

SOLUTIONS BUILDING COMMUNITY COLLABORATIVE A DEMONSTRATION PROJECT

Co-sponsored by San Diego Regional Center and San Diego County Mental Health Services

OVERVIEW OF CONTINUING SAT TEAM & SAT-C (CLINIC)

Background

The Support, Assessment and Treatment Team (SAT) is part of the Solutions Building Community Collaborative Project. The role of the team is to provide Specialty Consultation services to individuals in San Diego County that are 'dually served'. This refers to individuals who have both a diagnosed developmental disability and a diagnosed mental health disorder. This model was based upon current research and emerging best practice in this specialty area.¹ The SAT team is currently comprised of experts in both areas and systems. The primary members include: a consulting psychiatrist knowledgeable in both mental health and developmental disabilities, a consulting psychologist and behavior specialist with expertise in both mental health and developmental disabilities, a mental health 'navigator'; a social worker and administrator in the mental health system with knowledge and work experience in both systems and a developmental disabilities 'navigator'; a social worker and administrator in the Regional Center system with knowledge and work experience in both systems. Specialty consultation in the fields of substance abuse and forensics serve on the team when needed. A project manager; a masters level administrator, provides oversight and coordination of the team's activities. For the past 18 months the team has received an average of 1 referral a month for project participation and additionally, 1 referral a month from community providers (ERs, police, hospitals, MH system, etc) for one time consultation.

Referral Criteria for Project Participants:

- These are individuals with high frequency, high intensity behavior accessing multiple EMR systems.
- Individuals referred to the SAT team are now referred to by SDRC Service Coordinators to the Placement Review Team. (Other sources requesting project participation on behalf of someone, (i.e. probation, hospital staff, mental health staff) have been referred to the SDRC SC to make the referral to the project in order to maintain continuity and coordination of all current services.
- Collateral information is secured and distributed to team members to prepare for face to face interviews, observation, training and plan write up with recommendations, including follow up training, liaising, and navigation to eligible system resources.

NOTE: These initial plans are updated monthly and distributed to community partners (ERs, PERT, participating hospitals, county adm., RC adm, RC SCs, Crisis house Director, EPU, UBH, etc. to facilitate coordinated care including crisis care coordination among community systems.)

¹ Dual Diagnosis Consultation and Outreach Teams; Ontario Canada, The Interface Program of Children's Hospital; Cincinnati, Ohio, START Programs of UNH Institute on Disability, etc.

SAT-C-MONTHLY CLINIC – start date May 6, 2009

The Project is adding an additional component over the next year to reach individuals dually served who may not yet be high frequency, high intensity users of multiple systems.

Referral Criteria for Clinic Consultation:

- Dually Diagnosed Adults (have a developmental disability and co-occurring psychiatric condition) who have a *sudden* worsening in mental health symptoms, impairing their ability to cope with day to day life stressors, placing them at risk of losing their current supports and services. (Examples that may trigger such circumstances may include: medication changes, aging out of one system and transitioning to another, loss of a loved one, changes in residential, employment or day activities services, onset of other physical illness or physical injury, other traumatic events). As a result, support network and/or services are in need of consultation/training in any/all of the following: a medication review, training regarding mental health symptoms and/or dual diagnosis, medication effects, recommendations for other medical services, review of behavioral challenges with recommended intervention strategies, training in behavioral techniques, liaising work by psychiatrist, psychologist, MH or DD Navigators with current or necessary supports.

Referral Process:

--Brief summary of reason for referral, who is referring (SC, provider, family member, hospital, etc) All referrals from community will be screened by SDRS and the forwarded for clinic appt.

--Please send all referrals to Warren via email/phone and he will prioritize referrals *no later than two weeks prior to facilitate collateral review by team members.*

--Project Manager will be notified; collect collateral & distribute to team prior to clinic appt.

AT THE APPOINTMENT

--Team will interview, ask questions, provide recommendations & suggestions, including training needs? (team will provide), mental health navigation? (team will provide) or other system navigation/follow up.

--Team will write up a plan similar to current project plans to assist referring source in providing services/treatment.

--Team will *not* be available for IDT, IPP, IEP meetings or follow along care, due to limited resources. Consultation only, written plan and training when agreed upon.