A.M.B.E.R. clinic Albuquerque Multidisciplinary Behavioral Evaluation for Recovery and Resliency

Alya Reeve, MD, MPH
University Of New Mexico Health Sciences Center
Professor of Psychiatry, Neurology & Pediatrics
PI, Continuum of Care

Date: 8-7-2012

- Introductions
  - format and participants
- Definitions
- Challenges

Why AMBER?

- A name that has meaning
  - Personally
  - Metaphorically
- Behavior
  - reflects structure and function;
  - is complex, rich, with seemingly infinite variations.
- Emphasis on value and information from multiple disciplines, however you collect those sources.

Background

- Grew up in southern New England; parents were university professors; a lot of sports, arts, reading, and travel.
- Cultural mixture: American & European; only girl with older half-brothers and younger full brothers.
- BA in French & Zoology; MD from U Conn; residency U Conn, Dartmouth, Institute of Psychiatry London; fellowship NIMH: brain imaging.
- UNM since 1989; neuropsychiatry; DD since 1996.

Format

- 8-9 am: didactic review/discussion
- 9-11 am: openings for clinical case consultations; short – longer.
- 11 am: repeat topic from 8 am
- Open to receiving requests for specific topics/issues to address.

Definitions

- **Intellectual Disability**
  - **Not dementia**
  - **Formerly known as mental retardation, mental deficiency, feeblemindedness, idiocy, imbecility…**
  - **Different from specific Learning Disorder(s), e.g. math, etc.**

Definitions

- **Intellectual Disability**

  …is characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social and practical adaptive skills. This disability originates before age 18.

  [AAIDD, 11th edition]

Definitions

- **5 Assumptions:**
  - **Limitations in present functioning must be considered within the context of community environments typical of the individual's age peers and culture.**
  - **Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor, and behavioral factors.**

Definitions

- **5 Assumptions…**
  - **Within an individual, limitations often coexist with strengths.**
  - **An important purpose of describing limitations is to develop a profile of needed supports.**
  - **With appropriate personalized supports over a sustained period, the life functioning of the person with ID generally will improve.**

Significance of ID (2010)

- Diagnosis
  - Presence/absence ID; eligibility for services, benefits, legal protections
- Classification
- System of Supports
  - to enhance human functioning
  - to improve outcomes
  - to help implement person's choices
  - to assure human rights

When is a bonk an injury?

- **Traumatic: calvarium encounters external inflexible force (object; wall; ground) or overwhelming change in velocity (acceleration/deceleration)**
  - **With/without skull fracture (open/closed)**
- **Acquired: internal source of damage to neurons and associated tissues**
  - **Such as: bleeding, infection, anoxia, toxins**

A dilemma:

- Acute care saves the patient after trauma
- Maybe sent to rehab
- Goes home…
- Relief!!
- Improvement – wants to "be self, on own
- Enrolls in job/school
- Can't remember things; decreased speed; transportation problems; housing; responsibilities?…. Where to turn?

Extent of the problem

- Reported rates of traumatic brain injury:
  - MMWR May 6, 2011: 1.7 million US civilians TBI/yr
    - 1.4 M tx'd & d/c ER; 275K hospitalized; 52K died
  - TBI ~ 1/3 of all injury-related deaths
- War veterans
- Domestic violence: spouses, children, elders
- Accidents: falls, sports, transportation
- Highest in age groups: < 5; 15-19; >75 y
- Hospitalization rates increased; deaths decreased 1995-2006

Injuries

- Focal
  - Anterior temporal lobes
  - Posterior occiput
  - May be accompanied by seizure disorder later
- Multiple, additive (exponential?!)
  - Re-injury on top of injury
  - Ability to recover from many; decreasing ability as age.
  - Different locations have differing impact on functioning

Rehabilitative Strategies

- Long and slow process
- Physical, mental, spiritual must be integrated
- Social fabric needs re-weaving
- Challenge of poor generalization
- Impulse modulation
  - Anxiety and Mood
  - Substance abuse
  - Misperceptions
  - Sexual
  - Anger

Office

- Nonverbal and verbal reassurance
  - Lack of touch, eye contact → convey failure, distaste, negative judgment
  - Restate observed progress
- Concrete instructions
  - Stepwise
  - Written (do not accept understanding) & legible
- Attainable goals
  - Identify means to get them done

Places that function most like a system are most successful

(Atul Gawande 5-26-11)

- **Have to acquire an ability to recognize when you've succeeded and when you've failed for patients**
- **Develop ability to devise solutions for the system problems that data and experience uncover**

- **Recovering from brain injury, we are part of a system that the patient needs in order to be successful in his/her recovery.**

Challenges

- Working with teams
  - Need all the facets of supports
  - Enhance communication within operational support system
- Getting accurate data
  - Patient may not be reliable source
  - Need assistants in this task
- Consent/guardianship

Challenges

- Bad results
- No improvement
- Self-injury
- Suicide/homicide
  - At the extreme: Tarasoff
  - Feelings do not mean Action

What Next?

- 8-14-2012
- "Diagnosing mental illness(es)"

- Any requests? Questions? Comments?
- …be in touch!