

# Solutions Building Community Collaborative

Co-sponsored by San Diego Regional & San  
Diego County Mental Health

# What is it?

## **Solutions Building Community Collaborative is**

- a demonstration project
- sponsored by San Diego Regional Center and San Diego County Mental Health
- to collaborate across several systems
- in providing services and coordinating crisis care
- for high frequency, high intensity users of multiple EMS systems
- who are dually diagnosed (DD/MI).

# BACKGROUND

**“No special needs group strains the service capacity of community mental health/mental retardation services to a greater extent than people with dual diagnoses of developmental disabilities and psychiatric conditions.”**

**(National Association for the Dually Diagnosed, 2006)**

# Challenging Issues for Service Delivery

Current research and our own statewide information indicated that many of the behaviors and challenges that define this group of individuals are not typical of the majority's needs.

**This particular group has sophisticated and inter-dependent needs.**

# Definitions

- **Dual Diagnosis**

- A mental health diagnosis and a substance abuse disorder (common descriptor in mental health services)
- A mental health diagnosis and a developmental disability (common in services for developmental disabilities)

- **Dually Served**

- Receiving eligible services from more than one system

# Frequency of Dual Diagnosis

- Co-occurring Psychiatric conditions are *as likely* to occur in individuals with developmental disabilities as in the general population.
- Some research indicates possibility that mental illness occurs *at a higher rate* in this population. (Zubin and Spring's **Stress Vulnerability Model**)

# Access to Medical Care

- People with developmental disabilities are not ‘typical’ patients.
  - They are often not able to communicate their concerns as well as other patients.
  - Health care professionals are not trained to understand their atypical ways of communicating pain or discomfort (i.e. hitting, screaming, withdrawing, scared)
  - They often have trouble thinking abstractly about ‘how they feel’ and can’t answer questions like this.
  - Some people with Developmental Disabilities are used to giving the answer the person wants to hear, they want to please the person asking the questions so they say ‘yes’ or ‘no’ when asked questions if they think this is what the person is ‘looking for’

# Barriers to Diagnosis and Treatment \*

## ✓ **Diagnostic Overshadowing:**

Mental illness is overlooked or minimized as symptoms are attributed to the developmental disability.

(Example: difficulty concentrating attributed to mental retardation when a symptom of depression.)

## ✓ **Behavioral Overshadowing:**

The tendency to identify psychopathology as learned behavior while failing to recognize it is an indicator of mental illness.

(Example: identifying behavioral challenges as 'task avoidance' instead of loss of motivation due to schizophrenia.)

\* Information taken directly from the Dual Diagnosis Primer, M.A. Hughes, 2006. 

# Barriers to Diagnosis and Treatment \*

## ✓ **Medication Masking:**

The sedative effects of certain medications suppressing the presence of mental health symptoms.

(Example: experiencing agitation related to depression but due to limited communication skills unable to describe symptoms of depression.)

## ✓ **Episodic Presentation:**

Mental health symptoms that come and go and are not present when assessed by the mental health professional.

(Example, cycling out of a manic episode prior to doctor's appointment or assessment. )

# Barriers to Recognition and Treatment of Dual Diagnosis\*

- **Division of Services:**

The tendency for state funding mechanisms to fund services for mental health and developmental disabilities separately creating 'silo' systems where collaboration is more difficult to achieve.

- **Lack of Expertise:**

Each system's expertise not always equipped to meet needs that require expertise in both mental health and developmental disabilities.

# Looking for Solutions

➤ **A Statewide Needs Assessment, “Serving the Difficult to Serve”\***

funded by the California Department of Developmental Disabilities as a wellness project in 2005-2006 was completed

➤ **San Diego County Mental Health and San Diego Regional Center** build on previous work together to develop the local demonstration project.

\*see [www.sdrc.org](http://www.sdrc.org) for full report

# Summary of Data Analysis Statewide

1. 16.1 % (1 in 6 people)  
of the total number of people served by the Regional Center System are listed as having co-occurring psychiatric conditions.
2. 76% of these individuals are adults.
3. 17% of dually diagnosed ind.s in 'active status' are listed as having Pervasive Developmental Disorders.
4. 27% of persons residing in Developmental Centers are listed as having co-occurring developmental and psychiatric conditions.

# What do we Know?

Results of the Statewide Needs assessment were consistent with current research in this area:

Individuals who are 'difficult to serve' require expertise in mental health, & sophisticated behavior intervention strategies.

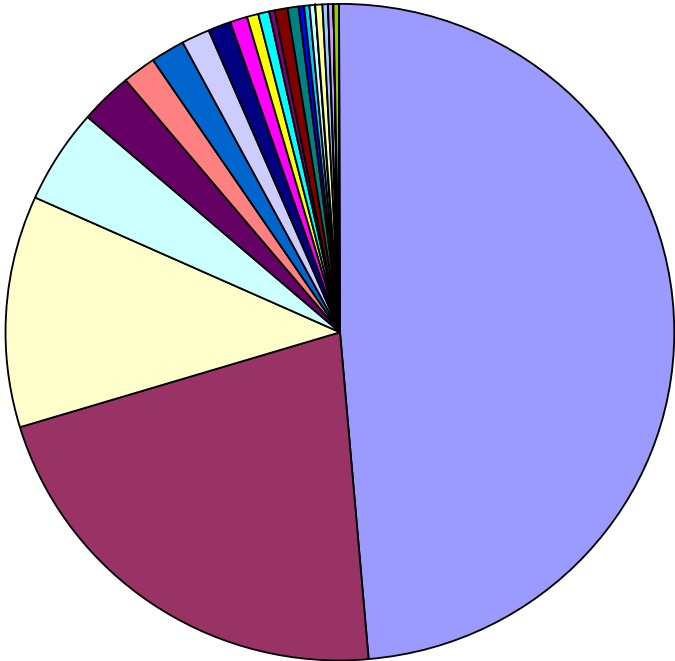
# Level of Retardation

**Research indicates those with difficult to serve needs in the community tend to be individuals with mild to moderate mental retardation.**

- **Current Project enrollment of 14; 12 have mild mental retardation- 2 persons Axis II unspecified (with reference to developmental delays)**

# Population by Residence Type

**Segmentation of Combined General and Autism Groups by Residence Type**



- PARENT/RELATIVE/LEGAL GUARDIAN
- CCF(4-6 BEDS)
- INDEPENDENT LIVING
- SUPPORTED LIVING
- ICF/DD-H 4-6 BEDS
- CCF(7-15 BEDS)
- CCF(16-49 BEDS)
- SNF/NF NURSING
- FOSTER HOME-CHILDREN-CNTY OR STATE
- ICF-DD/N (4-6 BEDS)
- CCF(1-3 BEDS)
- FAMILY HOME AGENCY - ADULTS
- CCF(50+ BEDS)
- CCF(RCFE)
- OTHER
- ICF/DD (INT.CARE FAC/DEV .DISABLED)
- PSYCH TREATMENT CTR
- CERTIFIED FOSTER HOME - CHILDREN
- COUNTY/CITY JAIL(SHORT TERM)
- ICF/DD-H 7-15 BEDS
- SNF/NF PSYCHIATRIC
- COMMUNITY TREATMENT FACILITY
- TRANSIENT/HOMELESS
- REHABILITATION CENTER
- CORRECTIONAL INSTITUTION (PRISON)
- SUB-ACUTE
- OUT-OF-STATE
- ICF-DD/N (7-15 BEDS)
- CCF SPECIAL HLTH CARE NEEDS/CHILDR
- CALIFORNIA YOUTH AUTHORITY
- ACUTE GENERAL HOSPITAL
- SUB-ACUTE PEDIATRIC
- ICF 99 UNKNOWN

# Current Project

- 1 in IMD
- 4 in Group Home settings
- 9 B & C or ILF (straight room and board)
- 1 lives with family member

# Special Behaviors Analysis

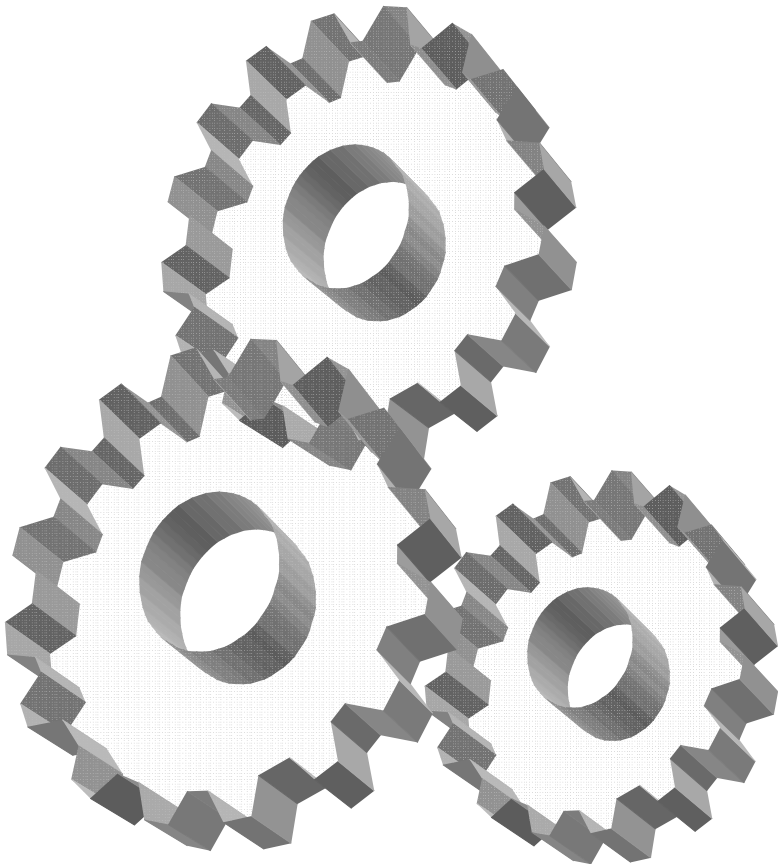
**3 groups emerge**

**Dev. Disability-MI**

**Substance Abuse  
Related**

**Disorders**

**Criminal  
Offender w. D.D.**



# Current Project

- 14 MI/DD
- 5 (36%) history of substance abuse
- 4 (28%) forensic history or current involvement

# Research of Successful Models

- Psychiatric in-patient- specialization for Dual Diagnosis
- Inter-agency collaboration for step down programs
- Cross disciplines collaboration; supporting specialization with difficult to serve individuals. (medical, behavioral, recovery groups, ancillary services).

# RESEARCH SUCCESSFUL APPROACHES

...Every successful model  
endorses a continuum of services  
across systems.

- Ontario, CA
- Boston
- New York; Long Island/Queens
- Chicago
- Kansas
- B.C., CA

# Summary

## Challenges in Service Delivery

- Multi-systems approaches may result in fragmented services which often result in inefficient services
- Systems are often required to implement ad hoc adaptation to their areas of expertise.
- Adaptation are often found to be minimally effective and sometimes counter –productive
- Dually served individuals are often unable to make sense of disparate message about treatment and recovery

# Summary

## Successes in Service Delivery

**Research and Demonstration Projects nationwide, cite successful approaches for these individuals using collaboration and cross systems specialty consultation.**

# PROPOSAL 2006

- Proposal from the statewide needs assessment incorporated the recommendations of the 21 Regional Centers and research in this area, focusing on cross systems collaboration, including specialty assessment and **networking to create a continuum of service.**
- State responds by funding 3 projects for 2006-2009.

# Progress in California

- **Statewide Mental Health/Development Services Collaborative** meets quarterly to address dually served issues ; 2 co-chairs, one from M.H. and one from DD systems
- 2006: 2 New Positions *jointly funded* by the Department of Mental Health and the Developmental Disabilities to act as **statewide liaisons for this group of dually served.**
- 2006: **Funds were made available for demonstration projects** to establish specialty consultation and cross systems collaboration
- 2008: Additional Funds made available based upon success of initial efforts.



# San Diego represents the 'South'



- Project Participants include individuals who are **dually served** with high frequency, high intensity behavior.
- 'All Systems' Training offered
- Support, Assessment & Treatment Team (S.A.T. Team) established modeling other successful approaches for dually served.

# Project Goals

- Maintain Community Tenure through focused, integrated and therapeutic service delivery.
- Maximize a person's ability to cope with day-to-day life stressors in socially appropriate and productive ways.
- Increase a person's support network and identify ways to use this network for crisis prevention and community integration.
- Create key linkages with specialty professionals and groups to mobilize existing resources and provide an ongoing forum for innovation and quality services.

# SOLUTIONS BUILDING

## *KEY COMPONENTS*

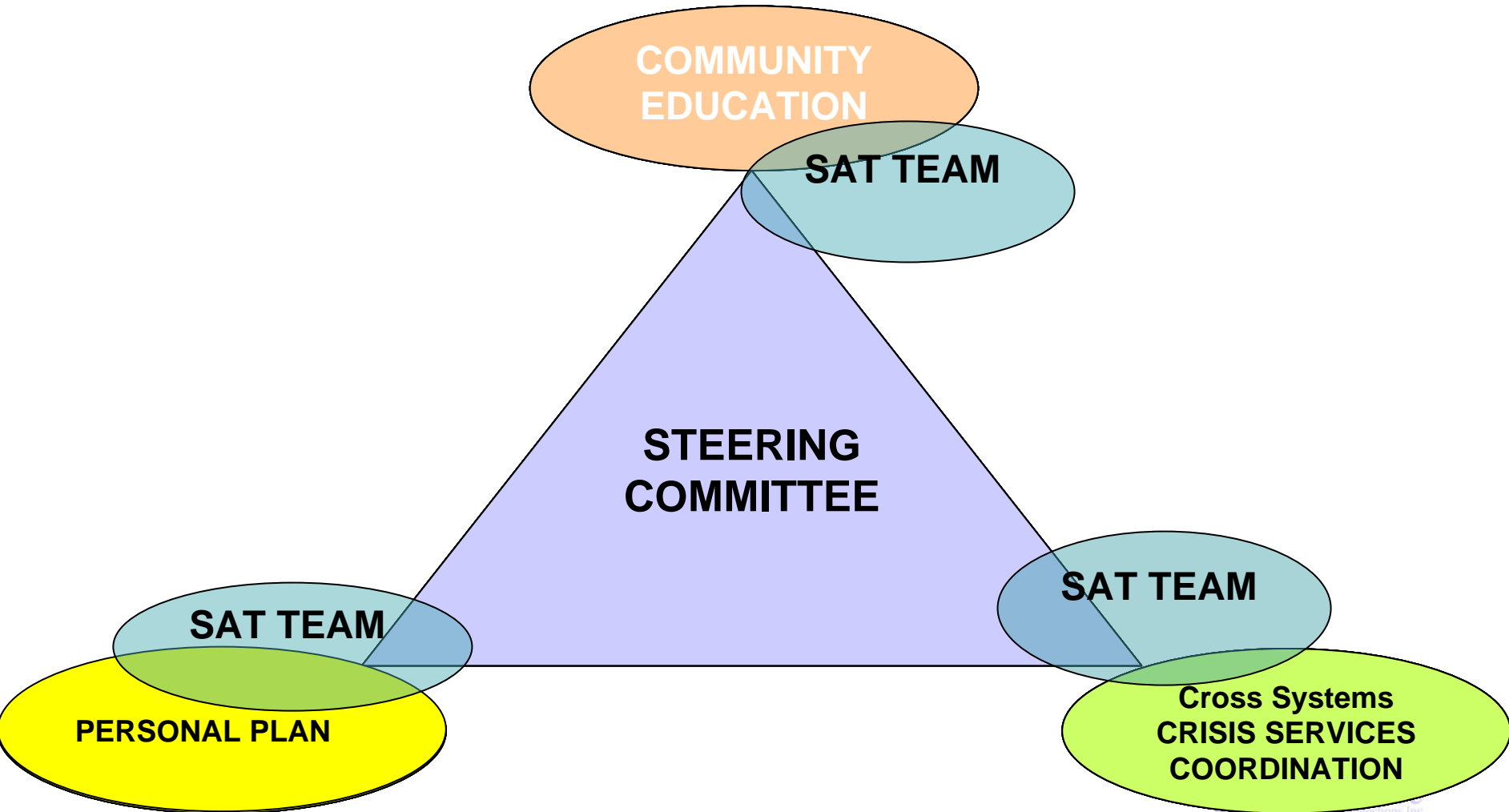
*all include collaboration*



- **Steering Committee**
- **Plan Development – unified care**
- **S.A.T. Team**
- **Community Training & Resources**
  - **Staff**
  - **All Interested Community Partners**

# MULTI-DIMENSIONAL PROJECT-

## 3 MAIN STRATEGIES



# Project Participants

- INDIVIDUALS WHO HAVE A DEVELOPMENTAL DISABILITY AND ARE SERVED BY THE SAN DIEGO REGIONAL CENTER **AND ALSO HAVE...**
- A CO-OCCURRING PSYCHIATRIC CONDITION (AXIS I/II DIAGNOSIS) AND ARE SERVED BY THE MENTAL HEALTH SYSTEM **AND MAY ALSO BE...**
- KNOWN TO THE CRIMINAL JUSTICE SYSTEM.
- **AND MAY ALSO BE ...**FREQUENT USERS OF THE EMERGENCY MEDICAL RESPONSE SYSTEMS (911, Mobile Crisis Teams, Psychiatric Hospitalizations, Hospitals' ERs)

# Steering Committee

- Meets regularly- provides input
- Representatives from key community stakeholders
  - COUNTY Leadership
  - County EPU
  - PERT Team
  - Regional Center
  - UBH
  - Crisis Houses
  - Navigator
  - Project Manager
  - Client Representative



# SUPPORT, ASSESSMENT & TREATMENT TEAM

Focus on Comprehensive Assessment, Plan Development and Resources connections

- ✓ **Consulting Psychiatrist**
- ✓ **Clinical Psychologist/Behavior Specialist**
- ✓ **DD Navigator**
- ✓ **Mental Health Navigator**

Commitment to Community Tenure for targeted Individuals

# Why Use the S.A.T. team?

- Similar Collaboration Approaches and Consultation Teams cite:
  - Reduced crisis related incidents
  - Increase in care coordination between systems
  - Decrease in cost by reducing overlapping service delivery
  - INCREASED QUALITY OF LIFE



# Roles of SAT team Members

SAT TEAM

## Team Psychiatrist

- Provides comprehensive case review of all collateral information collected related to mental health diagnosis.
- Assists in development of the medical/psychiatric aspects of the crisis services protocol.
- Conducts face to face interviews with all participants to further assessment.
- Provides at least weekly consultation to team regarding medical, and psychiatric implications for treatment for each participant.
- Available to medical, clinical and direct care staff regarding medical, psychiatric and psychopharmacological consideration in the treatment of each participant.

# Team Psychiatrist

- Trends or patterns in assessment?
- Trends or patterns in types of recommendations?
- Treatment considerations?
- Training considerations?
- Barriers to treatment?
- Resource development needed?
- Recommendations for replication

# Roles of SAT team Members

## Team Psychologist/Behavior Specialist

A light blue oval containing the text "SAT TEAM" in bold, black, uppercase letters.

- Conducts face to face interview with participant
- Meets with support staff to observe, review current strategies, available for consultation
- Assists Participant in completing initial WRAP plan when requested.
- Provides consultation to SAT team regarding current and recommended behavioral strategies where relevant
- Assists in development of Crisis services protocol regarding recommended behavioral strategies and successful implementation of person's WRAP.
- Provides training to staff when requested regarding WRAP, recommended behavioral strategies and understanding of dual diagnosis and related challenges specific to individual participants.

# Team Psychologist

- Trends or patterns in assessment?
- Trends or patterns in types of recommendations?
- Treatment considerations?
- Training considerations?
- Barriers to treatment?
- Resource development needed?
- Recommendations for replication

# Roles of SAT team Members

SAT TEAM

## Mental Health Navigator

- Provides weekly consultation to SAT team members regarding mental health resources for individuals dually served.
- Provides networking and liaising to facilitate access to appropriate county services.
- Informs team of training/education opportunities that would further team's knowledge of mental health and resources.
- Provides contact, policies and protocol information related to county resources, to team to facilitate cross systems education and collaboration .
- Provides information including networking and liaising to county partners to facilitate understanding and collaboration of project goals and outcomes and to further understanding of needs of the dually served.

# Mental Health Navigator

- Access to resources
- Systems knowledge
- Treatment considerations?
- Barriers to treatment?
- Resource development needed?
- Recommendations for replication

# Roles of SAT team Members

## Developmental Disabilities Navigator

- Acts as the designated Service Coordinator for each Project Participant.
- Provides weekly consultation to SAT team members regarding regional center resources for individuals dually served.
- Provides networking and liaising to facilitate access to appropriate regional center services.
- Provides contact, policies and protocol information related to regional center services to facilitate cross systems education and collaboration.
- Provides information to RC staff to facilitate further understanding of needs of project participants.



# DD Navigator

- Access to resources
- Systems knowledge
- Treatment considerations?
- Barriers to treatment?
- Resource development needed?
- Recommendations for replication

# Roles of SAT team Members

- **Project Manager-** facilitates SAT team efforts and project's goals.
- **Forensic Advocacy & Substance Abuse Consultation**
  - Both roles facilitate understanding of individual challenges and provides recommendations in the development of individual crisis services protocols. Provides consultation regarding potential specialty resources in their respective areas of expertise.



# Plan Development

- Comprehensive evaluation of previous and current services
- Recommendations /Referrals
- WRAP ~ adapted; simplified language/layout
- Training offered to Staff (WRAP/Dual Diagnosis)
- Crisis Protocol Developed as Part of Plan



PERSONAL PLAN

# Crisis Protocol

- Key Facts
- Designated Numbers
- Designated Hospital/Crisis House if applicable
- Escalation Hierarchy
- Delivered Electronically to Key Community Services
- Updated Monthly
- Faxed by UBH or RC in an Crisis
- Team Members available for consult
- RC SC immediate contact- engages SAT - facilitates discharge

**Cross Systems  
CRISIS SERVICES  
COORDINATION**

# Community Education

- Information Presentations to Key Community Stakeholders to date
  - County staff and committees,
  - county MH contractors,
  - RC staff
  - UBH
  - PERT
  - Hospitals
  - community support committees
- Training to Residential Providers
- Presentation at Statewide Mental Health Summit
- Presentation to County Hospital staff (12 training)
- Available to others when requested.




COMMUNITY  
EDUCATION

# Progress Update

- 44 Educational Presentations to date regarding project and needs of the dually served.
- Referral Process: 35 referrals made in 2006-7 to date
- 14 current participants; 2 deferred, new referrals ea. Month.
- Transition Age youth (21 % 18-24, 42% 18-26) emerge as particularly vulnerable.

# Summary

- ✓ High Frequency – High Intensity users of both Systems identified for the project
- ✓ Voluntary Participation- Participant agreements signed
- ✓ Plan developed for each participant that includes protocol for crisis services
- ✓ Information shared with ERS  unified approach to service delivery
- ✓ SAT Team Available
- ✓ Training Available
- ✓ Outreach & Follow-up
- ✓ Protocol Revision and Updates to ER
- ✓ Monthly Status Reports
- ✓ Steering Committee input



# QUESTIONS?

