Alta California Regional Center Presents:

Unlocking the Secrets to Success:

Providing Innovative Services to Children with Developmental Disabilities & Mental Health Needs

Tuesday June 18, 2013

Funded by a grant received by ACRC from the MHSA in collaboration with the Department of Developmental Services

Unlocking the Secrets to Success…

Conference Agenda

8:00 am	**Registration | Continental Breakfast | Networking**
9:00 am	**Mistress of Ceremonies** **Lori Banales** Director of Children's Services, Alta California Regional Center
9:10 am	**Welcome Remarks** **Phil Bonnet** Executive Director, Alta California Regional Center
9:20 am	**Louis Vismara, M.D.** Policy Consultant to Senator Darrell Steinberg
10:25 am	**Keynote Speaker** **Chris O'Brien, Pharm.D.,BCPP** Co-founder of the Bio-Behavioral Clinic
11:30 am	**Lunch**
12:30 pm	***Afternoon Session: North Bay Regional Center - Project Connect*:** Panel Facilitator: **Herman Kothe, ACRC** Expert Panel Members: **Steve Lohrer & Michele Rogers**
1:35 pm	***Afternoon Session: San Andreas Regional Center - Santa Clara Infant Family Early Childhood mental Health Certificate Program*** Panel Facilitator: **Mechelle Johnson, ACRC** Expert Panel Members: **Howard Doi, Janice Battaglia, Dr. Sherri Terao, & Julie Kurtz**
2:40 pm	**Break**
3:00 pm	***Afternoon Session: Westside Regional Center - The Los Angeles Transition-Age Youth Service Integration project (TAY SIP)*** Panel Facilitator: **Camelia Houston, ACRC** Expert Panel Members: **Aga Spatzier & Alicia Bazzano**
4:00 pm	**Final Remarks –** **Evaluations / Sign Out**
NOTE:	Continuing Education (6 Contact Hours): Please sign in at CE table, submit evaluation and attendance verification form and sign out at end of the day in order to receive your CE Certificate from SacState.

Unlocking the Secrets to Success…

Distinguished Speakers

Lori Banales, M.A.

Alta California Regional Center
Director of Children and Adolescent Services
Lori has worked in the field of Developmental Disabilities for the past 22 years. She began working at Alta California Regional Center in 1993, as a Service Coordinator, and became a Supervisor of Children's services in 2000. For the past seven years, Lori has been in the position of Director of Children's Services.

Janice Battaglia

Janice Battaglia is the Manager of the Inclusion Collaborative at the Santa Clara County Office of Education, in this role Ms. Battaglia coordinates trainings, develops professional development materials, facilitates various steering committee/board meetings, CPIN Special Ed Lead, and coordinates the creation of pilot inclusion programs locally and across the state. She is a SEEDS consultant for California Department of Education. She is on the advisory board for the Infant Family Early Childhood Mental Health Certificate Program in Santa Clara County. She has been a co-facilitator of a reflective practice transdisciplinary group for this program. Ms. Battaglia works closely with a variety of different community agencies to implement and support reflective practice and inclusive practices. She has worked with children with disabilities of all ages in various capacities: teacher, program specialist, assistant principal and principal. She has worked in the field of early childhood special education for over 30 years.
Ms. Battaglia presents on inclusion and other topics locally and state wide.

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Alicia Bazzano, MD, PhD

Alicia Bazzano, MD, PhD is the Chief Physician at Westside Regional Center and a clinical faculty in Pediatric Emergency Medicine at the Harbor-UCLA Medical Center. She completed medical school at UCLA, pediatric residency at Cedars-Sinai Medical Center and fellowship as a UCLA Robert Wood Johnson Clinical Scholar.

Phil Bonnet

Phil Bonnet has spent nearly 30 years in service to individuals and families who are affected by developmental disabilities. He has worked as a direct care staff in programs that serve people in residential, employment and supported living settings. He also worked for many years as the executive director of a non-profit organization providing residential and vocational service to adults with autism and other developmental disabilities. Phil served as the Executive Director at the Redwood Coast Regional Center based in Eureka, California for about 10 years. In September 2006, he started his current position as the Executive Director of Alta California Regional Center in Sacramento. Phil has served as a leader on numerous statewide groups to improve services for Californians affected by developmental disabilities.

Howard Doi, LMFT

Howard has worked in the field of Special Needs for over 30 years. He is currently a District Manager of the Early Start Program at the San Andreas Regional Center, and was one of the founding partners of the program in Santa Clara County. Howard began the Infant Family Mental Health Collaborative of Santa Clara County which has provided a forum for training and collaboration for those interested in this specialty. He was also one of the founders of the Infant Family Early Childhood Mental Health Certification Program which is countywide 10 month intensive training program regarding Infant Mental Health/Relationship Based practice. Howard holds an undergraduate degree in Behavioral Sciences and a graduate degree in Marriage and Family Counseling. He is a licensed therapist and continues to utilize those skills as a consultant in the community.

Contact Info:

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Julie Kurtz, LMFT

Julie Kurtz is a Regional Director with the Center for Family & Child Studies at WestEd. She formerly served as the Executive Director of the YMCA. Kurtz oversees the California Collaborative on Social Emotional Foundations for Early Learning (CA CSEFEL) Teaching Pyramid professional development efforts under WestEd's MAP to Inclusion and Belonging. Prior to her leadership role at the YMCA, Kurtz was the Deputy Director at FIRST 5 Santa Clara and at Kidango, a nonprofit child development agency providing quality care and education in 9 Bay Area (CA) cities to over 2,500 children daily. Kurtz was one of the founders of the Santa Clara Infant Family Early Childhood Mental Health Certificate Program, an intensive 10-month training program leading to endorsement for the California State Core Competencies.

She also started an early childhood mental health services contract in California's Alameda and Santa Clara counties, providing in-home mental health services to children 0-5 and their families. While at FIRST 5, Kurtz started the diabetes and obesity prevention and intervention programs, including organizational wellness for FIRST 5 and the funded partners. She is also a licensed Marriage and Family Therapist, operating a part-time private practice. In 2012, Kurtz was named 100 Influential Woman of Silicon Valley by the *Silicon Valley/San Jose Business Journal.*

Steve Lohrer- Project Connect NBRC

Steve Lohrer works with the Napa County Office of Education and serves as Director of Operations for Project Connect NBRC, Director of the Autistic Spectrum Disorders: Guidelines for Effective Interventions sponsored by the California Department of Developmental Services and Co-Director for the Desired Results *access* Project sponsored by the California Department of Education, Special Education Division. Dr. Lohrer received his PhD from the Columbia University School of Social Work in New York and was a Post-Doctoral Fellow in Developmental Disabilities Research at the University of Wisconsin, Madison. Dr. Lohrer has a background as a researcher, clinical social worker and program manager in the fields of developmental disabilities, aging, mental health and family caregiving. Additionally, he is the parent of two young children with special needs.

Chris O'Brien, Pharm D BCPP

Dr. O'Brien earned his Pharm D at the University of the Pacific and is a board specialist in Psychiatric Pharmacy. He has consulted for the Regional Center system since 1997. Dr. O'Brien has also consulted for the Sonoma Developmental Center and University Centers Excellence in Developmental Disabilities at the University of Southern California in the Department of Developmental and Behavioral Pediatrics as well as Child and Adolescent Psychiatry. He is experienced in providing psychopharmacological medication management in school age, child, adolescent and adults with a dual diagnosis. He cofounded the Bio-Behavioral Consultation clinic at San Gabriel Pomona Regional Center and North Bay Regional Center. He is currently the chairperson for the Human Rights Committee at South Central Los Angeles Regional Center.

Aga Spatzier, MPH

Aga Spatzier, MPH is a Wellness Coordinator at Westside Regional Center and her areas of focus have been in wellness promotion and education for individuals with developmental disabilities and their families as well as service providers. She is currently a project coordinator for the Los Angeles Transition-Age Youth Service Integration Project.

Michele Rogers, Ph.D

Michele Rogers, Ph.D. is the Executive Director and Co-founder of the Early Learning Institute. Ms. Rogers has her PhD in psychology with an emphasis in early childhood mental health/neurobiology. She has worked for several years on Sonoma County's Early Childhood Mental Health task force, focusing primarily on creating a system of care for children 0-5 that includes social-emotional supports. Ms. Rogers is a certified childbirth educator and lactation specialist; has been NCAST certified at the research level and completed her Fellowship in the UMass Boston Infant-Parent Mental Health Post-Graduate Certificate Program (Napa site). She serves on the public policy committee of the Infant Development Association and as chair of First 5 Sonoma's Professional Community Advisory committee. Ms. Rogers is also an established trainer for the Ages and Stages Questionnaire (Screening tool), and a frequent speaker on Leadership, Staff Development and Executive Management topics. The Early Learning Institute was a key site for California First Five's Special Needs Project.

Sherri Terao, Ed.D.

Sherri is currently the Division Director over the Santa Clara County Mental Health Department, Family & Children's Division and a licensed psychologist. Prior to this, Sherri held the position as Chief Program Officer at FIRST 5 Santa Clara County. Sherri has worked in the area of child welfare and completed her pre and post-doctoral training at the UC Davis Medical Center's Child Protection Center. She also worked at the University of Chicago's Chapin Hall Center for Children and directed the first national longitudinal study of youth aging out of foster care in three states. In 2008, Sherri was part of a collaborative that was awarded MHSA Department of Developmental Services funding which lead to the development of the Santa Clara County Infant-Family Early Childhood Mental Health Certificate Program. Sherri is also a graduate of the Napa Infant-Parent Mental Health Post-Graduate Certificate Program.

Louis Vismara, M.D.

Dr. Vismara is an interventional cardiologist and a parent of four children. Since his son, Mark, was diagnosed with autism he has dedicated himself to issues of child development, learning differences, diversity, and access to health care for under-served populations. Lou was a co-founder of the M.I.N.D. Institute and currently serves as the chair person of the M.I.N.D. Advisory Board. Lou was also a founding member of multiple advisory organizations including the UCD School of Education. In the year 2000, Dr. Vismara changed careers, retiring from his medical career, to work as a full-time senior policy consultant for the California Senate. Lou has worked on numerous health-related initiatives and was instrumental in the formation of the California Legislative Blue Ribbon Commission on Autism. Currently, Lou is a senior member of Sen. Darrell Steinberg's staff and also serves as the chief consultant to the Senate Select Committee on Autism & Related Disorders. Lou, who was born in Italy and immigrated with his family to San Diego as a child, is the recipient of BA degree from Stanford University; MD from Baylor College of Medicine. Prior to starting a cardiovascular group practice at Mercy General Hospital, Lou was a Cardiology Fellow and Faculty Member at the UCD Healthcare System.

Unlocking the Secrets to Success

Warm Up

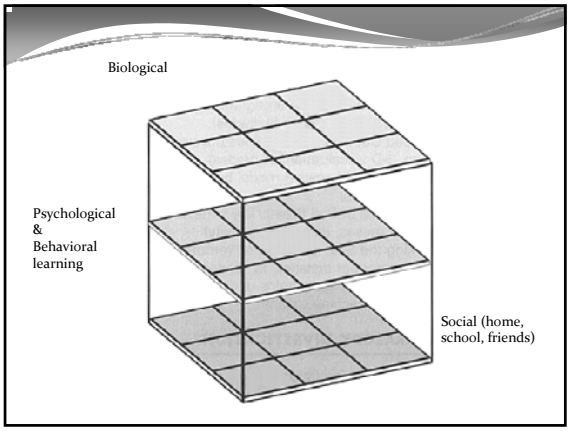
Chris O'Brien , Pharm.D. BCPP
Board Specialist Psychiatric Pharmacy

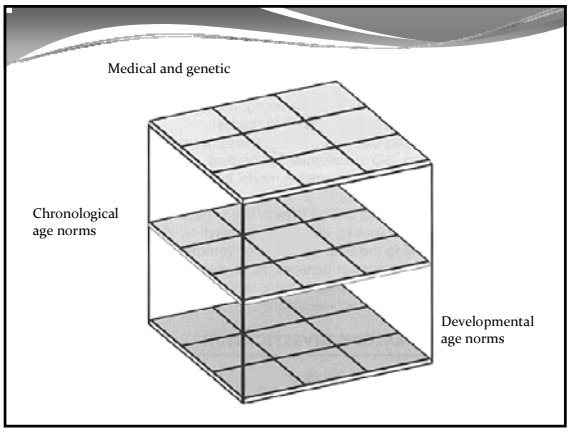
Disclosures

- Dr. Chris O'Brien declares no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

Goals

- Compare children with mental illness to those with a dual diagnosis
- Review approaches to assessment and treatment for children with a DD
- Provide high level view of some existing services
- Demonstrate need for service development
- Understand the benefits and limitations of novel service delivery methods such as Skype, video capture and data collection





Profile of Mental Functioning

- Capacity for Relationships
- Quality of Internal Experience
- Affective Experience, Expression and Communication
- Defensive Patterns and Capacities
- Capacity to Form Internal Representations
- Capacity for Differentiation and Integration
- Self-Observing Capacities
- Capacity for Internal Standards and Ideals

Assessment Challenges in DD

- Baseline Exaggeration
- Intellectual Distortion
- Psychosocial Masking
- Cognitive Disintegration
  - Sovner 1986

Childhood and Adolescent Mental Health Disorders

- Attention deficit & disruptive behavior disorders
- Learning disorders
- Motor skills disorders
- Psychotic disorders
- Mood disorders
- Anxiety disorders
- Somatoform, eating and tic disorders

Onset

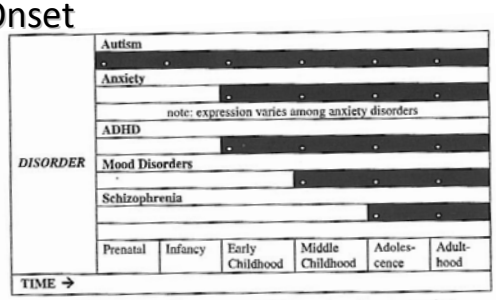


Fig. 1. Typical symptom onset and expression of childhood psychiatric disorders.

Childhood Mental Illness

- 15% of young people have a mental illness
- 20% will receive treatment from a mental health professional
- Variables
  - Diagnostic accuracy
  - Efficacy of treatment
  - Treatment choices
  - Compliance

Treatment guidelines

- Medication : Safe, effective, evidence based (in DD, usually lower than normal dosing)
- Medication reserved until trial of evidence based psychosocial treatments and usually only for moderate to severe symptomatology
- Assessment of individual, teachers and family
- Diagnosis drives treatment planning
- Therapy plus medication often better
- Discontinuation trials (most cases)
- Collect data

Psychosocial interventions

- Behavior Therapy
- Parent education and training
- Classroom and academic interventions
- Social skills training

Childhood mental illness

- 3 of the 10 leading causes of disability 15-44 yo's are MI
- Most adult MI begins in childhood
- Lifetime prevalence for children vary from country and region
- Depression 0.9 -3.4
- Mania 0 – 2.1%
- Any anxiety disorder 2 – 24%
- ADHD 1.7 – 17.8%
- Childhood onset schizophrenia 15% (varied by age) per 100,000 people (20% with ID)

Merikangas et. al 2009, Okkels et. Al 2010, Remschmidt 1994

Definition of Dual Diagnoses

- Coexistance of intellecutal disability and a diagnosis of mental illness (Graziano 2002)
- Intellecutal disability is below average intellectual functioning with deficits in adaptive functioning (APA 2000)
- Prevalence ranges from 20-35% in adults (Graziano 2002)
- In 4-18 years of age 40.7% and but only 10% received treatment (Einfeld 2007)

Developmental Disability (Title 22)

- Intellectual Disability (MR)
- Autism Spectrum Disorder
- Epilepsy
- Cerebral Palsy
- "Fifth Category"
  - E.g Traumatic Brain Injury
- Non-Regional Center definitions (i.e ADHD)

Living Situations of Californians with Developmental Disabilities

~155,000 people, total population

~100,000	live with family members
~34,000	live in a community care facility, an intermediate care facility or skilled nursing facility
~13,000	receive independent living or supported living services in the community
~4,000	live in developmental centers
~1,000	live in other places, such as foster family homes and county homes

- CDER 1999

*Number of Californians with Specific Diagnostic Conditions, July 1999**

Condition	Individuals With Condition Present	
Mental Retardation	110,810	84%
Cerebral Palsy	29,002	22%
Autism	11,233	8%
Epilepsy	31,184	24%
Other Types of Developmental Disabilities	11,411	9%
Visual Problems	17,846	13%
Hearing Problems	6,276	5%
Visual & Hearing Problems	5,828	4%
Ambulatory	103,634	78%
Medical Problems	28,806	22%
Special Aids Needed	32,719	25%
Technology Dependent	5,139	4%
Dual Diagnosis	10,945	8%
Severe Behaviors	9,038	7%
Behavioral Drugs	13,154	10%

Mental Retardation

- Significantly sub-average intellectual functioning (an IQ of approximately 70 or below)
- Deficits or impairments in adaptive functioning
- Onset before age 18

Mental Retardation – Incidence

- 1 – 3% of general population
- 1.5 time more common in boys than in girls
- Causes: 25% have known biologic causes

Incidence of Psychiatric Disorders in MR Population

- 40 – 70% of individuals have diagnosable psychiatric disorders
- Manifestations of MR may ***overshadow*** MI symptoms
- Increased incidence of Anxiety and Affective Disorders across whole MR spectrum
- More Schizophrenia spectrum disorders in those with mild developmental disabilities
- Existence of behavior disorder is negatively correlated with IQ (e.g., repetitive, self-stimulating, nonfunctional motor behavior, SIB and Pica)

Matson & Barrett, 1982

Co-Morbidity

- More often than not have a two or more diagnoses in addition to MR
- In a clinic sample of ADHD youth
  - 87% had one co-morbid condition
  - 67% had two or more (Kadesjo & Gillberg, 2001)
- Multiple disorders lead to more frequent mental health referrals

Lundby (2009) cohort Study (1947-1997)

- Dual diagnosis was more prevalent in Mild intellectual disability than in moderate intellectual disability.
- No subject with severe ID was diagnosed with a mental disorder.

Lundby continued

- Cummulative incidence for any mental disorder was 44 %
- Mood disorders 11.5%
- Anxiety disorders 11.5%
- Schizophrenia and other psychotic disoders 8%
- Mental NOS due to general medical condition 8%
- Dementia 3.8%
- Alcohol abuse 1.9%

Autism Spectrum Disorder

- Neuropsychiatric syndrome
- 3 domains
  - Communication/Language
  - Social interactions
  - Restrictive, repetitive behavior
- Onset prior to age of 3
- Increased incidence
  - 1/110 children (ASD)
  - 4:1 ratio male to female

Change, K. Child and Adolescent Psychiatry 2005
http://www.cdc.gov/ncbddd/actearly/index.html

Pervasive Developmental Disorders "ASD"

- **Autistic disorder** : Classic Autism. All three domains.
- **Asperger's syndrome**. Language preserved. Social problems & limited scope of interest.
- **Pervasive developmental disorder or PDD** – Autistic symptoms but do not meet diagnostic criteria for AD or AS
- **Rett syndrome.** Normal X 1-4 years then regress in domains. Almost exclusively girls. MECP2 gene.
- **Childhood disintegrative disorder**. Normal X 1-2 years and then regress in domains.

DSM IV – American Psychiatric Association

Autism Spectrum Disorders- Kids

- 70% of participants had at least one comorbid disorder and 41% had two or more.
- Social anxiety disorder 29.2%
- Attention-deficit/hyperactivity disorder 28.2% with 84% having a second comorbid Dx
- oppositional defiant disorder (28.1%)
- About 80% have an intellectual disability

SIMONOFF et. al 2008

High Functioning Adults ASD

Lifetime rate of axis-I disorders in adults with autism spectrum disorders (N = 122, if not other

							Criteria met DS	
	Autistic disorder (N=5)		Asperger's disorder (N=67)		PDD NOS (N=50)		Total (N=122)	
	N	%	N	%	N	%	N	%
Attention-Deficit/Hyperactivity Disorder	2	40	24	36	26	52	52	43
Chronic tic disorders	0	0	14	21	11	22	25	20
Mood disorder	3	60	35	52	27	54	65	53
Psychotic disorders	0	0	10	15	5	10	15	12
Substance related disorders	1	20	4	6	14	28	19	16
Anxiety disorder N = 119	0	0	34	51	25	50	59	50
Obsessive Compulsive Disorder	0	0	14	21	15	30	29	24
Impulse control disorder	0	0	4	6	7	14	11	9
Somatoform disorder N = 119	0	0	2	3	4	8	6	5
Eating disorder N = 119	0	0	2	3	4	8	6	5

Epilepsy

- Seizure clusters of nerve cells, or neurons, in the brain sometimes signal abnormally leading to motoric, mood or behavioral changes
- Partial, partial with generalization, generalized
- About 1% of the population with have a seizure or ongoing seizure disorder such as Epilepsy
- 16% will have an ID (Morgan et. al 2003)

Seizure Disorders

Table I: Diagnosis by group

Group (n)	*Percentage with psychiatric disorder (n)*				
	Any	*Emotional*	*Conduct*	*ADHD*	*PDD*
Complicated epilepsy (25)	56.0 (14)	16.0 (4)	24.0 (6)	12.0 (3)	16.0 (4)
Uncomplicated epilepsy (42)	26.2 (11)	16.7 (7)	16.7 (7)	0	0
Diabetes (47)	10.6 (5)	6.4 (3)	8.5 (4)	2.1 (1)	0
All other (10 202)	9.3 (946)	4.2 (427)	4.7 (483)	2.2 (228)	0.2 (25)

Any, any psychiatric disorder; Emotional, any emotional disorder; Conduct, any conduct disorder, including oppositional defiant disorder; ADHD, any attention-deficit–hyperactivity disorder; PDD, any pervasive developmental disorder (autistic disorder).

Davies et al 2003

Cerebral Palsy

- Umbrella term denoting non-progressive motor conditions that cause disability chiefly in body movement
- Abnormal muscle tone, reflexes, development & coordination
- Caused by damage to motor control centers during pregnancy, childbirth or up to age of 3
- 1.5 – 4 per 1,000 live births
- Isolated 41% (no ID)
- Seizures 34.8%
- Autism 9%

CDC CP data

Cerebral Palsy

TABLE 4: Mental health screening compared to having a psychiatric disorder (according to DSM children with cerebral palsy at school starting age.

SDQ-symptoms versus psychiatric disorders	Above 90th percentile on SDQ[a] *N* (%)	Psychiatric disorder present *N* (%)	S
Emotional symptoms versus emotional disorders[b]	14 (29.8)	5 (10.6)	
Conduct problems versus conduct disorder/ODD[c]	16 (34.8)	4 (8.5)	
Hyperactivity problems versus ADHD/ADD[b]	6 (12.8)	24 (51.1)	
Total Difficulties Score versus any psychiatric disorder[c]	31 (67.4)	26 (56.5)	
Peer problems versus any psychiatric disorder	41 (89.1)	26 (56.5)	
Impact score versus any psychiatric disorder	27 (57.4)	27 (57.4)	

PPV: positive predictive value; NPV: negative predictive value; [a]SDQ: strengths and difficulties questionnaire

Bjorgaas et al 2013

Fifth Category

- California Welfare and Institutions (W&I) Code Section 4512(a)
  - Individual functions in a manner similar to a person with mental retardation
  - Or requires treatment similar to that required by individuals with mental retardation
  - Examples:
    - Aspergers (changing with DSM V)
    - Traumatic brain injury

Any Trauma Risk for MI

2001

Variable	Total (N=20,507) N	%	Injury (N=6,116) N	%	No injury (N=14,391) N	%	OR	95% CI
Anxiety and acute stress disorders[a]								
2002	1,082	5.3	399	6.5	683	4.8	1.40	1.24–1.59
2003	1,175	5.7	450	7.4	725	5.0	1.50	1.33–1.69
2004	1,174	5.7	437	7.2	737	5.1	1.43	1.26–1.61
Depressive disorders[b]								
2002	1,097	5.4	450	7.4	647	4.5	1.69	1.49–1.91
2003	1,330	6.5	501	8.2	829	5.8	1.46	1.30–1.64
2004	1,360	6.6	503	8.2	857	6.0	1.42	1.26–1.59
Substance use disorders[c]								
2002	388	1.9	174	2.8	214	1.5	1.94	1.59–2.38
2003	407	2.0	192	3.1	215	1.5	2.14	1.76–2.60
2004	516	2.5	230	3.8	286	2.0	1.93	1.62–2.30
Disruptive behavior disorders[d]								
2002	1,046	5.1	379	6.2	667	4.6	1.36	1.19–1.55
2003	1,041	5.1	388	6.3	653	4.5	1.43	1.25–1.62
2004	1,022	5.0	380	6.2	642	4.5	1.42	1.25–1.62
Any psychotropic prescription[e]								
2002	2,218	10.8	893	14.6	1,325	9.2	1.69	1.54–1.85
2003	2,284	11.1	859	14.1	1,425	9.9	1.49	1.36–1.63
2004	2,394	11.7	887	14.5	1,507	10.5	1.45	1.33–1.59

[a] Includes posttraumatic stress disorder, acute stress disorders, adjustment disorders, panic disorder, social anxiety, obsessive-compulsive disorder, generalized anxiety disorder, and other childhood anxiety
[b] Includes major depressive disorder, dysthymia, and other depressive disorders
[c] Includes alcohol and drug use disorders
[d] Includes attention-deficit hyperactivity disorder, conduct disorder, and oppositional defiant disorder
[e] Includes antidepressants, anxiolytics, antipsychotics, and mood stabilizers

TBI versus any injury

Adjusted associations between injuries among youths in 2001 and psychiatric diagnoses and psychotropic medication prescription in 2002–2004[a]

	2001					
	Any injury		Traumatic brain injury		All other injury (non-TBI)	
Variable (2002–2004)	OR	95% CI	OR	95% CI	OR	95% CI
Anxiety and acute stress disorders[b]	1.21	1.02–1.44	1.19	.80–1.76	1.21	1.02–1.44
Depressive disorders[c]	1.30	1.10–1.53	1.66	1.14–2.43	1.30	1.10–1.53
Substance use disorders[d]	1.56	1.21–2.00	2.20	1.37–3.56	1.55	1.21–1.99
Disruptive behavior disorders[e]	1.10	.89–1.37	1.29	.80–2.07	1.10	.89–1.37
Psychotropic medication prescription[f]	1.37	1.20–1.57	2.16	1.59–2.93	1.37	1.20–1.57

Behavioral Phenotypes

- Gene-Brain-Behavior relationship
- Cognitive, linguistic, personality and psychopathology (DM-ID 2007)
- Childhood presentation may differ from adult
- Treat symptoms if impairing

Behavioral Phenotypes

- Angelman syndrome: HII, seizures, bouts of laughter, stereotypies
- Cri-du-Chat: HII, risk for ASD if translocations
- Down syndrome: Oppositional, HII, “charming person”
- Fetal alcohol spectrum disorders: HII, social skills deficits
- Fragile X syndrome: HII, PDD, anxiety, panic, mood

Behavioral Phenotypes

- Phenylketonuria (untreated): HII, anxiety, ASD, stereotypic movement, psychosis, skin picking
- Phenylketonuria (treated): HII, anxiety, phobia, OCD, psychosis
- Prader-Willi syndrome: Hyperphagia, anxiety, OCD
- Rubinstein-Taybi syndrome: ADHD, tic disorder, OCD, risk for ASD, higher risk for NMS
- Smith-Magenis syndrome: ADHD, tic disorder, OCD, ODD, BPD, psychosis, anxiety

Behavioral Phenotypes

- Tuberous sclerosis complex: ADHD, risk for ASD
- Velocardiofacial syndrome: ADHD, phobia's, anxiety, OCD, mood lability, perseveration, social withdrawl
- Williams syndrome: ADHD, anxiety, phobia's,

Case #1 S.L

- 13 yo African American girl lives with parents and 2 siblings
- DX: Learning disorder NOS, Borderline intellectual disability (testing done at age 5)
- CC: Aggression
- HPI: Staying in room more often, wakes up parents often, crying for no reason several day per week, also Onset, appears anxious during class and avoidant, school performance poor, onset 3 months.
- Shy, cooperative, poor eye contact, "I don't Know", restricted, linear and reality based without preoccupations, denies SIHI, IJK CNA

S.L

- Past psych hx unremarkable
- No comorbid medical concerns
- Family hx unremarkable
- Personal/developmental history: normal pregnancy, met milestones, social and language ok for developmental age
- Medication naïve
- IEP shows resources used in mainstream classes
- IPP shows no behavioral goals or additional services

S.L: FDA approved AD in children

- Fluoxetine(Prozac); age 7 for Depression and OCD
- Sertraline(Zoloft); age 6 for OCD
- Fluvoxamine(Luvox); age 8 for OCD
- Clomipramine(Anafranil); age 10 for OCD
- Paroxetine(Paxil); age 7 for OCD
- Imipramine(Tofranil) age 6 depression and enuresis
- Lower doses may be more effective in DD

SL: Some thoughts

- Sertraline for anxiety with depression starting at ½ normal dose
- Mitazapine for depression with sleep disturbance and daytime anxiety starting with ¼ normal dose
- Bupropion for depression with ADHD; less anxious and possible BPD
- _citalopram's when concern about interactions
- Quetiapine or Lithium if concern about suicidality
- Therapy can be as effective as medication and normally considered first
- Suicide risk lessens with age

Case #2: PH

- 7 year old Caucasian male lives with mom and 13 year old brother who has Autism attends non-public school
- CC: Aggression and poor sleep
- HPI: Has had increased aggression with brother and classmates after starting new school and parents separation, very affectionate towards mom, HII, broken sleep
- PPXH: In Pre-K was noted as more hyperactive and less attentive than peers and disinterested in others, transitions poorly, hyperarrousal in loud environments, RC intake (ADOS) revealed DX of AD

PH

- Past psych hx unremarkable
- HMO records unremarkable but client is mildly obese
- Family hx remarkable for father having borderline personality disorder and polysubstance abuse and is a computer programmer
- Personal/developmental HX: 34 week gestation delivered by c-section, mom tx fluoxetine for depression, did not breast feed, used words at 2 yrs, walked at 1.5 yr,
- Medication HX: Methylphenidate 5 mg bid – GI complaints, partial response to guanfacine 0.5 mg bid
- IEP includes BIP
- IPP shows behavioral and health goals; 18 hours/month respite

PH: approved medications ADHD

- Methylphenidate; age 6 years
- Vyvanse: age 6 years
- Adderall/Dexedrine; age 3 years
- Atomoxetine(Strattera); age 6 years
- Bupropion(Wellbutrin) age 7 years
- Guanfacine (Intuniv) age 6
- Clonidine (Kapvay) age 6

PH: Approved for AD

- Risperidone (Risperdal) age 5
- Aripiprazole (Abilify) age 6

PH: Some thoughts

- Alpha agonists are helpful for aggression, sleep, and HII or just "I"
- AP can help reduce irritability which leads to better focus, attention and sleep
- Consider melatonin for sleep if taking a stimulant
- Risk for sudden cardiac death with stimulants no higher than general population
- Can client tolerate labs? Baseline, 12 weeks then annually

Case#3 LG

- 17 yo Latino male, lives with parents and no siblings. Mom is an Acupuncturist and doctor of Eastern Medicine, dad is an active member in the Church of Scientology
- DX: GAD, Mild ID, Down syndrome, hypothyroidism
- Rx: Levothyroxine 100 mcg qd, hydroxyzine 50 mg tid, valerian root (unknown dose) qhs PRN sleep/anxiety
- CC: "I am a soldier and there are enemies everywhere"
- HPI: About 6 months ago LG became more aloof, grades dropped and less involved in self care. He recently recently kicked a neighbor whom he thought was a spie.

LG

- PPHX: unremarkable
- TSH 6 month's ago and was "high"
- FamHX: "mental illness does not exist"
- DD/Personal HX: full-term, natural delivery, breast feeding attempted, do not remember milestones, all special education classes
- IEP and IPP is not available at time of review
- MSE: LSA, well groomed, poor eye contact, followed directions, looking around room, stated "strong" when asked about mood, restricted affect, talked about things in disconnected way, believed member of special forces, denied AVH, IJK poor, denied SIHI

LG: FDA approved AP

- Risperdal; age 13 for Schizophrenia
- age 10 for Bipolar
- age 5 for Autism/irritability
- Abilify; age 10 for Bipolar

LG: Additional thoughts

- AP's, like most other psychotropic medication is used off label in children but may still evidence based
- Often times more frequent dosing is needed in children but LG's pharmacokinetics most likely similar to an adult

What is ABA?

- Applied Behavior Analysis
- ABA is the use of scientific principles of learning and motivation to teach effectively
- The core concept is that the consequences of what we do affect what we learn and what we will do in the future
- **Positive reinforcement:** behaviors that produce a good outcome are more likely to occur in the future
- People are motivated by what they get out of what they do
  - Examples: money, feeling good for helping someone, approval from others, satisfaction of a good book, etc.

The National Autism Center

National Standards Report 2009

- Comprehensive evaluation of educational and behavioral interventions for ASD
- Provide decision makers with information about how much research supports a particular intervention
- 7,038 abstracts reviewed and 5,978 were removed
  - Excluded studies were not specific to ASD
- Inclusion criteria
  - Individuals with Autism under age of 22
  - Autism, PDD-NOS, Asperger's Syndrome

Established	Emerging	Unestablished	Ineffective/Harmful
Several[a] published, peer-reviewed studies • SMRS scores of 3, 4, or 5 • Beneficial treatment effects for a specific target These may be supplemented by studies with lower scores on the Scientific Merit Rating Scale.	Few[b] published, peer-reviewed studies • SMRS scores of 2 • Beneficial treatment effects reported for one dependent variable for a specific target These may be supplemented by studies with higher or lower scores on the Scientific Merit Rating Scale.	May or may not be based on research • Beneficial treatment effects reported based on very poorly controlled studies (scores of 0 or 1 on the Scientific Merit Rating Scale) • Claims based on testimonials, unverified clinical observations, opinions, or speculation • Ineffective, unknown, or adverse treatment effects reported based on poorly controlled studies	Several[a] published, peer-reviewed studies • SMRS scores of 3 • No beneficial treatment effects reported for one dependent measure for a specific target (Ineffective) OR • Adverse treatment effects reported for one dependent variable for a specific target (Harmful) Note: Ineffective treatments are indicated with an "I" and Harmful treatments are indicated with an "H"

[a] Several is defined as 2 group design or 4 single-subject design studies with a minimum of 12 participants for which there are no conflicting results or at least 3 group design or 6 single-subject design studies with a minimum of 18 participants with no more than 1 study reporting conflicting results. Group and single-subject design methodologies may be combined.

[b] Few is defined as a minimum of 1 group design study or 2 single-subject design studies with a minimum of 6 participants for which no conflicting results are reported.* Group and single-subject design methodologies may be combined.

*Conflicting results are reported when a better or equally controlled study that is assigned a score of at least 3 reports either (a) ineffective treatment effects or (b) adverse treatment effects.

Established Treatments

- Behavioral (Broken down further but includes ABA, DTT, Early Intensive Behavioral Intervention)
- Joint Attention Intervention
- Modeling
- Naturalistic Teaching Strategies
- Peer Training
- Pivotal Response Treatment
- Schedules
- Self-Management
- Story Based Intervention

Emerging Treatments

- Communication Devices
- Cognitive Behavioral Interventions
- Developmental Relationship-based Treatment (Floor Time)
- Exercise
- Imitation-based Interactions
- Language training
- Massage/Touch Therapy

Unestablished Treatments

- Academic Interventions
- Auditory Integration Training
- Sensory Integration Therapy
- Facilitated Communication
- Gluten- and Casein-Free Diet

Approaches to Treatment – Cognitive Behavioral Therapies (CBT) to Address Skill Deficits

- Dominant modality in treatment today
- Effective with:
  - Panic disorder
  - Phobias
  - Promoting social behaviors - Depression
  - Anxiety
  - Parent stress
  - Anger management
  - Self-management
  - Social problem solving
  - Self-Instruction training
  - Social skills development
- Generally coupled with relaxation techniques, education, planned practice and generalization efforts

Approaches to Treatment: CBT to address Cognitive Distortions

- Assess for ability to
  - Distinguish between antecedent events and associated cognitions and emotions
  - Recognize that cognitions mediate the effects of events on emotions
  - Willingness to engage in "collaborative empiricism" to question the accuracy of cognitive distortion
- Reliability of self-reports
- Depression, anxiety, anger, and sex offences

Access to specialty care

- *Access to Specialty Medical Care for Children with Mental Retardation, Autism and other Special Health Care Needs*
- Multidimensional analysis of hassles of obtaining care
- Compares children with health/medical condition X 1 year with those with AD or ID
- 20 states

Table 1 Respondent, Family, and Child Characteristics and Insurance Coverage by Group

Characteristic	Contrast group (n = 1213) % or mean	Mental retardation (n = 434) % or mean	Autism (n = 152) % or mean
Respondent and family			
Respondent has high school degree or less (%)	33.5	23.3	21.1
Respondent has some college or more (%)	66.5	76.7	78.9
Family income (%)			
($0–$19,999)	34.1	23.5	29.1
($20,000–$39,999)	32.5	30.6	29.7
($40,000 and up)	33.4	45.9	41.2
Mean[a]	$33,472 (22,446)	$39,156 (22,929)	$36,621 (22,679)
Median	$25,000	$35,000	$35,000
Respondent is not married (%)	26.7	23.1	26.0
Respondent is not employed (%)	48.0	46.3	46.4
Respondent's health is fair or poor (%)	13.1	13.7	16.4
More than one child with special health care needs in family (%)	24.2	20.0	32.2
Child			
Child's age (mean)	8.3 (4.5)	9.9 (4.5)	8.4 (3.7)
Child is a racial/ethnic minority (%)	27.3	20.1	20.7
Child's health is fair or poor (%)	20.2	24.0	16.4
Child's health care needs are not stable (%)	25.0	30.8	26.8
Insurance coverage			
Medicaid pays for child's main health plan (%)	38.3	36.3	35.8
Child has public secondary health coveage (%)	36.0	39.9	32.6

Access problem domain	Contrast group	Mental retardation	Autism	(2, N = 1799)
Health Plan-Based Access				
Getting referrals for services	7.7	8.8	15.8	11.03**
The health plan would not pay	6.3	7.6	13.8	11.60**
Getting the number of visits needed	4.7	4.4	11.2	12.32**
The amount the family had to pay	4.0	4.6	11.2	15.19**
Percentage with at least one health plan-based access problem	14.9	15.4	28.3	18.03***
Provider-Based Access				
Getting appointments	8.7	9.0	15.8	8.20*
Finding skilled and experienced specialty doctors	7.0	9.9	18.4	23.32***
Coordination between specialty doctor and other providers	5.6	7.6	15.8	22.04***
Percentage with at least one provider-based access problem	14.3	17.1	28.9	21.46***
Percentage with any access problem	21.0	22.6	36.8	19.25***

*p < .05. **p < .01. ***p < .001.

Regional Center

- Definition: Diagnostic, counseling and service coordination center for developmentally disabled persons and their families (WIC 4620-4669)
- *Do not provide direct treatment*
- Contract with service providers
- 21 different personalities

University Centers for Excellence in Developmental Disabilities

- Developmental Disabilities Assistance and Bill of Rights Act of 2000
- 67 UCEDDs in the US and university affiliated
  - USC/CHLA, UC Davis/MIND Institute, UCLA/Tarjan Center
- Research, education and clinical services
- Diverse multidisciplinary teams (evidence based)
  - Developmental and Behavioral Pediatrics
  - Child and Adolescent Psychiatry
  - OT/PT and nutrition
  - Psychotherapy and counseling

Bio-Behavioral Consultation Clinic

- Funded through a DDS Wellness grant
- Serve clients that have high rate of involuntary psychiatric hospitalization
- Child psychiatrist, behavior analyst, psychopharmacologist
- Service coordinator participates
- Consultation and medication support
- 70% reduction in hospitalization compared to control group

Service Delivery Models/Trends

- Skype
- Phone/Texting virtual rounds
- Video and picture
- Expanded Electronic-Health Record Systems
- Integrated services (combining regional center case management with treatment teams)
- Holistic medicine

Questions?

Project Connect NBRC

Building Relationships in Early Childhood Mental Health in the North Bay
A project funded through the Mental Health Services Act

Early Start Advanced Practice Institute
May 6, 2013

Project Aim

Project Connect NBRC

To promote the development of a tri-county, interagency model of coordinated, culturally appropriate early childhood mental health services that support young children's social-emotional health and well-being in Napa, Sonoma, and Solano counties.

Overview

- **Mental Health Services Act (MHSA) Funded**
  DDS oversees innovative RC projects
- **3-year project**
  FY 11-12 – FY 13-14

Core Features

- Create cross-county collaborative focused on early childhood mental health issues
- Promote use of evidence-based / best-practices & professional development
- Develop resources and disseminate information
- Conduct ongoing evaluation of project goals and activities

Leadership Council

Key stakeholders with a commitment to early childhood mental health, early intervention, and family advocacy in Napa, Sonoma, and Solano counties.

Leadership Council

Members Represent:

ALDEA Children & Family Services
Children's Nurturing Project
County Mental Health
Department of Health Services
Developmental Disabilities Area Board
Early Learning Institute
Easter Seals
First 5
Matrix Parent Network and Resource Center
Parents CAN
SELPA
…..and growing

Focus Areas

Focus Areas represent barriers, challenges, or gaps within the early childhood mental health systems in Napa, Solano, and Sonoma Counties.

Focus Areas:

- *Best Practice Model*
- *Universal Screening*
- *Access to Care*
- *Professional Development*
- *Community Outreach*

Action Items

Focus Area Task Teams are charged to identify and complete a number of Action Items (discrete deliverable objective tasks or activities.

UNDER CONSTRUCTION

Core elements of a Community Early Childhood Mental Health System

Consider our analog of building a house

When I say, "I'm building a house" –

What image do you get in your mind?

Most houses have:

- Roof
- Foundation
- Windows
- Doors
- Bathroom
- Kitchen
- Bedroom

And yet…

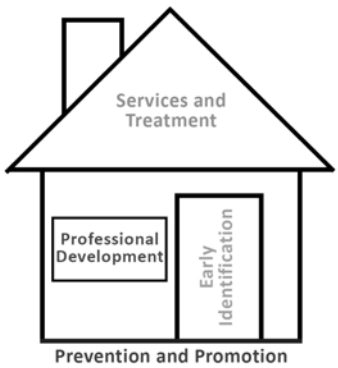
Houses don't all look the same.

It is how we put these elements together that result in tremendously different dwellings.

We make choices based on:

- Size
- Neighborhood
- Availability
- Cost
- Potential return on investment
- Urgency

If Your Community's ECMH System were a house, what would it need?



Does your Community need a Brand New Subdivision?

Or

Does Your House Simply Need An Addition, A Renovation or A Remodel?

How will you figure this out?

You First Need to Know

What You Have

In Order To Know

What You Need!

ECMH Community Assessment Tool

Divided into 5 major parts:

1) Prevention and Promotion
2) Early Identification
3) Services
4) Treatment
5) Professional Development

Contains a ranking guide:

5 – Essential element (red) Early Identification

4 – Core element (orange)

3 – Important element (yellow)

2 – Preferred element (light green)

1 – Desirable element (green)

Contains a definitions guide:

What does “Medical Home” mean to you?

Asks three basic questions

Do we have it?

If so:

- How much do we have?
- Are we using it?

Question #1 & #2:

Do we have the capacity to provide (X) for all those who need it?

1)Fully
2) Partially
   - Below 50%
   - Above 50%
3) Not at all
4) Don't know

Question #3:

Are we fully utilizing this capacity?

1)Fully
2) Partially
   - Below 50%
   - Above 50%
3) Not at all
4) Don't know

Who fills out the assessment?

Community Partners across disciplines

We want to know:

•Professional Capacity/Job
•Service Setting (private practice, agency, etc.)
•Geographic area/region served
•# of clients typically served in a year and their ages

Group vs. Individual Answers

Community groups that want to take on the tool in a group/committee setting will likely yield rich conversation…and will take much longer.

Individuals who complete the assessment may not know all there is to know but this is simply more information on which to build your house.

Data Synthesis

The answers on the assessment tool should help communities decide where and what to focus on:

- Where should you put effort, money and time?
- What do you have that you are under-utilizing? Why is that?
- What geographic areas need attention?
- Is there any one sector or area whose answers are really different from the majority of your community? Is this a communication issue?

Right or Wrong isn't really the point

The Community Assessment tool is designed to help set priorities for an individual community based on their goals and resources.

It also offers Best Practice rankings of the elements in a way that is easy to see.

It is a great way to narrow the conversation and take action!

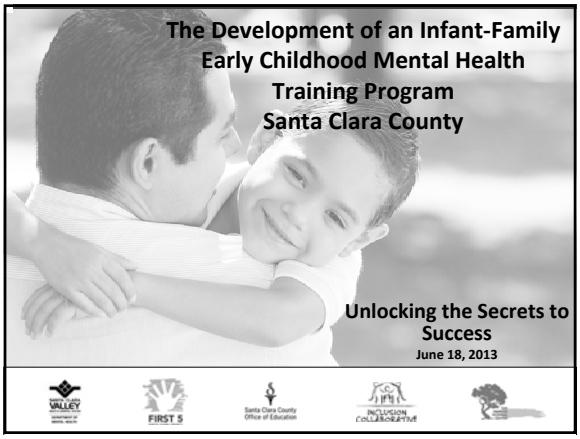
Questions?

Website / Portal

www.projectconnectnbrc.net

Project Key Milestones & Timeline

September 2011	Leadership Council Established
January 2012	Project Connect NBRC Website Established
February 2012	Leadership Council Reviewed Barriers, Challenges, and Gaps in services within Napa, Solano, and Sonoma Counties and identify priority Focus Areas.
May 2012*	Final selection of Focus Areas and Focus Group Task Team Leaders
September 2012	Additional members added to Priority Focus Area Teams
December 2012	Focus Area Task Teams will select Action Items
2013	Professional Development / Family Advocacy Event* (75-100 early childhood providers and/or family advocates) **note*: Professional Development / Family Advocacy events are held in addition to activities conducted around Focus Areas, but may be related to one or more Focus Areas (Project Connect NRBC Staff will provide coordination and technical support in planning and implementing events).
Jan 2013-June 2014	Implementation of Action Items
2014	Professional Development / Family Advocacy Event * (75-100 early childhood providers and/or family advocates) **note*: Professional Development / Family Advocacy events are held in addition to activities conducted around Focus Areas, but may be related to one or more Focus Areas (Project Connect NRBC Staff will provide coordination and technical support in planning and implementing events).
June 2014	Focus Area Task Teams will have successfully completed 2-3 Action Items



The Development of an Infant-Family Early Childhood Mental Health Training Program Santa Clara County

Unlocking the Secrets to Success

June 18, 2013

Presented by:

Janice Battaglia, MA, Manager, Inclusion Collaborative, Santa Clara County Office of Education, Advanced Transdisciplinary Mental Health Practitioner, Reflective Practice Mentor (RPM)

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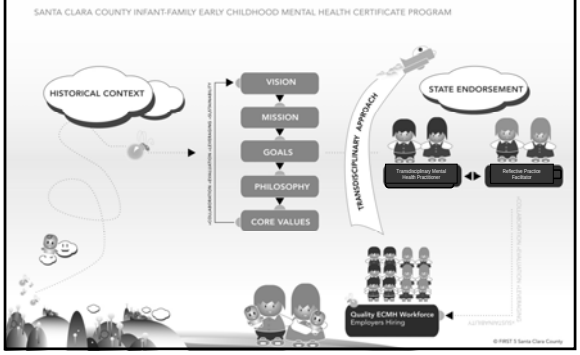
Our Journey



Historical Context

California Infant Family Early Childhood Mental Health (IFECMH) Competencies Framework

- Designed training program around core competencies http://cacenter-ecmh.org/
- 10-month program focused on the development of Transdisciplinary Mental Health Practitioner
- Previously established pathways for early childhood mental health:
  - De Anza Community College Early Childhood Mental Health Certificate Program
  - UCSF Community Clinicians Training
  - Oakland's Children's Hospital
  - Napa Infant Mental Health
- Transdisciplinary Approach
  - Group selection and make-up
  - Co-Facilitation model
- Targeted supervisors/managers for cohort – theory of change across systems

Program Development Process

- Consultation with Mary Claire Heffron, Ph.D., Clinical Director, Children's Hospital and Research Center, Oakland
- Application process for facilitators
  - Selection of facilitators
  - Interview process
- Application process for participants
  - Selection of participants
  - Interview process
- Alignment of training topics with competencies
  - Selection of Trainers
- Continuous quality improvement through evaluation review

Santa Clara County Infant-Family Early Childhood Mental Health Certificate Program (SCC I-FECMHCP)

Vision

Children, prenatal through age five, and their families in Santa Clara County have seamless access to a comprehensive system of care that has diverse infant-parent and early childhood mental health programs, supports and resources staffed by a well-trained and competent workforce.

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SCC I-FECMHCP Mission

The Santa Clara County Early Childhood Mental Health Certificate Program is a collaborative community partnership that provides strategic professional development that will strengthen a diverse workforce of collaborative and transdisciplinary partners (including but not limited to: early intervention; drug and alcohol programs; early care and education; social services; mental health; public health; legal/court systems and medical, etc.) to work effectively within and across systems serving children, prenatal through age five and their families.

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A Strategic Approach – Systems Leaders

- Individual meetings conducted with systems leaders
- Focused recruiting efforts
- Conducted interviews with supervisors of participants at commencement of program
- Regroup with systems leaders to share data/evaluation outcomes
- Conducted systems leaders group meeting
  - San Andreas Regional Center
  - Mental Health Department
  - Social Services Agency
  - Department of Family and Children's Services
  - FIRST 5
  - Judges
  - Court System
  - Public Health Department
  - Department of Alcohol and Drug
  - Education
  - Early Head Start & Head Start
  - Early Start Program
  - Higher Education
  - Community Based Organizations

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Grant Funded 2008-2011

- Collaborative application to Department of Developmental Services to create Santa Clara County Infant-Family Early Childhood Mental Health Certificate Program (May 2009)
  - San Andreas Regional Center
  - Kidango
  - Santa Clara County Office of Education
  - FIRST 5 Santa Clara County

- Commitment from FIRST 5 Santa Clara County to support Early Childhood Mental Health (ECMH) Workforce Development
- Funding awarded 2008-2011 (approx. $135k/year)

2008-2011 Program Components

- Trainings
  - Monthly 3 hour didactic trainings + 1 hour Reflection on topic (aligned with competencies)
  - 9 full days of trainings
- Reflective groups
  - 2 x/month
  - 2 hours / session
- Reflective individual sessions
  - One hour per session
- Reflective facilitator meetings
  - Monthly in groups (2 hours/ session)
  - Monthly individual with lead (1 hour / session)

Development of a Logic Model and Data/Evaluation Plan

- Participants and facilitators across systems and disciplines
- Satisfaction of Participant, Facilitator, and Supervisor
- Increased knowledge of Early Childhood Mental Health principles
- Use and promotion of relationship-based practices
- Development of shared language related to core competencies
- Increased cross-collaboration among/across systems
- Knowledge of Infant mental health competencies across agencies

Sustainability Efforts 2011-2013

- Commitment from **FIRST 5 and Santa Clara County and Mental Health Department** to support ECMH Workforce Development
- Fiscal support Santa Clara County Mental Health Department
- In-Kind support for infra-structure
  - FIRST 5 Santa Clara County
- In-Kind Support for Advisory Board
  - FIRST 5 Santa Clara County
  - San Andreas Regional Center
  - Santa Clara County Department of Mental Health
  - Santa Clara County Office of Education

Infrastructure

- **Santa Clara County Department of Mental Health**
  - Primary financial support for program
  - Invoices and contracts
  - Budget
  - Reflective practice for facilitators
  - Reflective practice facilitation for participants (individual and group)
- **FIRST 5**
  - Reflective practice facilitation for participants (individual and group)
  - Monitor and tracking participant hours
  - Collecting programmatic requirements
  - Facility for trainings and reflective groups
  - Program coordination
  - Video library
  - Training rooms and technology support
  - Continuing Education Units

Infrastructure (Continued)

Advisory Board

- FIRST 5 Santa Clara County
- Santa Clara County Mental Health Department
- San Andreas Regional Center
  - Grantee 2008-2011
- Santa Clara County Office of Education
  - Evaluation and data collection
  - Continuing Education Units

New Track 1
2012-13
Advanced Reflective Practice (ARP) Groups

Purpose: continued participation with reflective practice facilitation

Eligibility: past graduate of IFECMHCP

- Co-facilitation with Mentor in training and Endorsed Reflective Practice Mentor
- Reflective groups
  - 2 x/month
  - 2 hours / session
    - Monthly readings aligned to competencies
    - Monthly case presentations
- Reflective facilitator mentor meetings
  - Monthly with mentees in group (2 hours/ session)
  - Monthly individual with co-facilitator-mentor lead (2x/month 1 hour / session)
- 20 hour Project to bring training concepts back to agency and infuse reflective practice/infant mental health into system

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New Track 2
2012-2013
Reflective Practice Mentor

Purpose:

1. Increase capacity number of Reflective Practice Facilitators in Santa Clara County.
2. Accrue hours toward endorsement for Reflective Practice Facilitator I, II or Mentor

Eligibility:

1. Past graduate of IFECMHCP
2. Application and interview process

- Attend Reflective Practice Training (2 day training)
- Books, articles and readings aligned to competencies
- Co-Facilitate Reflective Groups
- Didactic Trainings Optional
- Reflective facilitator meetings
  - Monthly in groups (2 hours/ session)
  - 2x Monthly individual with co-facilitator group lead (1 hour / session)
- 20 hour Project to bring concepts back to agency and infuse reflective practice/mental health into system

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Sustainability and Leveraging of Resources

- FIRST 5 sponsored trainings
  - Touchpoints (3 days)
  - Age and Stages Questionnaires (ASQ)/ASQ Social Emotional)
- Mental Health sponsored trainings
  - Reflective Practice (1 or 2 days)
  - Diagnostic Classification (DC): 0-3R (1 or 2 days)
  - Compassion Fatigue
  - Cultural Competency
- Learning Partnership
  - Mental Health
  - Dept. Drug and Alcohol
  - Social Services Agency
  - FIRST 5
- Materials

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Reflections from IFECMHCP Participants

The Four T's of Success

- Time
- Trust
- Transdisciplinary
- Team Approach

Questions and Answers

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Santa Clara County
Infant-Family & Early Childhood Mental Health Certificate Program

The Santa Clara County Infant-Family & Early Childhood Mental Health Certificate Program (IFECMHCP) is a unique training program that meets the knowledge, skills and reflective practice requirements for endorsement as a Transdisciplinary Infant-Family and Early Childhood Mental Health Practitioner in the State of California as outlined in the *California Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health, Revised (http://cacenter-ecmh.org)*. IFECMHCP 12-13 is funded by Santa Clara County Department of Mental Health and through in-kind support from FIRST 5 Santa Clara County, Santa Clara Office of Education – Inclusion Collaborative, and San Andreas Regional Center. Since 2009, over 80 practitioners have completed the program.

IFECMHCP is committed to transdisciplinary training and therefore accepts applicants from a wide range of professional disciplines, including mental health, prevention and early intervention, nursing, medicine, drug treatment programs, social workers, early care and education and other related fields. The program aims to provide in-depth training and reflective practice for providers working with young children and their families. IFECMHCP offers providers the opportunity to gain the foundational knowledge necessary to practice from a family-centered, culturally competent, developmentally appropriate and relationship based framework for serving young children across the continuum of infant-family and early childhood mental health.

IFECMHCP consists of three program tracks, at the core of each track is a reflective practice/facilitation component, designed to help participants learn to apply and adapt theory and intervention techniques to the settings where they practice.

Infant Family and Early Childhood Mental Health Certificate Program (IFECMHCP): Provides participants with a combination of interactive, didactic instruction and reflective practice. Participants meet for monthly seminars and reflective practice sessions over a period of 11 months. The content of the training seminars include basic theories related to social emotional development, assessment and intervention techniques for infant and early childhood mental health services that address the culture and context of the child and family.

Advanced Reflective Practice for Infant-Family & Early Childhood Mental Health Practitioners (ARP-IFECMHP): Provides participants with the opportunity to receive advanced reflective practice to support direct service with families and integration of IFECMH concepts into practice. A prerequisite of this track is completion of the IFECMHCP or its equivalent.

Reflective Practice Facilitation/Mentor for Infant-Family & Early Childhood Mental Health Practitioners (RPFM-IFECMHP): Provides participants a combination of a) interactive, didactic instruction related to IFECMH and reflective practice b) providing reflective practice to others and c) receiving reflective practice over an 11-month period. A prerequisite of this track is completion of the IFECMHCP or its equivalent. This track is intended to prepare participants for endorsement as a Reflective Practice Facilitator I, II, or III/Mentor in California.

For more information about the Santa Clara County Infant-Family & Early Childhood Mental Health Certificate Program, please contact:

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Los Angeles Transition Age Youth Service Integration Project

Westside Regional Center

Acknowledgements

- MHSA grant funded project from DDS
- Project Partners:
  - North Los Angeles County Regional Center
  - Los Angeles County Department of Mental Health
  - Santa Clarita Child and Family Center

Transition Age Youth (TAY)

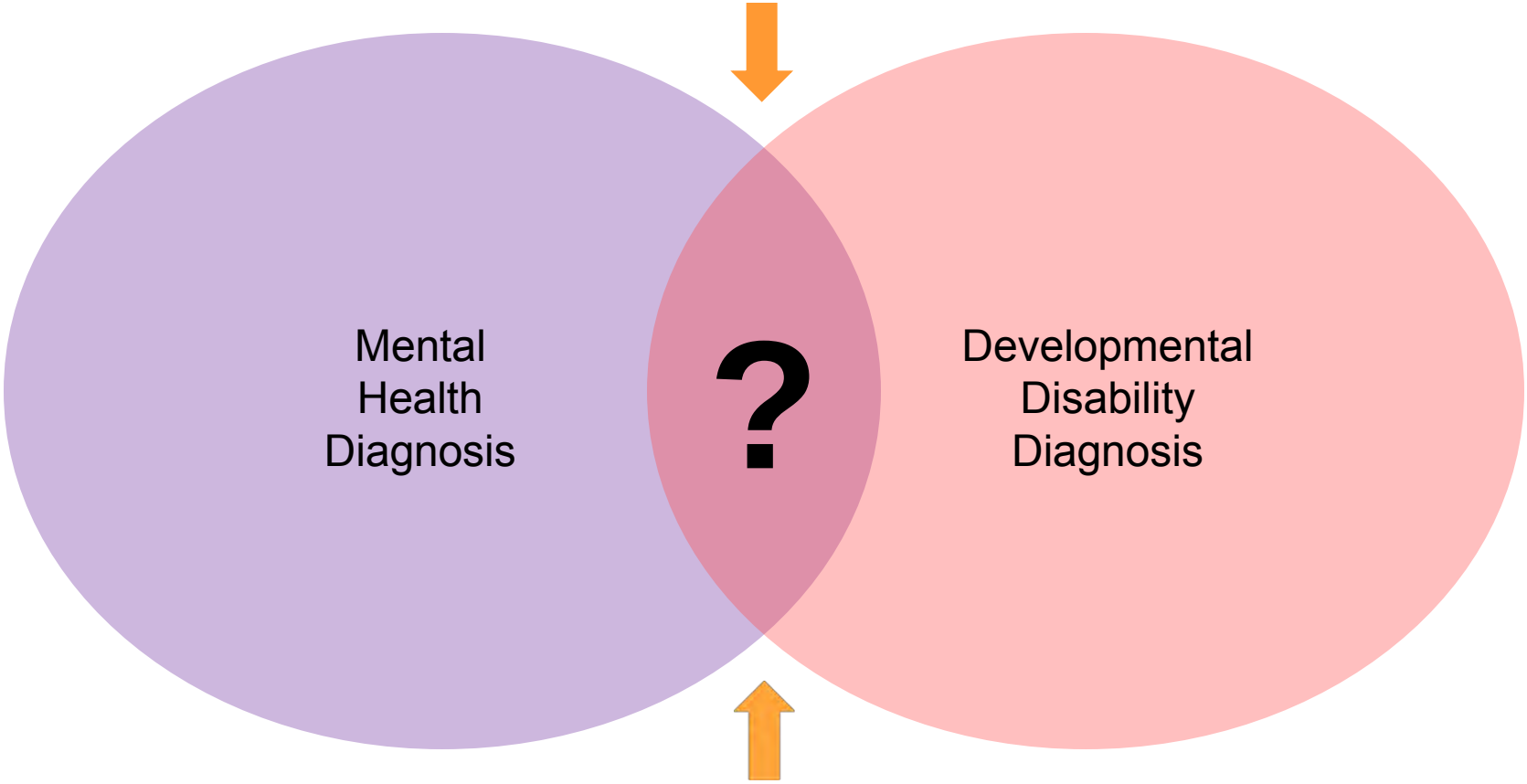
- TAY: 14-25 years old
- Domains of transition:
  - Post-secondary education
  - Employment
  - Housing
  - Health care
  - Finances
  - Social/recreation/community life

Transition Age Youth (TAY)

- TAY with developmental disabilities[1]
  - 27% of all people with developmental disabilities
  - ~30% of clients at WRC
  - ~35% of clients at NLACRC
- TAY with mental health conditions[2]
  - ~8%-30% range of lifetime prevalence of attention, mood, anxiety disorders among 18-29 yr olds

Source: [1]DDS, 2011; [2] Kessler, et al, 2005, Merikangas, et al, 2010

Who are Dually Diagnosed TAY?



Los Angeles Transition Age Youth Service Integration Project

- Project aims
  - Develop a profile of dually diagnosed TAY
  - Identify local needs, barriers, and patterns of service use during transitions
  - Create interventions and collaborations to improve outcomes of TAY in West and North Los Angeles

Needs Assessment

- Phase I – Chart Abstractions
- Phase II – Key Informant Interviews

Chart Abstractions

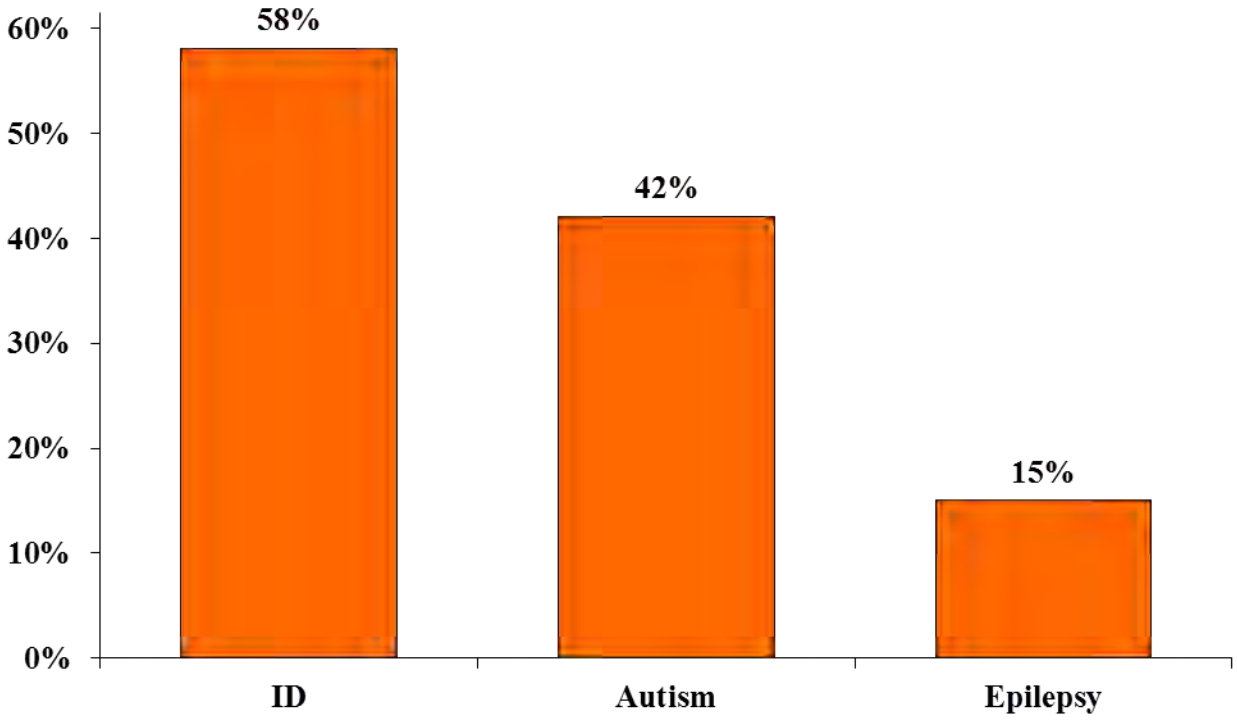
- Created a list of all dually diagnosed clients at WRC (N=1379)
- Randomly selected charts to review (N=400)
- Identified dually diagnosed TAY (N=137)

Phase I - Profile of Dually Diagnosed TAY

- Demographics (N=137)
  - Male = 76%
  - English Speakers = 72%
  - Family Home = 79%
  - Race/Ethnicity:
    - White = 34%
    - African American = 28%
    - Hispanic/Latino = 26%

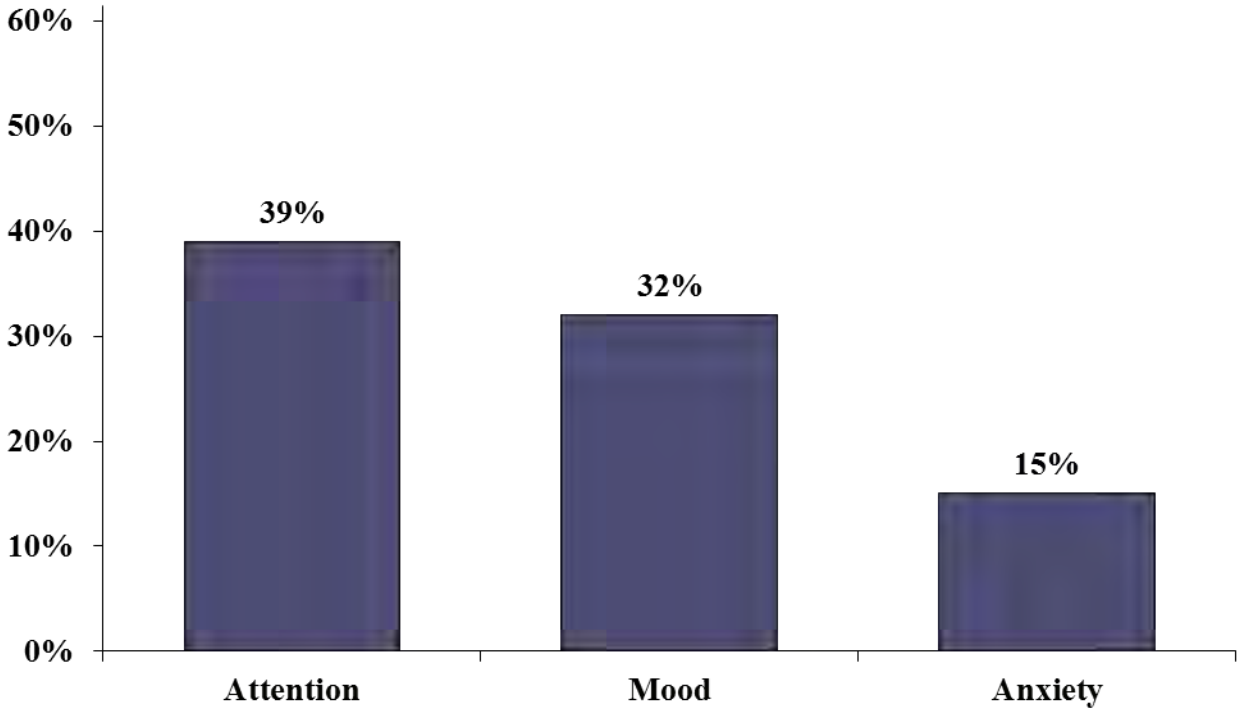
Profile of Dually Diagnosed TAY

- Most prevalent developmental diagnoses



Profile of Dually Diagnosed TAY

- Most prevalent mental health diagnoses



Profile of Dually Diagnosed TAY

- Health care access and utilization
  - Psychiatric medications = 85% (n=117)
  - Seen by Mental Health Professional = 70% (n=92)
    - Seen by psychiatrists = 59%
    - Seen by other = 12%
    - Seen by both = 29%
  - Psychiatric hospitalizations = 15% (n=20)

Phase II – Key Informant Interviews

- Semi-structured, in-depth interviews to:
  - Learn about challenges and successes of transition processes from informed community experts
  - Help formulate recommendations for interventions

Phase II – Key Informant Interviews

- Participants (N=22)
  - Key informants = individuals who have:
    - Knowledge of needs of TAY
    - Experience assisting in the transition process
  - Psychologists, physicians, program managers, education specialists, parent and client's rights advocates

Phase II – Key Informant Interviews

- Resulting Themes:
  - Cross-system collaboration and communication
  - Awareness about services and resources
  - Individualized transition-specific services
  - Communication between clients, families and providers

Tailored Intervention

- Informed by needs assessment
- Ecological perspective: Multiple targets of intervention
  - Agencies
  - Service providers
  - Families & TAY

Targets: Agencies

- TAY Collaborative meetings
  - Based on successful models: Interagency Committee and Coordinating Council
  - Coordinated case management across agencies
  - MOU's, policies, procedures and trainings

Targets: Agencies

- TAY Collaborative meetings
  - Bringing together representatives from:
    - Los Angeles County Department of Mental Health
    - Regional Center
    - Department of Child and Family Services
    - School Districts: Los Angeles, Culver City, Santa Monica
    - Family Resource and Empowerment Center

Targets: Agencies

- TAY Collaborative meetings
  - Anticipated outcomes
    - Identify a point-person at each agency for referrals
    - Clarify referral criteria and referral processes for each agency
    - Share responsibility for addressing the needs of dually diagnosed TAY and their families
    - Create workable solutions that can be implemented in a timely fashion

Targets: Service Providers

- Motivational Interviewing
  - Client-centered, evidence-based communication and counseling approach
  - Enhances motivation to change behavior
  - Assist providers in helping TAY and their families make difficult changes during transition

Targets: Service Providers

- Motivational Interviewing
  - Pilot training program at the regional centers
    - 2-day workshops in Summer and Fall of 2013
    - Estimated participation: 60 providers
    - Training includes demonstrations, role-play, group exercise and practice

Targets: Families & TAY

- Resource Guide
  - Comprehensive listings of programs and services
  - Includes checklists and domain-specific information about the transition process
  - Will be distributed to youth and families residing in LA County
  - An online resource guide will be available on www.reachacrossla.org

Next Steps and Future Directions

- Program evaluations
- Potentially expanding MI trainings to other agencies and families
- Establish preventive services for mental health at regional centers

Challenges

- Time and labor intensive
- Obtaining and sustaining participation
- Delayed impact of the interventions due to:
  - The length of the transition process
  - Reaching across multiple domains and systems of care

Strengths

- Interventions are useful for a broad range of challenges that TAY and providers face
  - Collaborative – strengthens relationships between agencies to address specific needs of TAY
  - MI – teach providers a communication method that empowers TAY to make individualized changes
  - Resource Guide – offers practical recommendations for multiple domains of the transition process

Strengths

- All three arms of the intervention can be replicated at other agencies
- Investing in providers' skill development benefits current and future clients

WRC MHSA Research Team

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- Uchechi Mitchell, MSPH, Research Assistant
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The Certificate of Excellence in Dual Diagnosis (DD-MI)

People we serve may have complex needs, including issues with substance abuse and/or mental illness in addition to the diagnosis of developmental disability. These inter-dependent needs often require multiple systems of care to work together in supporting individuals to live successfully in their local communities.

The **Certificate Of Excellence** was developed to support continued expertise in this specialty area. It is part of the Solutions Building Community Collaborative in San Diego funded by the California State Department of Developmental Services and is co-sponsored by San Diego Regional Center and San Diego County's Health & Human Services Agency.

The **Certificate of Excellence** is an on-line resource designed to provide up to 30 hours of training and information for professionals who work with and for persons with a dual diagnosis in developmental disabilities and mental health disorders.

One can take the classes for free or receive CEU's for a fee of $5 per hour session.

To access the program please to go the website:
WWW.SOLUTIONSBUILDING.ORG

Below is the list of class sessions

Understanding Dual Diagnosis (4 hours)

- Introduction
- Unit 1: Developmental Disabilities
- Unit 2: Mental Health Disorders
- Unit 3: Dual Diagnosis

Clinical Diagnosis (6 hours)

- Introduction
- Unit 1: Challenges and Barriers in Differential
- Unit 2: Introduction to the DSM-IV
- Unit 3: Common Diagnoses for the Dually Served
- Unit 4: Case Examples and Theoretical Models

Behavioral Strategies (5 hours)

- Introduction
- Unit 1: Dual Diagnosis
- Unit 2: Getting Started: The "Plan"
- Unit 3: Behavior Theory
- Unit 4: Interventions and Strategies

The "Other" Dual Diagnosis (4 hours)

- Introduction
- Unit 1: The Scope of the Problem and Definitions
- Unit 2: Substances of Abuse
- Unit 3: Screening and Assessment
- Unit 4: Mental Illness
- Unit 5: Referral to Treatment

Therapies Overview (2 hours)

- Introduction
- Unit 1: Challenges of Traditional Therapeutic
- Unit 2: Most Common Theoretical Approaches

Psychopharmacology (3.5 hours)

- Introduction
- Unit 1: Assessment Principles
- Unit 2: Common Conditions and Psychopharmacology

Cross-Systems Collaboration (3.5 hours)

- Introduction
- Unit 1: What is Collaboration and Why Do We Care?
- Unit 2: Dual Diagnosis - What is It?
- Unit 3: What's Working?
- Unit 4: Cross-Systems Panel

Certificate of Excellence - Overview / Review (2 hours)

- Introduction
- Class 101: Understanding Dual Diagnosis
- Class 201: Clinical Diagnosis
- Class 301.1: Behavioral Strategies
- Class 301.2: The "Other" Dual Diagnosis
- Class 301.3: Therapies Overview
- Class 301.4: Psychopharmacology
- Class 401: Cross-Systems Collaboration

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