</td>
<td>Behavioral observation with Behavioral and Clinical Recommendations</td>
<td>Behavioral and Clinical Recommendations</td>
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- to consider Substance Abuse Recovery programs and upon successful completion of this type of program, recommend other support services for Caylen to help him get into the MH system including accessing TAY sober living services, WRAP and Psychiatric and Counseling Support through the mental health system. Forensic Navigator to contact MIO, with concerns - Caylen had Anna Guzman in the early stages - new PO. MIO may provide her better support.
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<td>SC requesting additional behavioral input/strategies with recommendations, medical/psychiatric overview with recommendations, medication review, navigation/access to cross systems services (i.e. mental health) and consultation needs in forensic and substance use/abuse</td>
<td>Intermittent Explosive Disorder? Diagnosis dated and current-unclear</td>
<td>Possible forensic involvement, possible Drug and Alcohol involvement</td>
<td>Unknown</td>
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<td>Shared Home 9/20/2011</td>
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Troy Swartz has a long history of being in and out of jail. Has two warrants after he got out of jail; unclear what for. Told SC he is not on probation. Tamara will check into to confirm status of warrants, probation, and possibly report of Troy's demeanor when in jail as he is in so often. Request SC to contact team if Troy is re-arrested.

Substance Use: Recommend Mary investigates possible anger management classes provided by MH or DOA system. Difficult to determine

Psychiatric History and Overview by Dr. Connor
<p>| A | B     | C               | D                                                                 | E                                                                 | F                                                                 | G                                                                 | H     | I       | J     | K     | L     | M                                                                 |
|---|---|-------------|---|---|---|---|---|---|---|---|---|---|---|---|
| 34 | James Vanausdavie s | 6/1/1985 | July 6th, 2011 | Loves ILS workers and the agency LIFE. Hx of one wants him to rent to him due to frequent calls to 911 and ambulances, prior wraparound with PERT team who put him in jail for 5 days in April due to excessive non emergency use of EMS system. Hx of substance abuse, will go to meetings but when confronted about use of exaggeration thereof, will leave. | at 13: 317 Mild Mental Retardation. Phonological Disorder, 315.39 (reflective of poor speech articulation which is not sufficiently accounted for by the diagnosis of mental retardation alone.F34 | Axis I Adjustment Disorder, chronic with Mixed Disturbance of Emotions and conduct | Medical conditions unknown, problems with primary support group, educational and social problems and past problems with housing and basic living arrangements. | 4 (As of June 2009) | (16) | (0) | Homeless 6/24/2011 | Recommend medical/psychiatric by Dr. Connor to aid outpatient and inpatient stays that may have fragmented information due to frequent visits.|</p>
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<td>Yvonne</td>
<td>6/5/1983</td>
<td>August 5th, 2009</td>
<td>housing questions, medication questions, employment questions, family conflict; looking for review/discussion of status with possible solutions or ideas to pursue on her behalf</td>
<td>Autism; mild to moderate</td>
<td>Bipolar mood disorder, manic, rule out schizoaffective disorder, excited type with delusions</td>
<td>Hypertension, Hep. B, mild vision impairment with correction, psychosocial stressors, conflict with family; GAF: 40/55 awaiting housing at Casa Pacifica</td>
<td>(2)</td>
<td>(4)</td>
<td>ILF Escondido, CA:</td>
<td>13 3/28/2011</td>
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SUMMARY REPORT

for

SOLUTIONS BUILDING COMMUNITY COLLABORATIVE
Phase I

A Demonstration Project Co-Sponsored by

San Diego Regional Center
and
San Diego Department of Health and Human Services

Submitted to:
San Diego Regional Center
San Diego Department of Health and Human Services
Project Steering Committee
MH/DS Statewide Collaborative

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Project Funded by
California’s State Department of Developmental Services
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Executive Summary

Solutions Building Community Collaborative is a demonstration project that completed Phase I. It examined the effectiveness of several strategies for cross systems collaboration. Research indicates that collaboration enhances the support of persons with dual diagnosis (developmental disabilities and co-occurring psychiatric illness). This report summarizes the goals of the project and its current outcomes. It also provides background information on the issues that prompted this effort.

The project goals were to improve the ability of individuals with dual diagnoses to more successfully manage community living, mitigate the cost of overlapping systems care and to develop outcomes that contribute to emerging best practice in this specialty field.

To meet these goals, the specific objectives were to increase a person’s ability to cope with day to day stressors, to improve cross systems coordination including crisis care coordination, to create key linkages in support networks that would improve access to eligible services across systems, and to identify areas where new resources were needed.

In Phase I, the project used current research to develop three main strategies to accomplish these objectives. The first strategy was to provide comprehensive education in dual diagnosis to all community stakeholders. The second strategy was to provide expert consultation and assessment for project participants using a Specialty Assessment and Treatment (SAT) team. The third strategy was to create cross systems plans including a crisis care coordination protocol. These plans were then distributed to multiple systems with regular updates.

Phase I spanned the 30 months between January, 2007 and June, 2009. In support of comprehensive community education, this project provided 83 presentations to the community including ERs, hospital psychiatric inpatient and outpatient programs, residential providers, board and care operators, county and regional center staff, day programs, clubhouses, administrative committees, and regional and statewide presentations to various systems. In addition, two large conferences were held in San Diego (2008) and in Ontario (2009) with a total of over 500 attending from multiple systems of care.

The Project began taking referrals for participants in June, 07. The project has averaged about one referral a month with a total of 25 participants as of 4/30/2009. Referrals were from several community sources, including Regional Center staff and service coordinators, county programs, the San Diego Probation Department, hospital staff, and one family member.

As awareness of the project grew, ‘non participant’ consultations also occurred with various systems. These systems included local area hospitals, the probation department and regional center staff requesting assistance from the SAT team. These requests were on behalf of individuals who did not necessarily meet the initial project criteria, but were nevertheless dually diagnosed and at risk of losing certain community services or the ability to remain living in the community. The SAT team responded with consultation, training and systems navigation. These additional consultations averaged approximately one per month with 19 consultations as of 4/30/09.

For the 22 months through October, 2008, the following statistics were reported:
- 86% of project participants had a diagnosis of mild mental retardation
- 71% of participants having a diagnosis of schizoaffective/mood disorders NOS.
- 42% of all persons referred were transition age youth
- 36% of all participants were triply diagnosed with additional substance abuse related disorders
- 31% diagnosed with borderline traits
- 28% also have forensic involvement
- 23% with antisocial traits
- The median number of medications used per participant is 8, with the median number of psychotropic medications at 4 per person.
Poly Pharmacy is an issue for many, with the highest incidence of one person having 42 current prescriptions due to high access to different emergency medical services over a short period of time, at the time she joined the project.

For the 29 months through May, 2009, these additional statistics were also noted:
- 5 participants had moved into or returned to a locked setting (developmental center or jail). 3 of these individuals were transition age youth.
- At 29 months, 39% of all referred continue to be TAY (transition age youth)
- While sample size and project duration were too small for complete statistical analysis, comparison of participant prior histories and project participation suggests that their need for crisis services was reduced and their ability to maintain community tenure was improved. However, overall the length of stay for hospital and crisis house visits could not be clearly connected to project participation. In one example, intensive focused intervention and support reduced hospital stays to zero for one participant. Nonetheless, their high risk behavior in the community resulted in the individual being transferred to a locked setting for longer term stabilization. On the other hand, intensive wrap around services for another participant prevented a ‘third strike’ arrest that would have resulted in a prison sentence. These wrap around services supported the longest period of sobriety in her life with reports ranging from 6 to 9 months. This 48 year old woman with moderate mental retardation and a major Axis I disorder continues to live in the community with intensive support from mental health, regional center and probation services.

During Phase I, the project identified new tools for this area, as effective in supporting individuals with Dual Diagnoses. These were using the Wellness Recovery Action Plan (WRAP)\(^1\), Dr. Sweetland’s Intervention Structure, \(^2\)and the Reiss motivational profile of basic needs.\(^3\) The WRAP has been a very successful tool in the mental health system, and with minor accommodations for persons with developmental disabilities, this was a very useful to many of the project participants. The project also identified DBT/DD (Dialectical Behavior Therapy adapted for persons with developmental disabilities) as a much needed resource to be developed for individuals with dual diagnosis. As a result of the comprehensive education provided in Phase I, and the very positive response including ongoing requests for further education, the project began development of a 40 hour certificate program of 8 classes in best practice for persons with dual diagnosis. This is targeted to begin in August. 2009.

The project has seen enthusiastic support from multiple systems who view the cross systems collaboration as an important next step in assisting individuals with very complex needs to successfully manage community living.

The Phase I project outcomes support the research that Cross Systems Collaboration enhances the abilities of individuals with complex needs to cope with day to day life stressors in meaningful and productive ways. Of primary interest is the benefit of extensive education regarding intervention strategies specifically for dual diagnoses. Cross systems networking created key examples of how such coordination reduces overlapping care across systems, improves crisis care coordination and increases community tenure. Another primary outcome was Creating cross systems plans that inform of current supports and services, including improving crisis care coordination across systems by creating a crisis protocol for high users of multiple systems. This plan included providing specialty assessment and consultation for participants using the SAT Team.

The Solutions Building Community Collaborative is funded by the California’s state Department of Developmental Services, sponsored by San Diego Regional Center and co-sponsored by San Diego Health and Human Services Mental Health Services. The project is funded for Phase II by the state Department of Developmental Services. Phase II will continue strategies in Phase I to enlarge sample size and generate longitudinal data for evaluation. Phase II will add an additional component of a monthly consultation clinic for

\(^{1}\) http://www.copelandcenter.com

\(^{2}\) Attachment D

\(^{3}\) http://www.idspublishing.com/reiss.htm
dually diagnosed individuals who meet different criteria than those in Phase I. Specifically, the clinic will be for individuals who experience a sudden worsening of mental health symptoms, placing them at risk of losing services or community living. This approach will be evaluated to determine the effectiveness of cross systems intervention earlier in the timeline of a person's use of multiple services.

Section I
Background -- The Specialty Field of Dual Diagnosis

The field of Dual Diagnosis (ID-MI) continues to grow as we learn more about the needs of this specialty population. Pilot projects, research and new resources continue to emerge that contribute to best practices in this field. The current issues for this field begin with the history of deinstitutionalization that occurred in these different systems. This movement and the challenges it brings to us today are highlighted below in a Supreme Court Report of 2007\(^4\). While this particular report focuses primarily on persons with mental health challenges, the issues outlined and the history highlighted, follows the same path for persons with intellectual disabilities and persons dually diagnosed. Following is an excerpt from this report which traces this history now resulting in trans-institutionalization.

"200 years ago, people with severe and disabling mental illnesses in the United States were often confined under cruel and inhumane conditions in jails. This was largely due to the fact that no alternative system of competent mental health treatment existed. During the 1800's, a movement known as moral treatment emerged that sought to hospitalize and treat individuals with mental illnesses rather than simply incarcerating them. The first state psychiatric hospitals were opened in the United States during the 1800's, and were intended to serve as more appropriate and compassionate alternatives to the neglect and abuse associated with incarceration. Unfortunately, overcrowding at these institutions, inadequate staff, and lack of effective treatment programs eventually resulted in facilities being able to provide little more than custodial care. Furthermore, physical and mental abuses became common and the widespread use of physical restraints such as straight-jackets and chains deprived patients of their dignity and freedom. The asylums intended to be humane refuges for the suffering had instead turned into houses of horrors.

By the mid-1900's, more than a half million people were housed in state psychiatric hospitals across the United States. The system was stretched beyond its limits and states desperately needed some alternative to addressing this costly and ever-expanding crisis. Around this same time, the first effective medications for treating symptoms of psychosis were being developed, lending further support to the emerging belief that people with serious mental illnesses could be treated more effectively and humanely in the community. This period marked the beginning of the community mental health movement.

In 1963, Congress passed the Community Mental Health Centers Act which was intended to create a network of community-based mental health providers that would replace failing and costly state hospitals, and integrate people with mental illnesses back into their home communities with comprehensive treatment and services. In what would be his last public bill signing, President Kennedy signed $3 billion authorization to support this movement from institutional to community-based treatment. Tragically, following President Kennedy's assassination and the escalation of the Vietnam War, not one penny of this authorization was ever appropriated.

As more light was shed on the horrific treatment people received in state psychiatric hospitals, along with the hope offered by the availability of new and effective medications, a flurry of federal lawsuits were filed against states which ultimately resulted in the deinstitutionalization of public mental health care. Unfortunately, there was no organized or adequate network of community mental health centers to receive and absorb these newly displaced individuals. The fact that a comprehensive network of community mental health services was never established following deinstitutionalization has resulted in a fragmented continuum of care that has failed to adequately integrate services, providers, or systems; leaving enormous gaps in treatment and disparities in access to care. Furthermore, the community mental health system that was developed was not designed to serve the needs of individuals who experience the most chronic and severe manifestations of mental illness. Lack of strategic funding and programming, and adherence to treatment guidelines that do not necessarily reflect current best practices have affected certain segments of the population in particularly devastating ways.

For many individuals unable to access care in the community, the only options to receive treatment is by accessing care through some of the most costly and inefficient points of entry into the healthcare delivery system including emergency rooms, acute crisis services, and ultimately the juvenile and criminal justice systems. (highlight added)

There are two ironies in this chronology that have resulted in the fundamental failure to achieve the goals of the community mental health movement and allowed history to repeat itself in costly and unnecessary ways. First, despite enormous scientific advances, treatment for severe and persistent mental illnesses was never deinstitutionalized, but rather was transinstitutionalized from state psychiatric hospitals to jails and prisons. Second, because no comprehensive and competent community mental health treatment system was ever developed, jails and prisons once again function as de facto mental health institutions for people with severe and disabling mental illnesses. In two centuries, we have come full circle, and today our jails are once again psychiatric warehouses. 5 (Supreme Court Report 2007)

Recent research and pilot efforts have done much to mitigate this issue of transinstitutionalization and to provide quality care to persons with complex needs. This project is one of those efforts. However we can see in our own state where transinstitutionalization continues to put pressure on multiple systems including Regional Centers, County Mental Health services, jails, prisons, hospitals, emergency rooms, local law enforcement, and crisis teams.

As we support the continued efforts of the deinstitutionalization movement, the numbers of individuals with serious mental illness returning to the community and working to maintain community tenure has dramatically risen in recent years. In our own state, this has been coupled with little to no increase in budget dollars for core services in the California mental health system to meet these needs.6


In discussing these issues in the field of developmental disabilities, Beadle-Brown et al. note that supporting movement from institutions to community settings continues to demonstrate that outcomes are better in the community than in the institution. However, it does not bring about automatic improvement in quality of life or access to effective healthcare and treatment. These transitions clearly require proactive and thoughtful consideration with adequate support including funding from multiple systems.

As in the field of mental health, the individuals who remain in developmental centers or other institutional settings and are now re-entering the community, are often those individuals with dual diagnoses or other very complex and challenging needs. This has required proactive and innovative planning to provide quality care in community settings.

Our approach to care for these individuals with dual diagnosis historically offers services in separate and distinct systems, commonly referred to as silo’d systems. This means specific systems provide specialized expertise in treatment and services for individuals with a common designated diagnosis. However, when providing services to individuals living with complex needs, dually or triply diagnosed, these systems are pressed to provide ad hoc adaptations to their unique areas of expertise. This often results in fragmented services and sometimes minimally effective care. This is also challenging for the individual recipients of care who must make sense of individual and often disparate messages about their treatment and care from multiple systems. These challenges have often resulted in an increased need for care that results in overlapping care by multiple systems, naturally raising the overall cost of care to meet the same needs. The issue of silo’d systems without clear, proactive planning toward collaboration, contributes to problem of transinstitutionalization.

A Statewide needs assessment was conducted in 2005-2006 that included providing a more detailed profile of the individuals in California who are dually diagnosed. This report also included research of current successful models serving individuals with complex needs. Each of the models cited offered a continuum of services. The continuum of services model is a strategy that requires a multi-systems approach and long-term investment and development by all allied stakeholders. These models reported developing a network or continuum of services that creates opportunities for independence, self-determination and community integration for individuals with difficult to serve needs, using existing partnerships and creating new ones where none exist.

This idea of cross systems collaboration and it’s successes is well documented in the ‘other dual diagnosis’ (mental illness and substance abuse) in recent years, successful collaboration between drug and alcohol systems and mental health systems have created a very effective treatment model for this group of people.

Part of the 2005-2006 needs assessment was to propose solutions that could be considered in California. Based upon this proposal, The Solutions Building Project was designed to provide an organized implementation of a new strategies in cross systems collaboration in one geographic area, that included ongoing evaluation and recommendations for potential replication in California.

In San Diego County, partnering with other systems had begun among multiple systems several years ago. One example of this is the work of the SDRC, SDCMH, and DSS in collaborating to provide services to adolescents with complex needs using a contractor of SDCMH that provides mental health services. San Diego stakeholders building on this previous work, actively participate in and support the Solutions Building Community Collaborative.

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8 http://www.mosaiclink.org/documents/SERVING_THE_DIFFICULT_TO_SERVER. INITIAL REPORT.01.12.06.pdf
9 http://www.nami.org/Content/ContentGroups/Helpline1/Dual_Diagnosis - Substance_Abuse_and_Mental_illness.htm
10 SDRC: San Diego Regional Center, SDCMH: San Diego County Mental Health, DSS: Department of Social Services
Section II

PROJECT DESCRIPTION

Solutions Building Community Collaborative

SDRC and SDCMH have collaborated extensively in this demonstration project and are the co-sponsors of its efforts. The project has also received enthusiastic support from San Diego's area emergency rooms and hospitals, the Police Emergency Response Team (PERT), the Sheriff's department, the San Diego Probation Department, county mental health contractors, and regional center vendors. The project's steering committee has representatives from key community stakeholders from these systems.\(^\text{11}\)

As 76% of persons dually diagnosed in California are adults,\(^\text{12}\) the project's first efforts were to focus specifically on dually diagnosed adults who are high frequency, high intensity users of multiple systems, using a disproportionate amount of resources in these systems and are at risk of failing to live successfully in their local communities.

Project Objectives:

1. Maintain and/or increase Community tenure through focused, integrated and therapeutic service delivery.
2. Maximize a person's ability to cope with day-to-day life stressors in socially appropriate and productive ways
3. Increase a person's support network and identify ways to use this network for crisis prevention and community integration
4. Provide appropriate, therapeutic environments to facilitate mental and behavioral health strategies.

Project Strategies: Recognizing that these objectives are inter-dependent, three basic strategies to meet them were developed.\(^\text{13}\) The project used extensive community education to all interested community stakeholders,\(^\text{14}\) a cross systems plan and crisis care coordination.\(^\text{15}\) These strategies were implemented using a Specialty Assessment and Treatment (SAT) team\(^\text{16}\) who were individual experts from multiple systems. A steering committee comprised of key stakeholders from multiple systems provided oversight to these efforts.

METHOD AND DISCUSSION

1. Community Education

Project efforts indicate that the need for community education should not be under estimated in it's power to inform and enhance collaboration. Initial project projections were for 10 community stakeholder trainings to inform the project, eligibility and emerging best practice in dual diagnosis. The response from the local community was overwhelming interest. Clearly,

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\(^{11}\) See Appendix C for current Steering Committee Members

\(^{12}\) See Appendix A for Project Overview and Graphic Illustration of these strategies

\(^{13}\) A listing of community stakeholder presentations to date available upon request

\(^{14}\) Sample plan available upon request

\(^{15}\) See Appendix B for members, roles and responsibilities of the SAT team
individuals dually served while relatively few in number (~20% of DD population), use a disproportionate amount of services by all systems. This creates intense interest in solutions. The feedback has been more requests for more training from direct care staff to administrators and within all known community stakeholder groups.

The goal of community education was to reach as many systems and stakeholders as possible regarding dual diagnosis, effective strategies for focused and integrated treatment and to inform of the project and its purpose, to encourage support and participation.

This strategy highlighted the following information:

- Increase each system’s awareness of the inter-dependency of needs of individuals dually and triply diagnosed. Often, systems assign primary cause to complex needs (behavioral; ‘attention seeking’, mental health, substance abuse, criminal behavior). This does not serve the individual or the system well. Typically the presenting issues were inter-related and thus, best practice would indicate an interactive cross systems treatment approach.

- Inform or enhance existing knowledge of current best practice for individuals dually diagnosed.

- Inform of the Demonstration project, it’s goals and services to encourage project referrals from multiple systems and thus provide more coordinated treatment demonstrating this model for a specific number of individuals.

- Increase general awareness of individual systems’ services and their primarily areas of expertise as well as their limitations, as it relates to dually and triply diagnosed individuals.

Outcomes:

Over the 30 month period, project staff and steering committee members provided 83 presentations and networking opportunities regarding dual diagnosis and the project’s work. Additionally, two major conferences were held; one in San Diego and one in Ontario with over 500 attendees from multiple systems.

- 17 trainings were to area hospitals, including ER staff, inpatient and intensive outpatient staff. One of the clearest responses to this networking was the occurrence of ‘non participant’ consultations. The project averaged one of these consultations a month.

- The project provided 7 workshops to different groups, with an average attendance of 30 people. One workshop was provided to medical staff on latest developments in psychopharmacology and treatment for this specialty population. One workshop was provided to clinicians, therapists and counselors regarding the use of the Reiss profile and it’s benefits as a tool in both assessment and treatment. 5 workshops were provided to direct care staff of multiple systems regarding dual diagnosis, best practice and effective behavioral strategies.

- The project provided 10 residential trainings to RC group homes and MH board and care operators. The attendance for these ranged from 2 to 17 people.

- The project provided 49 presentations including networking opportunities to multiple stakeholders, including the San Diego Probation Department, the PERT academy, administrators in Mental Health, administrators in the Regional Center system, MH contractors and their programs, Regional Center staff and their vendors (not including
residential) and a workshop presentation at a Mental Health Resources Fair, sponsored by
the project.

- The project supported two major conferences with nationally known experts in dual
diagnosis and highlights including a presentation of other related local efforts in Los
Angeles County.

- The project developed an online survey\(^\text{17}\) in September, 2008 and distributes regularly to
all subsequent trainings to use as one tool to gain feedback regarding project training. This
survey has had minimal impact with only 25 respondents.

- Evaluation forms are distributed to all workshop and conference trainings with extremely
positive feedback and requests for more training in dual diagnosis.

- Based upon the very positive responses from presentations and training, the project is
developing a 40 hour Certificate of Excellence\(^\text{18}\) program in best practices in dual
diagnosis. This is scheduled to begin in August, 2009.

This comprehensive approach to training resulted in improved collaboration. As awareness of
the project increased through this educational effort, referrals to the project increased.

- Hospitals, ERs and the Probation department began to refer individuals to the project.
While these stakeholders recognized that many of the referrals did not meet the criteria of
the project they were hoping to secure consultation and information regarding discharge,
treatment, and access to services. This resulted in an average of 1 person a month
receiving ‘non participant’ consultation. In these cases, referring agencies were looking to
verify:
  - Does this person receive Regional Center services and if so, who can we contact?
If not, can you recommend a resource to help them with access to specific
services? (i.e. housing, MH services, Ind. Living Support Services, nursing care,
counseling, transportation, etc.).

The DD and MH navigators of the SAT team were often able to work closely together to assist with
the non participant consultations. Using navigation, 18 of these consultations were provided
requested information or support to referring agencies. For 1 of the 19 consultations, the project
was unable to offer any substantial support, in this case, to the Probation Department.

Community Education efforts contributed to each system’s knowledge of other systems’ resources.
For example,
  - Some systems staff were not aware that Regional Centers do not provide mental health
services to consumers, rather, develops memorandums of understanding as mandated by
law\(^\text{19}\) as to how dually diagnosed individuals will be served by all eligible systems.
  - Some staff was not aware that the County Mental Health system is severely underfunded
and no longer provides day program services. They were not aware that the only
psychiatric day programs are intensive outpatient or partial hospital programs offered
through the hospitals typically available only to persons who have Medicare or private
insurance.

\(^{17}\) Survey link: https://www.surveymonkey.com/s.aspx?sm=Lsv3qoyzyUzwxfwd1GXzhQ 3d 3d
\(^{18}\) See this link for a draft of classes and class descriptions.
http://www.mosaiclink.org/newdocs/SOLUTIONS%20BUILDING%20CERTIFICATE%20OF%20EXCELLENCE.pdf
\(^{19}\) http://www.dds.cahwnet.gov/statutes/WICSSectionView.cfm?Section=4696-4697.htm
Some systems were not aware that there is a cross systems taskforce developing strategies for individuals with a dual diagnosis of developmental disability and substance abuse (DD-SA).

Some staff thought that if a person is a Regional Center consumer, they are not eligible for County Mental Health services. Further, some staff were not aware that a developmental delay does not necessarily reflect cognitive impairment (i.e. for some persons with cerebral palsy, epilepsy, etc.).

Many staff was not aware that the County Mental Health system currently serves many Regional Center consumers although Reg. Center and Mental Health staff are not always aware of this. Many individuals with dual diagnosis do not tell a mental health provider they receive Regional Center services and vice versa.

2. Cross Systems Plans

This strategy was developed to encourage integrated treatment, and to increase crisis care coordination. The plan provided up to date information to multiple stakeholders on individual's high frequency use, current service providers from all systems and a snapshot of medical, psychiatric and clinical assessment. The idea of a cross systems plan was modeled from existing research of other collaborative work and also from the success of the local SHARI program through San Diego Behavioral Health Services. These approaches successfully use collaboration with providers, doctors and hospitals to reduce the number of unnecessary hospitalizations for mental health clients including those with an additional developmental disability.

Each project participant received a Cross Systems Plan that in Phase 1, was updated monthly and distributed to all participating community stakeholders. This plan was developed by members of the SAT team, using information from their face to face interviews with the participant, a completed Reiss Profile, information from the Regional Center Service Coordinator, the Regional Center file, and information from current providers and systems for the individual. This plan unifies services information from multiple systems/sources to aid individual systems in providing coordinated care.

The Cross Systems Plan was intended to serve as a tool for both emergency personnel and current providers. The plan summarizes existing resources across all systems, provides current contact information for those resources and provides a snapshot history of medical and psychiatric information as well as a review of clinical issues and behavioral recommendations for that individual. As well, the plan was updated monthly with current hospitalizations and medications to aid emergency personnel (ERs, Inpatient staff) in a more complete assessment of an individual's current needs.

As part of the clinical assessment, the Reiss Profile was completed by staff who knew the individual for at least 3 months. This profile was then developed by the team's clinical psychologist and proved be a very useful tool to direct care providers. The Reiss Profile was made

20 The San Diego County Mental health Services SHARI (Special Help for At-Risk Individuals) Project is a collaborative effort to reduce the number of unnecessary hospitalizations among mental health clients. Developed in partnership with mental health providers, private psychiatrists and local hospitals, the program aims to reduce the number of repetitive hospitalizations for an identified group of clients with extensive histories of hospitalization. At no additional cost to the county, the project has proven to decrease the number of hospitalizations and improve the level of care for mental health clients. This success translates into savings totaling hundreds of thousands of dollars for the ten clients who participated in the project over the course of one year.

21 The Reiss Profile: http://www.reissprofile.com/cgi-bin/tests/base.pl?homepage
available to staff who requested it. As the project progressed and knowledge of the Reiss profile increased, other community clinicians began to request the profile be completed for some non participants who were dually diagnosed and dually served, to aid in their treatment strategies, particularly in outpatient treatment programs.

Included in the medical overview were recommendations for follow up to assist current providers who do not have the benefit of a comprehensive collateral review of past and current services as well as a face to face interview in non crisis circumstances. Often recommendations included were 'rule outs' including dental, neurological, and general medicine. However, on some occasions, a review of history or medications, would suggest current medications contra-indicated and this was provided via plan and telephone or email contract to treating providers. In the clinical section, recommendations were made including an escalation hierarchy, self soothing strategies for that individual with behavioral recommendations, and often an adapted WRAP and Reiss Profile information. In both of these sections, the availability of the team for further consultation or training of line staff was reinforced.

**Outcomes**

- The Cross Systems plan provided an up to date snapshot of the individual's history and care needs. It served to provide a better understanding of the physical and psychiatric components of behavioral issues as well as provide concrete recommendations for treatment and intervention based upon this comprehensive review of existing collateral information and face to face interviews with the individual. With high frequency users of multiple systems, this level of information had not typically been available to ERs, the PERT team and hospitals who typically triage the presenting issues of the emergent situation.

- Participants were flagged in the county's system of care as Solutions Building and when possible, the current plan was sent to the hospital when a participant was to be admitted. This provided comprehensive information immediately to hospital staff. One drawback to this strategy was that the admitting doctor did not always receive the plan immediately. It was usually with the hospital social worker or nursing staff.

- Participating hospitals also contacted the project or the Reg. Center Service Coordinator for the current plan if it had not been received by all staff. As a result, some hospitals began to request this information of all Reg. Center admissions, not realizing at first, this was a small pilot project and this level of information is not possible for all consumers. Ideally, a cross systems plan could be developed for highest users of multiple systems in the future, but this would require planning, funding and forethought, as this would apply to several hundred consumers in San Diego.

- Hospital and Emergency Room staff was very supportive of the project's efforts and open to further information and training by the clinical psychologist who provided several trainings to hospital staff regarding ways to adapt environment and treatment strategies for individuals dually diagnosed that were admitted for inpatient psychiatric care.

- The SAT team also provided several trainings and was available for follow up training to most providers.

- The development of each plan and the ensuing team consultation served in many cases to provide individuals with increased access to services across both systems. The increased communication also facilitated efforts to minimize polypharmacy. For
example, for one individual frequent trips to ERs and multiple hospitals within a very short time (often multiple hospitals within one month), resulted in 42 current prescriptions being prescribed and in the hands of the participant.

As referrals increased, it became apparent that participants fell roughly into three categories for intervention. Dr. Sweetland developed a useful intervention structure for the team, that was used for participants. 22

- Some individuals fell into the *Triage* category. These were individuals that had very chaotic lifestyles with frequent residential changes including homelessness, frequent hospitalizations and requiring ongoing intervention to treat acute symptoms. In these instances, attempts were made to provide a comprehensive plan with some interventions including navigation by the team during plan development.

- The second category, *Crisis Stabilization* was for individuals with a primary desire/motivation to live with independence and able to accept outpatient supports, accepting new ways of coping and seeking support when feeling unsafe.

- The third category, *Enrichment* was for persons with a primary desire/motivation to live with independence, having the skills to cope with stressors with support with decreasing hospitalizations.

3 of the 25 participants were deferred from project participation for various reasons. 4 persons were still in process at the time of this report. Of the 18 remaining,

For all referred, cross systems plans, follow up and training were provided to all interested support members and participants including training in dual diagnosis and implementation of behavioral strategies including WRAP, escalation hierarchies, and other individualized coping strategies.

11 Participants entered the project in the *Triage* category, 6 of these considered higher risk. 4 persons (3 high risk) improved and moved to *Crisis Stabilization* with systems navigation, consultation and learning new coping strategies offered through the plan development. 3 other persons referred in this category have since lost community placement, residing in developmental centers for longer term stabilization. 4 participants continue in this level where continuing to treat acute symptoms is needed, with one individual now with the County’s SHARI program and experiencing some success in decreased hospitalization with close collaboration by the county and Regional center services. Of note is that 1 of the persons considered high risk and now in Crisis Stabilization was re-arrested for a drug offense but nonetheless returned to *Crisis Stabilization* as the mental health, forensic and regional center services quickly mobilized to make changes in environment and supports to successfully re-establish the individual in the community.

This second category *Crisis Stabilization* is the category that 7 participants were in upon referral to the project. 3 moved to the third, more independent category *Enrichment*. 1 person (Transition Age Youth) in this category was briefly moved to High Risk for follow up due to ongoing forensic behavior issues but has since

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22 See Appendix ___ for intervention structure
returned to crisis stabilization. 8 persons are now in the crisis stabilization follow up.

The third category, Enrichment was for individuals with a comparative reduction in hospitalizations and/or were using support and changes in support, to manage day to day living. This category was for persons who were acquiring the skills to cope with day to day stressors including using their existing support systems. 3 persons are currently in this less intensive category continuing to work toward increased independence and stable community living.

3. Crisis Care Coordination

Noted improvement in Crisis Care Coordination was facilitated by the development of the Cross Systems Plan that included proactive strategies for crisis situations including regularly updated contact information for all accessed services and an identified emergency contact name and number. Plans typically provided an individualized ‘escalation hierarchy’ that persons developed with the help of the team. This strategy was intended to providing alternative means to accessing help before calling 911 or going to the hospital, if indeed an individual was experiencing distress that was escalating but not necessarily at a point of danger to self or others. All project participants were encouraged to continue to use 911 or the ER system if a circumstance was life threatening or a perceived emergency requiring this type of intervention.

These plans were then flagged with the county’s administrative services organization; United Behavioral Health who monitors and approves the utilization of medi-cal dollars particularly for hospitalization. This process assisted about 50% of project participants with only medi-cal insurance. Plans were also provided to ER and hospital staff by the SDRC Service Coordinator, including the other 50% with more than medi-cal insurance (usually medicare).

Outcomes:

- The high frequency users of ER and hospital systems are well known to the county’s hospitals. Some of these were project participants. The majority of hospitals quickly became familiar with the Solutions Building protocol and accessed the team frequently to assist with discharge planning, defer hospitalization planning and liaising with other needed resources in both systems.

- United Behavioral Health (UBH) played a key role in getting information to hospitals quickly and in providing recommendations or feedback to the project steering committee in how to improve cross systems collaboration.

- The use of the Reiss profile, Dr. Sweetland’s Intervention structure, team training and weekly team consultation contributed to increased communication across systems, enabling systems to more effectively coordinate individual efforts, thus reducing overlapping care significantly.

- Working with the County’s Emergency Psychiatric Unit and the Regional Center, a plan to use the Regional Center’s Independent Living Support (ILS) services and transportation vouchers for some individuals that did not meet medical necessity upon triage at the ER was useful to the county staff. Previously, discharging someone back to the community in very late hours of the evening early hours of the morning was of particular concern that in doing so would place individuals with a dual diagnosis at risk in the community setting. Working with some ILS workers and assigning some transportation vouchers for particular individuals provided the hospital staff with a way
to discharge and ensure either supervised or safe transport via taxi, for an individual back to their residence. ILS workers were then able to follow up with a person’s support team to determine if other supports were needed.

- A key contributor to success in all three strategies was the active involvement from administrators of both county staff, UBH, county contractors and SDRC administrators on the project steering committee.

Section III  SUMMARY

The SAT Team provided extensive community training to multiple systems and to emergency response personnel. The team also provided Cross Systems Plans development for project participants. The recommendations made by the psychiatrist regarding medical/psychiatric issues and by the psychologist regarding recommendations for escalation hierarchy, use of an adapted WRAP, and other behavioral strategies have facilitated and sometimes leveraged the efforts of Service Coordinators, or other systems’ providers to provide more comprehensive services to further assess and treat individuals.

The outcomes in Phase I confirm the effectiveness of using strategies such as training, a cross systems consultation team and cross systems plans to encourage collaboration including integrated treatment strategies. The SAT team’s primary advantage in these efforts is that it ‘belongs’ to no single system. The psychiatrist is a consultant in private practice and works in some mental health programs of the county. The psychologist is in private practice and works occasionally as a vendor in both systems for assessment/counseling (county) or behavioral intervention (RC). The mental health navigator works full time as an administrator for one of the major MH contractors in the mental health system. The DD navigator works full time as an administrator in the RC system. The SAT team has access to Forensic and Substance Abuse/Recovery expertise through our current partner agencies. Therefore, in spite of the continued silo systems approach for the dually served, the SAT team is able to move in and across systems in a neutral and facilitative manner.

Phase I of this project provided a solid foundation for cross systems communication and collaboration in the treatment and care of individuals with dual diagnoses. The Phase I work pointed to the need for additional consultation to individuals who are experiencing a sudden worsening of mental health symptoms that may be placing them at risk of losing services in the community. In Phase II, the project will add a consultation clinic that may expand its efforts to more individuals who are dually served. The once a month consultation clinic with the SAT team is intended to provide consultation and navigation earlier, in the hope that the individuals needs can be met and high frequency use of multiple systems is not needed. Building upon Phase I liaising and training, the SAT team will support existing providers in accessing resources across systems, providing consultation regarding presenting symptoms, medication reviews and behavioral strategies. The team members will also provide whenever possible, requested training to direct care staff and providers. The clinic provided its first consultations on May 6, 2009 and has had several referrals with a waiting list established the first month. The clinic’s initial feedback has been very positive and it is anticipated that this additional resource to the project will further contribute to the emerging best practices in this specialty field.

Resources identified as useful or as needing further development (i.e. WRAP, Certificate of Excellence/DBT/DD) will also be pursued in Phase II of this demonstration project.

Replication of this project in other parts of the state will require Regional Centers, County Mental Health, Probation and Hospitals to be willing to work on Cross Systems Assessment, Consultation,
Systems Navigation, and Cross Systems training. Such an effort is greatly enhanced by the use of a Cross Systems Team (the SAT Team). This approach will be best served by braiding funding from multiple systems to support investment in the effort. Braiding funding is the cost effective approach. The previously held arguments that dually diagnosed individuals 'belong' to one system or another and thus are the sole funding responsibility of one given system, simply has not been successful. With or without a given system's knowledge, individuals with multiple diagnoses are seeking expert help from multiple systems of care to meet their needs. Without collaboration, multiple systems used continue to overlap their care efforts and provide adaptations to treatment creating fragmented services to individuals. Individuals must then add to their challenges, the challenge of navigating multiple and often disparate messages about their care. This fragmented approach does not protect budget dollars, it squanders them. This fragmented approach does provide the best care possible. The best care possible draws from the expertise of many systems and provides it in an integrated and collaborative fashion.

SECTION VI REFERENCES
References/Resources:

- Psychiatric Disorders and Developmental Disabilities: publication by Dr. Sharon McGilivery and Dr. Darlene Sweetland.
- Reiss Motivational Profile — [http://www.idspublishing.com/mrdd.htm](http://www.idspublishing.com/mrdd.htm)
- Psychiatric and Behavioral Disorders in Intellectual and Developmental Disabilities; Bouras and Holt
- The International Consensus Handbook of Psychotropic Medications and Developmental Disabilities; Reiss and Aman
- Manual of Diagnosis and Professional Practice In Mental Retardation; Jacobson and Mulick
- Dual Diagnosis: An introduction to the mental health needs of person with developmental disabilities; Griffiths, Stavrakaki and Summers
- Facilitator Training Manual for Mental Health Recovery including WRAP; Mary Ellen Copeland
- Wellness Recovery Action Plans by Mary Ellen Copeland, Ph.D.
- Intentional Care, training resources for staff: [http://www.intentionalcare.org/](http://www.intentionalcare.org/)
- Practice Parameters for the Assessment and Treatment of Children, adolescents, and Adults with Mental Retardation and Co morbid Mental Disorders; J. Am. ACAD Child Adolescent. Psychiatry. 38:12 Supplement December 1999
- Implementing Dual Diagnosis Services for Clients with Severe Mental Illness; Psychiatric Services52:469-476 April 2001 (Note: this refers to MI/CA). However evidence based practices apply to MI/DD., 2001

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23 For more information about the ongoing work of the project please visit [http://www.mosaiclink.org/SolBuild.html](http://www.mosaiclink.org/SolBuild.html). or call 951-973-7337.
Substance-related disorders in Person with Mental retardation; Sturmey, Reyer, Lee & Robek; (NADD Press, 2003)

Dual Diagnosis in Ontario's Specialty (Psychiatric) Hospitals 2005 Phase I/II Summary Report

Psychopathology in Young People with Intellectual JAMA, October 25, 2006 Vol 296 No 16

The Dual Diagnosis Primer: Edward E. Hughes, M.A. 2006; A training Manual for family members, Case Managers, Advocates, Guardians and Direct Support Professionals


Estimating the prevalence of mental disorders in people with MR; Public Health/July-August 2004/Volume 119

Serving Individuals with co-occurring developmental disabilities and mental illnesses: systems barriers and strategies for reform; national association of State Mental Health Program Directors (NASMHPD); www.nasmhpd.org


Psychiatryonline@psych.org

eVoice [evoice@enews.ama-assn.org]

AMNews [amnews.online@enews.ama-assn.org]

AMA Bookstore [ama.bookstore@enews.ama-assn.org]

National Alliance on Mental Illness: www.nami.org

Dialectical Behavior Therapy; DBT/DD; Julie Brown LICSW; http://www.behavioraltech.org/training/trainers.cfm?tid=93

Dual Diagnosis Consultation and Outreach Team (DDCOT); http://www.providencecare.ca/objects/content_revision/download.cfm/revision_id.183362/workspace_id.4/DDCOT%20Brochure.pdf/
SECTION V ATTACHMENTS

ATTACHMENT A
SOLUTIONS BUILDING PROJECT OVERVIEW

The San Diego Regional Center and San Diego County Mental Health Services have joined together to support the Solutions Building Demonstration Project. This is a collaborative effort across multiple systems with a specific focus on adults who are dually served, with high frequency, high intensity behaviors that result in the frequent use of crisis services. These services include frequent unplanned psychiatric hospitalizations, use of 911 and the PERT team and the SDRC's mobile crisis team.

Dually served individuals have a developmental disability and a co-occurring psychiatric illness. Many of these adults may also have a substance abuse related disorder and may also be known to the criminal justice system.

The Project uses three methods to accomplish its goals. These are intensive outreach and training opportunities to all interested community partners about the needs of individuals who are dually served, the use of a team of experts formed from several systems for consultation, assessment and treatment recommendations (the SAT team; Specialty Assessment and Treatment) and a formal crisis services protocol that relies upon the coordination of several programs/systems including the RC, CMH, Hospitals and county EMS to ensure effective crisis services and minimize hospitalizations when appropriate. (See diagram)
The Solutions Building Demonstration Project includes a Support, Assessment and Treatment (S.A.T.) Team that provides specialty consultation services to individuals in San Diego County that are ‘dually served’. This refers to individuals who have both a diagnosed developmental disability and a diagnosed mental health disorder. Dually Served individuals face even greater challenges than most as their unique needs require expertise in Developmental Disabilities and Mental Health. Research indicates that education in dual diagnosis needs, crisis care coordination, specialty consultation, and collaboration across all systems are critical to the success of these individuals. The SAT team includes experts in both of these areas and works across all systems to meet the needs of these individuals as well as providing consultation and education to all interested community partners. The SAT team’s efforts are sponsored by the San Diego Regional Center and San Diego County Mental Health Services.
ATTACHMENT J
SAT TEAM OBJECTIVES

- Provide a comprehensive review and assessment of all information including, medical, clinical, behavioral and general information made available to the team for project participants.
- The team then provides information, training and facilitation of person-specific strategies for each person to access appropriate services and maintain community tenure (i.e. WRAP, warm lines, hotlines, project carry cards, etc.)
- The team then develops a cross systems plan of medical history, current medical profile, personal and emergency contact information, key behavioral strategies, current and recommended services and a crisis protocol that includes an escalation hierarchy, emergency numbers and selected emergency resources. This crisis protocol is updated monthly and shared electronically with SDRC, SDCMH, service providers, local EMS and area hospitals.

Team members

- Project Manager
- Developmental Disabilities Navigator
- Mental Health Navigator
- Consulting Psychiatrist
- Consulting Psychologist
- Consulting Forensic Specialist
- Consulting Drug/Alcohol Specialist

Team Member Roles

Project Manager:
- Provides oversight and direction to the activities of the SAT team.

Developmental Disabilities Navigator:
- Provides key information regarding Regional Center services including eligibility, intake process, supports and services.
- Assists the Team in navigating RC services to facilitate connections for eligible individuals and increased communication across all systems.

Mental Health Navigator:
- Provides key information regarding Mental Health services including eligibility, intake process, supports and services.
- Assists the Team in navigating MH services to facilitate connections for eligible individuals.

Consulting Psychiatrist:
- Provides comprehensive review of available medical information, creating a current history and medical profile with recommendations.
- Available for consultation to other medical professionals and community partners. Facilitates education and training related to psychiatric care and pharmacology for this specialty population.

Consulting Psychologist:
- Provides comprehensive review of available clinical information including behavioral strategies, creating a summary of successful strategies and recommendations. Provides training in self-directed strategies to individual participants. Facilitates education and training related to clinical intervention and support.

Consulting Forensic Specialist:
- Provides key information regarding forensic/criminal justice issues, facilitating access to services where eligible.

Consulting Drug/Alcohol Specialist:
- Provides key information regarding drug and alcohol services, facilitating access where eligible.
ATTACHMENT C

Solutions Building Project Local Steering Committee Members

1. San Diego Regional Center; Director of Community Affairs
2. San Diego Regional Center; Director of Casemanagement Services
3. San Diego County Mental Health Services; Assistant Deputy Director, Adult & Child Forensic Services/MHSA Coordinator
4. San Diego County Psychiatric Hospital; Psych. SW Coordinator
5. P.E.R.T.; Director (Police Emergency Response Team)
6. United Behavioral Health; Medical Director
7. United Behavioral Health: Clinical Director
8. Community Research Foundation; Director of START/Crisis Houses
9. Solutions Building Project Manager
10. Solutions Building Mental Health Navigator
### Intervention Structure

<table>
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<tr>
<th>Triage</th>
<th>Crisis Stabilization</th>
<th>Enrichment</th>
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</thead>
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<tr>
<td><strong>Behavioral Profile</strong></td>
<td><strong>Behavioral Profile</strong></td>
<td><strong>Behavioral Profile</strong></td>
</tr>
<tr>
<td>- Recent frequent hospitalizations</td>
<td>- History of successful periods without hospitalization</td>
<td>- Has not been hospitalized in past month</td>
</tr>
<tr>
<td>- Recent unsuccessful residential experience</td>
<td>- History of successful residential experiences</td>
<td>- History of successful residential experiences</td>
</tr>
<tr>
<td>- Current significant depression</td>
<td>- Current significant depression</td>
<td>- Currently participating in satisfying daytime activities</td>
</tr>
<tr>
<td>- Current expressions of feeling unsafe</td>
<td>- Current thoughts of feeling unsafe</td>
<td>- Infrequent thoughts of feeling unsafe</td>
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<tr>
<td>- Recent unsafe behavioral reactions to depression or anger</td>
<td>- Is accepting of learning new ways of coping with unsafe thoughts</td>
<td>- Is able to seek out support and monitoring from outside person when feeling unsafe</td>
</tr>
<tr>
<td>- Recent police involvement</td>
<td>- Is able to seek out support and monitoring from outside person when feeling unsafe</td>
<td>- Personal/motivational profile</td>
</tr>
<tr>
<td>- Need for continual monitoring and support from outside person</td>
<td></td>
<td>- Primary desire/motivation is to live with independence</td>
</tr>
<tr>
<td><strong>Personal/motivational profile</strong></td>
<td><strong>Personal/motivational profile</strong></td>
<td>- Has the skills to cope with stressors with support</td>
</tr>
<tr>
<td>- Need for continual intervention to treat acute symptoms.</td>
<td>- Primary desire/motivation is to live with independence.</td>
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as of 4/30/09 N = 18
** moved to a less intensive level of intervention

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<th>CRISIS STABILIZATION ENTRANCE</th>
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<td>I. C</td>
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</tbody>
</table>

*Lost Community Placement

**E. H.  D. E. – temporarily – county jail – returned to community

**A. C.  B. K. – temporarily – county jail – returned to community

**A. D.
The Solutions Building Demonstration Project includes a *Support, Assessment and Treatment (S.A.T.) Team* that provides specialty consultation services to individuals in San Diego County that are 'dually served'. This refers to individuals who have both a diagnosed developmental disability and a diagnosed mental health disorder. Dually Served individuals face even greater challenges than most as their unique needs require expertise in Developmental Disabilities and Mental Health. Research indicates that education in dual diagnosis needs, crisis care coordination, specialty consultation, and collaboration across all systems are critical to the success of these individuals. The SAT team includes experts in both of these areas and works across all systems to meet the needs of these individuals as well as providing consultation and education to all interested community partners. The SAT team’s efforts are sponsored by the San Diego Regional Center and San Diego County Mental Health Services.
SAT TEAM OBJECTIVES

- Provide a comprehensive review and assessment of all information including, medical, clinical, behavioral and general information made available to the team for project participants.
- The team then provides information, training and facilitation of person-specific strategies for each person to access appropriate services and maintain community tenure (i.e. WRAP, warm lines, hotlines, project carry cards, etc.)
- The team then develops a cross systems plan of medical history, current medical profile, personal and emergency contact information, key behavioral strategies, current and recommended services and a crisis protocol that includes an escalation hierarchy, emergency numbers and selected emergency resources. This crisis protocol is updated monthly and shared electronically with SDRC, SDCMH, service providers, local EMS and area hospitals.

TEAM MEMBERS

- Project Manager
- Developmental Disabilities Navigator
- Mental Health Navigator
- Consulting Psychiatrist
- Consulting Psychologist
- Consulting Forensic Specialist
- Consulting Drug/Alcohol Specialist

TEAM MEMBERS ROLES

Project Manager:

- Provides oversight and direction to the activities of the SAT team.

Developmental Disabilities Navigator:

- Provides key information regarding Regional Center services including eligibility, intake process, supports and services.
- Assists the Team in navigating RC services to facilitate connections for eligible individuals and increased communication across all systems.

Navigators:

- Provide key information regarding Mental Health services, Forensic services, Inpatient services, drug and alcohol services including eligibility, intake process, supports and policies.
- Assists the Team in navigating services to facilitate connections for eligible individuals.

Consulting Psychiatrists:

- Provide comprehensive review of available medical information, creating a current history and medical profile with recommendations.
- Available for consultation to other medical professionals and community partners.
- Facilitates education and training related to psychiatric care and pharmacology for this specialty population.

Consulting Psychologist:

- Provides comprehensive review of available clinical information including behavioral strategies, creating a summary of successful strategies and recommendations.
- Provides training in self directed strategies to individual.

For more information please contact: Mosaic Connections @ 1-951-973-7337
SOLUTIONS BUILDING COMMUNITY COLLABORATIVE

PROJECT OVERVIEW

The Solutions Building Community Collaborative began in January, 2007. The intention of the collaborative is to improve the services provided to persons with dual (DD-MI) diagnoses by pooling the expertise of the multiple systems involved, thus contributing to emerging best practices in this specialty field. The goals of the funding partner (State Department of Developmental Services) and the host agency (San Diego Regional Center) and their co-sponsor (San Diego Behavioral Health Services) are as follows:

1. Maintain and/or increase Community tenure through focused, integrated and therapeutic service delivery.

2. Maximize a person's ability to cope with day-to-day life stressors in socially appropriate and productive ways

3. Increase a person’s support network and identify ways to use this network for crisis prevention and community integration

4. Provide appropriate, therapeutic environments to facilitate mental and behavioral health strategies.

Project Strategies: Recognizing that these objectives are inter-dependent, three basic strategies to meet them were developed. The project uses extensive community education to all interested community stakeholders, cross systems planning and consultation and crisis care coordination. These strategies are implemented using a Specialty Assessment and Treatment (SAT) team16 who were individual experts from multiple systems. A steering committee comprised of key stakeholders from multiple systems provided oversight to these efforts.
PHASE I

In Phase I, Project leaders focused on high intensity, high frequency users of the community’s emergency medical response systems including the Emergency Rooms, psychiatric inpatient hospital stays, the PERT team, 911 calls and police officers.

Phase I work began with the development of a Steering Committee with administrators and leaders from multiple systems including the Regional Center, County Behavioral Health services, the County Health care agency managing county Medi-Cal dollars, the County Hospital, the Police Emergency Response Team leader, the Director of Crisis Houses in the County, a representative from a mental health agency and the Project Director.

Based upon extensive research, the project developed a Support, Assessment and Treatment (SAT) Team including the Project Director, a psychologist and behavior specialist, a psychiatrist, and system navigators to assist with accessing appropriate services across the systems including a developmental disabilities navigator from the Regional Center system, a mental health navigator from the County Behavioral Health System, a Hospital Representative, and later, substance use disorders and forensic navigators. This team provided comprehensive assessment, strategies, navigation and training in dual diagnosis to facilitate appropriate community based services for each individual referred.

The outcomes in Phase I confirm the effectiveness of using strategies such as training, a cross systems consultation team and cross systems plans to encourage collaboration and integrated treatment strategies. This initial phase provided a solid foundation for cross systems communication and collaboration in the treatment and care of individuals with dual diagnoses. The Phase I work pointed to the need for additional consultation to individuals who are experiencing a sudden worsening of mental health symptoms that may be placing them at risk of losing services in the community.

PHASE II

In Phase II, the project added a consultation clinic that expanded the project’s efforts to include more individuals who are dually served including those experiencing a sudden worsening of symptoms. The once a month consultation clinic with the SAT team provides consultation and navigation earlier in a person’s illness in the hope that the individuals needs can be met and high frequency use of multiple systems will be reduced or eliminated. Building upon Phase I work, the SAT team supports existing providers in accessing resources across systems, providing consultation regarding presenting symptoms, medication reviews and behavioral strategies. The team members also provide whenever possible requested training to direct care staff and providers. The clinic began on May 6, 2009 and as of June, 2010 has provided consultation, training, advocacy, systems navigation and clinical care to 22 individuals over 13 months. Referrals were primarily from Regional Center staff with some referrals from other sources including UCSD, Community Health Group, family members, regional center and mental health providers. The clinic’s initial feedback has been very positive and it is anticipated that this additional resource to the project will further contribute to the emerging best practices in this specialty field. The SAT team was able to provide systems navigation, medication reviews, behavioral assessment, training, clinical recommendations, medical recommendations and follow up consultation to referring community members.
In Phase II resources identified as useful and needing further development included using Wellness Recovery Action Plans (WRAP), formalizing education to the community (the Certificate of Excellence) and adapted therapy using the principles of dialectical behavior therapy or DBT (SKILLS). In Phase II, support was provided to other projects through consultation including an MHSA (Mental Health Services Act) grant with Westside Regional Center, and training in Dual Diagnosis in LA and in Northern California to other providers.

Phase II again provided extensive community based education including 6 provider trainings around San Diego county, the third annual conference in Dual Diagnosis, the second annual Mental Health Resources Fair, the second annual Grand Rounds Presentation for doctors, and six classes in the Certificate of Excellence program.

PHASE III

Phase III of the Solutions Building Community Collaborative will continue efforts in Phase I & II including Clinic Consultations and extensive Community Education efforts. In Phase III, referrals to the Clinic were expanded to include Transition Age Youth (TAY) as well as all other adults with a dual diagnosis. In Phase II the 40 hour Certificate of Excellence in Dual Diagnosis was begun. Phase III will continue these classes and the Certificate Program including putting this program online for those unable to travel to San Diego for the face to face class instruction. Other Community Education included the annual Mental Health Resources Fair, the 4th Annual Conference in Dual Diagnosis, the continuation of Provider Trainings around the county and the 3rd Annual Grand Rounds presentation for the medical profession. Phase III continues to provide monthly clinic consultations available to all community stakeholders who serve individuals with dual diagnosis and are in need of additional assessment, training support, or systems navigation. Added to the team in this phase is an Alcohol and Drug navigator and a Forensic navigator. This Phase includes a pilot project in group therapy specifically for individuals with dual diagnosis, using the SKILLS approach authored by Julie Brown. This approach is based upon the principals of Dialectical Behavior Therapy and found to be effective for persons with dual diagnosis (DD-MI). This Phase will conclude in April 2012 with a summary report of outcomes including data analysis and the outline for Project Continuation on a permanent basis. At present, data indicates an average of 1 formal referral each month and 5-1 additional informal referral each month, serving a current total of 64 and 51 persons respectively.

The Project has provided training and information to over 3,500 stakeholders. For more information about this project, please call Peggy Webb, SBCC Project Director at 951-973-7337 or email at admin@mosaiclink.org. Extensive information about the project is also available at www.sdrc.org.
THE SOLUTIONS BUILDING
COMMUNITY COLLABORATIVE...
PRELIMINARY FINAL REPORT
AND FUTURE RECOMMENDATIONS

People Web M.A. / Project Director
Sponsored by: San Diego Regional Center
Dec 6, 2011

The Collaborative
- Deinstitutionalization Project
  • Focused on implementing successful projects in the area
  • Designed to measure success of identified strategies
  • Mentoring opportunity for Best Practice and
  • Collaboration
• Tentative: January or March 2012
• Funded by the State Department of Developmental Services
• Co-Sponsored by San Diego Regional and San Diego County Behavioral Health Services

PROJECT BACKGROUND
- Central goal: Success of the De-Institutionalization Project results increases number of persons in local communities
- Persons with Dual Diagnosis require services from more than one system of care
- Persons with Dual or Triple Diagnosis require expertise in more than one area and sophisticated behavioral intervention strategies.
PROJECT OBJECTIVES
To assist adults with serious diagnoses who are inadequately served without needed services from more than one system of care for:

- To improve overall community tenure through focused, integrated and therapeutic service delivery by all needed systems.
- Maximize patient's ability to cope with day to day life stresses in socially appropriate and productive ways
- Increase personal support network and identify ways to use this network for crisis prevention and community integration
- Provide appropriate therapeutic environments to facilitate behavioral health strategies.

Project Summary – Model is Successful in San Diego
- Use of SAT Team shows significant reduction in Residential and Psychiatric Hospitalizations
- Identifying key Resources provides key support to previously underserved in Self Directing Care, receiving Education, Regression Therapy and underscoring interventions in order to inform therapeutic interventions
- Phases I-II can be summarized into 7 key strategies
- Can be replicated using existing funding streams

SBCC – A Model of Collaboration Phases I to III
Effective Strategies in Cross Systems Collaboration

1. Engaging Systems Support based on...

DATA

2005-2006 Statewide Needs Assessment
- 2005-2006 Needs Assessment resulted in the development of a framework for increased expertise in Dual Diagnosis.
- 1 in 3 persons with a Developmental Disability documented in the database with co-occurring psychiatric conditions—known to be an under-estimated based upon data collection.
- Persons with dual diagnosis very vulnerable with special conditions including Substance Use and Criminal Justice involvement.
DATA – PHASE I

For the specified cohort of October, the following statistics were recorded:
- Delayed gratification of the diagnosis of mild mental retardation
- Delays in the program for the development of cognitive disorders
- Delays in the program for the development of mental retardation

The most significant delay was the cognitive system, which is B, with the next most significant delay being A followed by D. It is important to note that the higher incidence of cognitive delays is influenced by the delays high to different emergency medical centers during the phase of time of joining the project.

DATA – Phases I – III

Following the completion of Phase I, there was a significant reduction in the number of days in days and hospitalizations.

The severity of the effect of the diagnosis of mental retardation and the high incidence of residential placements are evidenced by a high incidence of hospitalizations compared to the previous phases. This reduction is represented in the graph below the graph of the difference in number of residential placements before and after the GAT team intervention.

DATA – Phases I – III

Residential Changes

Difference in Number of Residential Placements before & after GAT Team Intervention

- Phase I
- Phase III
- GAT Team Placement

Residential Placements before & after GAT Team Intervention
2. **Steering Committee**

- Director of the Health Insurance Request Center
- Assistant Director of the County, Behavioral Health Services
- Local Mental Health from County Hospital
- Director of the Health Insurance Request Team
- Director of Educational Development
- Medical Director of Health Insurance Agency managing county medical dollars
- Unification Manager, Health Insurance Agency
- Project Director
- Representative from one of the County's Major Mental Health Agencies

3. **Support, Assessment & Treatment Team (SAT)**

- Director, under successful efforts (i.e. Ontario Canada)
- Project Director
- Psychiatric (G)
- Psychiatric Behavior Specialist
- Systems Navigator
  - Regional Center System Developmental Disabilities Navigator
  - Mental Health & Hospitals System, Mental Health Navigator
  - Criminal Justice System, Forensic Navigator
  - Alcohol & Drug System, Substance Use Disorders Navigator

**Psychiatrist**

- Extensive Records Review
- Initials and Current Diagnosis
- Medication Review
- Recommendations
- Liaising with inpatient/outpatient physicians
- Educate SAT Team regarding best practice for complex medical and psychiatric needs
Psychologist/Behavior Specialist

- Observation and Interviews
- Assist in Teaching Classes in the Certificate of Excellence
- Facilitate Caregiver/Support Person Group in SKILLS pilot
- Clinical Recommendations
- Behavioral Assessment with plan if applicable
- Training to direct care staff for Rec’d Strategies

Frequent Recommendations from the team in Phase I

- Neuropsychological exam or psycho-neurological exam if completed and necessary
- Medication taper for individual, staff or family
- Escalation hierarchy including behavioral strategies for individuals with dual diagnosis
- Support staff consider the Reiss profile
- Consider assisting individual with WRAP Plan
- Consider individual and Group Therapy – SKILLS SYSTEM
System Navigators
Inform
Access
Advocate
Exchange & Cooperation

4. CRISIS CARE COORDINATION...
ACROSS SYSTEMS
- PROACTIVE
- ESCALATION HIERARCHY
- CROSS SYSTEMS PLAN

5. Community Education – over 3000 persons and counting...
- Phase I- III - Network presentations in
- Phase I - AASAP Certificate of Excellence
- Phase I- III - 5 annual Grand Rounds for physicians
- Phase I- III - Mental Health Resource Fairs with special topics
- Phase I- III – 5 Annual Statewide conferences
- Phase II- III - 30+ Provider Trainings county wide
Community Education

- Phase II - Online Certificate of Excellence - training
- Phase III - training and collaboration with other state projects, including Yuba City, San Francisco, Los Angeles.
- 4 years participation in the Statewide Collaborative on Dual Diagnosis and Forensic Mental Health.

6. RESOURCE DEVELOPMENT

- Reiss Profile
- WRAP
- The Skills System

REISS PROFILE

- Assisted by: Steven Reiss
- 30 basic needs
- 300 questions
- Computer stored
- 2 raters
- Likert Scale: Range from Strongly Disagree to Strongly Agree
RMP-IDD

What it adds to an assessment...
- Offers more provider-concrete feedback based on actual data assessment.
- RMP Description:
  Not positive or negative.
  More than most people, experiencing.
  Very energetic, active, person.
  Enjoy learning.
  Often behaves in ways that draw attention to self.

WRAP

EXCERPT FROM WRAP

Key elements of WRAP:
- Web-based tracking
- Document review
- Mental Health Assessment
- Identifying Early Warning Signs and an Action Plan
- Identifying When Things Are Breaking Down and an Action Plan
- Crisis Planning
- Post Crisis Planning

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THE SKILLS SYSTEM

The Skills System is a set of nine coping skills and three areas that we can use to handle our emotions, stresses, and actions in ways that help us reach our personal goals. Knowing how to feel, express, and problem-solve clearly helps us experience life fully, while making good decisions for ourselves.

excerpt from www.theskillssystem.com

The Skills List
1. Clear Picture
2. On-Track Thinking
3. On-Track Action
4. Safety Plan
5. Self-care
6. Problem Solving
7. Expressing Myself
8. Getting It Right
9. Relationship Care

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9 Coping Skills

Connect
On-Track Thinking
On-Track Action
Safety Plan
Self-care
Problem Solving
Expressing Myself
Getting It Right
Relationship Care

All the Time Skills
Calm Only Skills

For more information, visit www.theskillssystem.com
Feedback from Pilot Participants

- The handouts were helpful for learning new skills.
- The appointment was appreciated.
- The handout was useful.
- The handout was clear.
- The handout was helpful.
- The handout was informative.
- The handout was easy to follow.
- The handout was well-organized.
- The handout was concise.
- The handout was comprehensive.
- The handout was practical.
- The handout was beneficial.
- The handout was straightforward.
- The handout was user-friendly.
- The handout was accessible.

Why it works...

1. Basic skills taught using visual cues, practice, and repetition.
2. "Open-Door" group that allows for practice and integration of skills.
3. It is positive and there is no judgment. Therefore, the person feels successful even when they are having difficulty.
4. Care providers act as "coaches" at home.

7. Replication and Sustainability

- Online Training: will
- Be... 
- Phase III Final report with recommendations for individual systems, using existing funding to continue cross systems collaboration
- Support and mentor similar efforts in Los Angeles: www.marchacroyal.org
- Project Barriers – can we mitigate them?
Project Barriers - can we mitigate?

- Research and utilization of Change and Improvement
- Promote health and support education in dual diagnosis and dual systems collaboration
- Engage providers treat substance abuse as a medical issue
- Increased funding for treatment
- Need for new resources
  - Willingness of systems to reach across the table to fund changes
  - Dual Diagnosis effectiveness in the system

Systems can/do work together

- Regional Center
  - Medical Action Team
  - Treatment Services
  - Behavioral Health Services
  - Individual Citizen
  - Clinical Action Teams
  - Client and Case Management

Proposed Plan

...Integrate Service Delivery
What does an Integrated Services Delivery look like?

Taken from the CLASP article February, 2004
Center for Law and Social Policy
1915 15th Street, NW, Suite 400 Washington, DC 20005
www.clasp.org

5 Elements

5. Single Point of Entry - no 'walled garden'
- Comprehensive assessments - making an appropriate plan
- Co-location - ideal to provide services provided in one location, if
- A Sense of Partnership - staff day to day interactions with
- Cross training for staff is essential to mitigate sliding or 'stove

Is this a New Idea?

- Collaboration together on parlour-like single service models
- Comprehensive Community Health Network both providing and enrolling
- Collaboration to streamline systems and focus on dual diagnosis.
Summary

Object: Implementing Cross-Systems Intervention (SAT 2004). removes unnecessary hospitalizations and multiple
residential placements. Collaboration has a stabilizing effect on
people in need.

Using multi-disciplinary teams in other systems with adaptation makes
an impact. NYRCH, DSH, and Los Angeles police regulation and
behavioral health responded to the 9-11 events.

Collaboration intuitively reduces overlapping costs from
multiple systems' separate efforts.

Collaborative increases quality of care when all systems work
together. (see research in all other areas of social services
systems delivery from Washington, D.C. to Canada to
Australia, to San Diego, CA.)

Replcation?

Savings in hospital and state dollars provide multiple
improvements that can be made. For Sat2004, a total of 12
system-level of experts, including staff, police, and
caregivers, identified needs.

Police officers identified a relatively smaller number of
problems. However, high-frequency, high-regret events are
small number creates a noted
growth in their system.

Police advocates were asked, and for persons seeking safety
from a crisis, to identify key roles being provided

DHs and Hospitals are spending thousands of dollars to
encourage and
redirect people that need of those who set them out to
suicide, support and help from the community. (To
identify.

People with Dual or Triple Diagnosis are vulnerable in the community
and often become known to the criminal justice system. Stays in
county jails require extra supervision and often separate them
from
the
genome population creating a stream on yet another overcrowded
system.

Replcation... Isn't it worth a try?

Diverting costs already spent on overlapping care to
fund appropriate assessment and systems navigation
that has been shown to have a stabilizing effect in
this project.

With Cross Systems Collaboration, individuals are
able to direct their own care, more effectively
manage their emotions and corresponding behavioral
expressions and seek more effective solutions to
community living.
SBCC Steering Committee

A Plan to Start...
Current SAT Team members have pledged volunteer time in an effort to continue the work of the demonstration project.

Real Change Begins with You...

QUESTIONS AND DISCUSSION
ATTACHMENT N

A SAMPLE OF SUCCESSFUL EFFORTS IN CROSS SYSTEMS COLLABORATION*

*This list is only a sampling to highlight the extensive nature of this strategy

1. The Effects of Cross-System Collaboration on Mental Health and Substance Abuse Problems of Detained Youth.  


5. Collaboration—together we can find the way in dual diagnosis Center for Developmental Disability Health Victoria, Suite 202, 3 Chester St., Oakleigh, 3166 Australia.  
Caroline.Mohr@med.monash.edu.au ; http://www.ncbi.nlm.nih.gov/pubmed/11901661

6. The Nisonger Center:  http://nisonger.osu.edu/aboutus

7. Dual Diagnosis Consultation and Outreach Team:  
http://www.pccchealth.org/cms/sitem.cfm/clinical_services/geriatric_psychiatry/dual_diagnosis_consultation_outreach_team/