

The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred) and no references, tables, or figures. Send material to Francine Cournos, M.D., at the New York State Psychiatric Institute (fc15@columbia.edu) or to Stephen M. Goldfinger, M.D., at SUNY Downstate Medical Center (smgoldfingermd@aol.com).

Creating a Medical Home for Homeless Persons With Serious Mental Illness

Individuals with a serious mental illness, especially those who have experienced homelessness, have high rates of medical comorbidities and early mortality. Our “housing first” program combines supported housing, assertive community treatment (ACT), and primary care in order to address these complex service needs. The program began in October 2008 and serves 125 individuals who have met the federal definition of chronic homelessness and have an axis I diagnosis of serious mental illness. Two separate city departments in Philadelphia, the Office of Supportive Housing and the Department of Behavioral Health, made the program possible. U.S. Department Housing and Urban Development funds (Shelter plus Care) provide housing subsidies with the expectation that consumers pay one-third of their income (usually Supplemental Security Income or Social Security Disability Insurance) toward rent. Medicaid funding for intensive case management supports consumers’ independent living. Services are configured and staffed as two ACT teams.

Through collaboration with a local academic medical center, a primary care physician has been embedded

within the ACT teams from the program’s outset. This physician provides on-site primary care services for two half-days per week, joining each team’s morning meeting on those days and working closely with the team nurses to provide overall health assessment and coordination, including a disease registry. When needed, the primary care physician also makes home visits with an ACT team member to actively engage individuals who would not otherwise receive medical treatment. Follow-up care and specialty care referrals occur either at the housing-first agency or at the physician’s hospital-based practice. Consistent with ACT’s multidisciplinary operational approach, key relationships between nursing, psychiatry, and primary care have been established during usual ACT service provision, with the addition of both monthly integrated care program meetings and team “medical rounds” allowing for a sustained focus on consumers’ ongoing health needs.

This integration of primary care is made possible through the combination of an individual research fellowship that allowed for flexibility in the physician’s schedule and institutional support from the academic medical center that is committed to piloting innovative approaches to care. The sustainability of integrated primary care within these teams is based on soliciting ongoing grant funding.

Through the first full calendar year of the program (October 2008–December 2009), 106 clients enrolled in the program, and housing stability exceeded 90%. Epidemiological monitoring during this period revealed that 92% of clients had a chronic medical condition in addition to a serious mental illness. Thirty-two clients received integrated primary care based on consumer choice and specific team referrals. (Thirty-six clients reported having an outside primary care doctor, and 34 clients had no regular contact with a primary care physician and declined further health care evaluation.) With assertive community treatment as a

platform to deliver primary care services, a majority of these clients were screened for hypertension (97%), diabetes (81%), obesity (88%), and hyperlipidemia (63%), as recommended by the National Association of State Mental Health Programs Directors. Those with positive screens are receiving ongoing treatment. During our second year of program operation, 15 more individuals began receiving integrated primary care through this focus and continued outreach.

Providing integrated primary care within ACT has also enabled clients to receive, when necessary, comprehensive, coordinated tertiary care services, such as treatment for cancer and chronic kidney disease. Although the affiliation with the medical center has facilitated referrals for additional care, there continues to be a high rate of missed appointments (approximately 30%), which underscores the need for proactive, ongoing team support. For clients receiving care from outside primary care providers, it has been difficult to maintain open communication and exchange of timely information in order to medically support consumers’ health conditions, which underscores the need for integrated care.

Given the challenge to provide a person-centered medical home for people with multiple diagnoses who are currently not well served by the existing system of clinic-based care, a modified ACT team is well suited to provide effective comprehensive treatment. Thus far, our program demonstrates that through collaborative primary care partnerships (such as primary care physicians or family nurse practitioners) ACT can serve as a medical home for individuals with psychiatric disabilities and co-occurring serious health problems. With ongoing effort to measure outcomes, this program can help inform the development of a comprehensive model of integrated care.

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“Keshet”: Enhancing Cognitive Communication Skills in Families

Family interventions in mental health focus primarily on consumer outcomes, and family well-being is viewed only as an intermediate outcome. Because they are usually the most stable entity in the lives of people with mental illness, families can benefit from exposure to intervention strategies and instruction in the techniques and methods that are typically used by professionals as part of their therapeutic practices. One such area is a deeper understanding of cognition, to learn how it is affected in mental illnesses, how to identify cognitive strengths and weaknesses, and how cognitive communication skills based on mediation can enhance learning, adaptability, participation, and recovery.

Keshet (“rainbow” in Hebrew) is a course designed for family caregivers seeking support, techniques, and methods within academic settings to improve coping. It is a standardized cognitive educational course that helps family caregivers appreciate and develop skills for empowering communication. The *Keshet* course focuses on teaching parents about cognition and mediation, which are considered a basis for the concepts of brain plasticity, cognitive modifiability, and the conversion of experiences into a source of learning.

Mediating interaction is a specific human intervention that differs from providing exposure to stimuli. The mediator—a parent, caregiver, teacher, or therapist—interposes him- or herself between the world of stimuli and the consumer, child, or student in order for him or her to assimilate the stimuli into internalized cognitive

structures that can lead to change. An interaction becomes a mediating interaction when there is at least an explicit intentionality on the part of the mediator, with the child or consumer reciprocating that intention. Other elements of a mediating interaction include transcending the here-and-now, relating to other situations, adding a meaning to the stimulus, regulating behavior, boosting feelings of competence, and sharing experiences. Emphasis is placed on relationships between cognition and emotion and their impact on effective communication. One of the central aspects of *Keshet* is knowledge translation, whereby caregivers are provided some practical tools traditionally used by therapists in translating research to actual practice. One of the central methods used in *Keshet* to meet this need is the use of “meaningful interactional life episodes” (MILEs). Participants use written dialogue to describe actual interactions they have had. For example:

“I picked up the phone to call my daughter. I asked her, ‘How are you?’

“She replied, ‘The same, not well. Nothing helps me to get over this depression, I don’t have any strength, and I don’t want to go on living.’

“I replied, ‘You’re not making enough of an effort to get out of it, you’re not occupying yourself with things you enjoy that’ll help you overcome the depression.’

“My daughter answered, ‘Okay, you don’t understand,’ and she slammed down the phone.

“After the episode, I felt guilty that I had hurt her, not being able to understand that she’s incapable of leaving her house and doing things that she enjoys.”

We analyze these MILEs, according to the themes introduced as the course progresses. The above example was used to demonstrate and teach the significance of different perspectives. Other areas of focus include emotions, cognition, and actions; mediation parameters; and clear and masked intentions.

Since *Keshet*’s initiation in 2001,

over 300 parents have participated in the 45-hour biweekly three-hour program. One or two participants from each group have become moderators of future *Keshet* groups. We developed a moderator manual and structured outline of theoretical content using standardized presentations and assignments. Moderators receive standardized training, and there is ongoing supervision and instruction. The course consists of lectures, workshops, home assignments and exercises, reading of material, viewing and analyzing documentary films on recovery concepts, and writing and analysis of the MILEs.

Participants have reported a higher level of knowledge and confidence and an improvement in their interactions after the completion of the course. A quasi-experimental study (N=49) found that *Keshet* significantly increased the hope of families concerning the well-being of their ill family member and the family’s relationship with him or her. A study of five *Keshet* courses (N=88) focusing on the perceived value of participating caregivers found that *Keshet* changes the ways participants perceive and think about the diverse life situations with which they have to cope. Participants reported that analysis of MILEs was beneficial and useful in linking theory and practice. Among the changes experienced by participants were feelings of improved communication with the family member with mental illness, improved marital relationships, improved caregiver organizational skills, and more time invested in personal goals and interests.

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