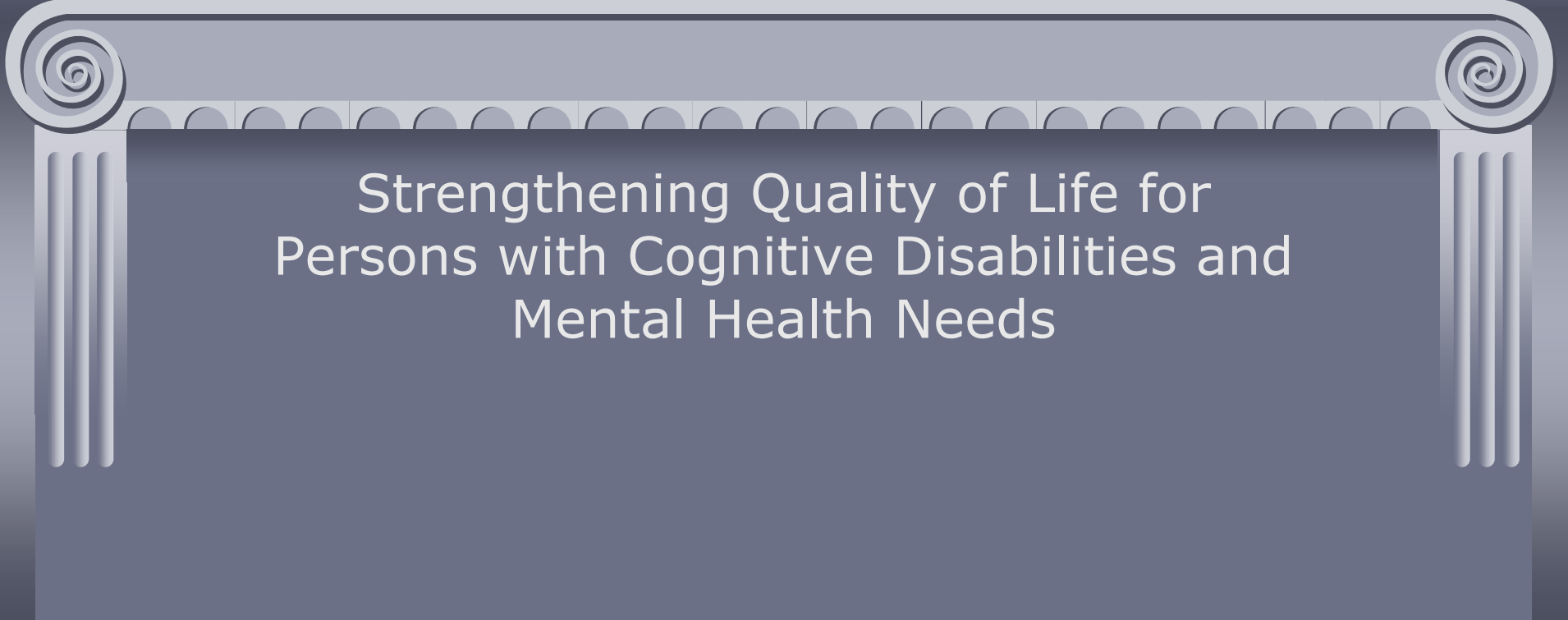
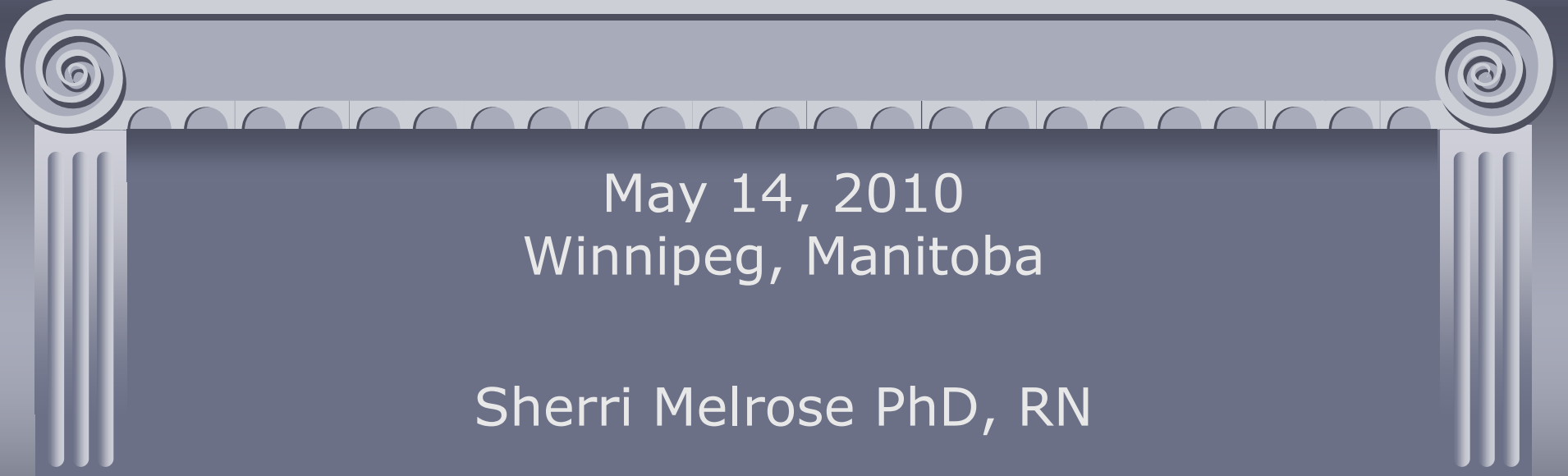


Creating a Client Self Managing Plan for Mental Wellness



Strengthening Quality of Life for
Persons with Cognitive Disabilities and
Mental Health Needs

Presented at the
**Keeping One Step Ahead: Practical
Approaches to Mental Health Promotion**
11th Canadian Conference Collaborative Mental Health Care



May 14, 2010
Winnipeg, Manitoba

Sherri Melrose PhD, RN

Athabasca Campus Athabasca Alberta



Online Programs in the Centre for Nursing & Health Studies

- ◆ Students are post licensure nurses & health care professionals across Canada
- ◆ Remain in their home communities
- ◆ Undergrad degree in nursing -BN
- ◆ Graduate degrees –MN, -MHS, -NP
- ◆ Are you or do you know someone who is an AU graduate?
....alumni all over the world....

CASS

Calgary Alternative Support Services

- ◆ Supporting adults with cognitive disabilities in Calgary since 1988
 - ◆ Community living & access
 - ◆ Innovative day program
 - ◆ Competitive employment placement
 - ◆ Financial management
 - ◆ 'Service navigation' support

AU/CASS Research Team

- ◆ Front line Community Support Coordinators Diane Percy & Stacy Schikowsky –trained in the Wraparound Model
- ◆ Carol Urness, Executive Director
- ◆ Katherine Kautz, Executive Manager
- ◆ Sherri Melrose, P.I.



Research Approach

- ◆ **Framework**–Constructivist: individuals create knowledge via social process
- ◆ **Design**–Naturalistic action research
- ◆ **Data collection/analysis** -15 taped transcribed interviews with individuals who have both cognitive disabilities & mental health concerns will be analyzed for themes

Problem

- ◆ Responding to crisis with costly ER visits & antipsychotic meds is not working
- ◆ Clients left feeling alone & isolated



Background

- ◆ Adults with cognitive disabilities experience mental ill-health at a prevalence rate of 40.9% 3 to 4 times greater than the general population ¹
- ◆ 75% of participants with mild to moderate cognitive disabilities had all experienced at least 1 traumatic event during their life span, predisposing them to significantly increased odds of a mental disorder ²

- ◆ Hospitalized adults with cognitive disabilities can be expected to spend more days in hospital ^{3,4,5}
- ◆ Challenging behaviors, although not listed as DSM-IV-TR psychiatric diagnosis, have consistently been identified as a reason for admission to hospital ^{1,6,7,8}
- ◆ Aggression, self injury & non-compliance not necessarily linked to disturbances in psychiatric functioning ^{9,10}



A Different Approach

Wraparound Model

A client driven, team process based on an individualized plan, focusing on the strengths of the participant and their team members, that develops strategies to effectively address their needs on a day to day basis

Its holistic approach fosters inter-sectoral collaboration and collective community responsibility to support individuals dealing with multiple and complex problems

Process

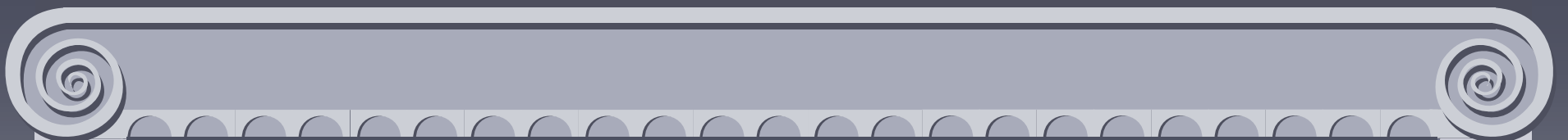
- ◆ A facilitator helps clients choose a team of professionals & lay people to 'wraparound' them



- ◆ The team helps clients assess their strengths & then develops a plan to use these strengths to holistically address their needs
- ◆ Participants choose their own goals and how quickly they want to achieve them, thus decreasing their sense of powerlessness. Instead, the individuals are helped to direct their own change process
- ◆ Regular monthly meetings

4-Part Self Managing Plan

1. Wraparound Team—**who & where** (6wks)
2. Planning —**what** (facilitator documents) (3wks)
3. Implementation—**how & when** (51 wks)
(evaluated from client's perspective)
4. Transition Plan – Strategies to maintain gains, plan future changes & identify needed supports for when encountering future crisis (23 wks)



The Wraparound model is congruent with the community inclusion movement - but it also appeals to the those wanting to reduce costs.

By empowering the individual and focusing on strengths, their energy works towards a better quality of life for themselves.

After the initial "investment" - there is less need to staff care to keep them safe and without risk and less need for psychotropic drugs.

In the system of keeping people safe and reducing risk, people fought the system they were in, resulting in the need for more staff and more drugs.



Could a self managing wellness plan strengthen quality of life for those with both cognitive disabilities & mental health concerns?
...Our Research Question...

Does a

Can anyone have we ever told you how much your support means to us?

© Jaybee 2001

Literature Review

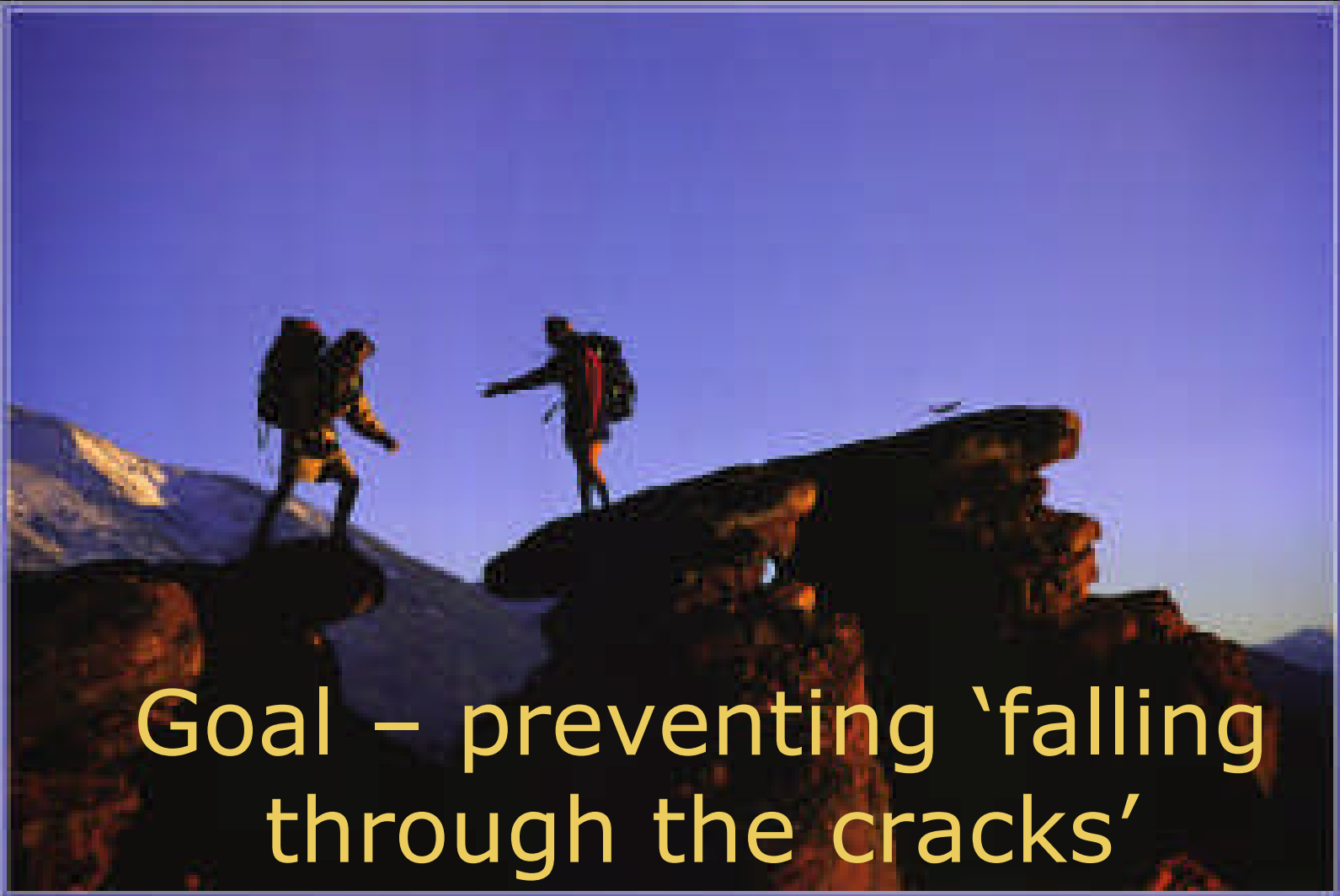


Model previously used with children & adolescents – not with cognitively impaired adults (PDD)



Environmental Scan

- Literature applying the model
- Other agencies applying the model



Goal – preventing ‘falling through the cracks’

ENCOURAGEMENT

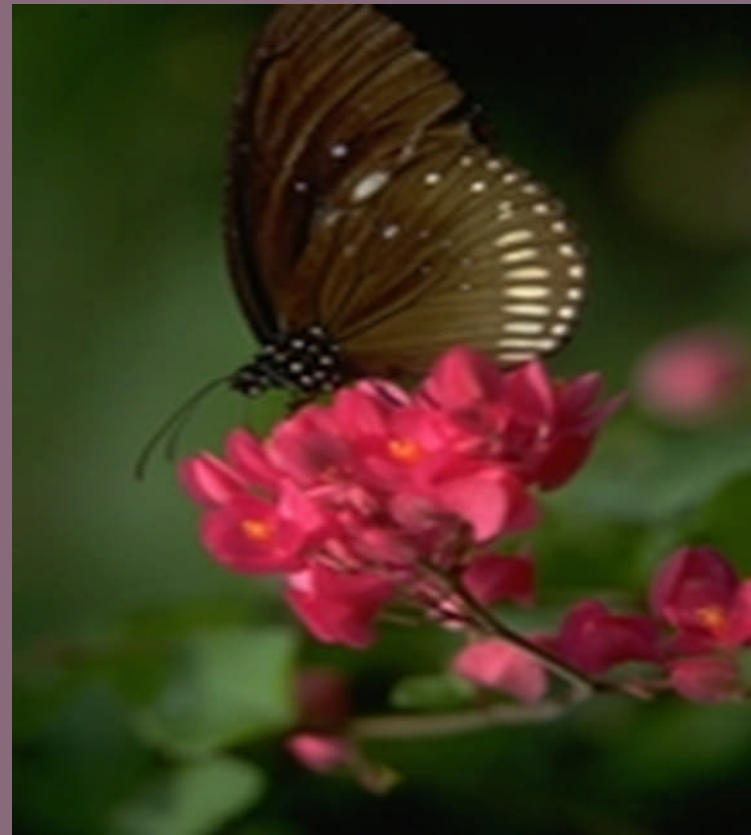
Encourage others and share in the joy of success.

Next Steps

- ◆ Funding. Proposal to 'Collaborative Research Grant Initiative: Mental Wellness in Seniors and Persons with Disabilities'
- ◆ Partnerships. We would like to connect with others who might be interested in partnering with us or who have had success meeting mental health needs of cognitively impaired adults

Working Together

- ◆ Any ideas
Resources
suggestions...
for us to help
strengthen our
research plans?





References

1. Cooper, S., Smiley, E., Morrison, J., Williamson, A., & Allen, L. (2007). Mental ill-health in adults with intellectual disabilities: prevalence and associated factors. *British Journal of Psychiatry, 190*, 27-35.
2. Martorell, A., Tsakanikos, E., Pereda, A., Gutiérrez-Recacha, P., Bouras, N., Ayuso-Mateos, J. (2009). Mental health in adults with mild and moderate intellectual disabilities: The role of recent life events and traumatic experiences across the life span. *The Journal of Nervous and Mental Disease, 197*(3), 182-186.
3. Bouras, N., Martin, G., Leese, M., Vanstraelen, M., Holt, G., Thomas, C., Hindler, C., Boardman, J. (2004). Schizophrenia-spectrum psychoses in people with and without intellectual disability. *Journal of Intellectual Disability Research, 48*, 548-55.
4. Morgan, V., Leonard, H., Bourke, J., & Jablensky, A. (2008). Intellectual disability co-occurring with schizophrenia and other psychiatric illness: Population-based study. *The British Journal of Psychiatry, 193*, 364 - 372.
5. Saeed, H., Ouellette-Kuntz, H., Stuart, H., & Burge, P. (2003). Length of stay for psychiatric inpatient services: A comparison of admissions of people with and without developmental disabilities. *The Journal of Behavioral Health Services and Research, 30*(4), 406-417.
6. Cooper, S., Smiley, E., Allan, L., Jackson, A., Finlayson, J., Mantry, D., Morrison, J. (2009). Adults with intellectual disabilities: prevalence, incidence and remission of self-injurious behaviour, and related factors. *Journal of Intellectual Disability Research, 53*(3), 200-216.
7. Cooper, S., Smiley, E., Jackson, A., Finlayson, J., Allan, L., Mantry, D., Morrison, J. (2009). Adults with intellectual disabilities: prevalence, incidence and remission of aggressive behaviour and related factors. *Journal of Intellectual Disability Research, 53*(3), 217-232.
8. Whitaker, S., & Read, S. (2006). The Prevalence of psychiatric disorders among people with intellectual disabilities: An analysis of the literature. *Journal of Applied Research in Intellectual Disability, 19*(4), 330-345
9. Allen, D. (2008). The relationship between challenging behavior and mental ill-health in people with intellectual disabilities: A review of current theories and evidence. *Journal of Intellectual disabilities, 12*(4), 267-295.
10. Allen, D. & Davis, D. (2007). Challenging behaviour and psychiatric disorder in intellectual disability. *Current Opinion in Psychiatry, 20*(5), 450-455.