

Consultation Report
SABHC Project for Persons with MR/DD
Consultant: RRTC on Substance Abuse, Disability, and Employment
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I. Description of Service Provision Request

The Savannah Area Behavioral Health Collaborative (SABHC) in Chatham County has received a grant in aid for \$210,000 from the state to establish services for persons with mental retardation/ developmental disability (MR/DD) who also experience alcohol - drug or mental health problems. The funding has been provided to assist a collaboration of programs and services including SABHC (specifically including Recovery Place for alcohol and drug services) and Coastal Center for Developmental Services, Inc (CCDS). It is the goal of the collaborative to provide services for the target population based as much as possible on best practices as published in national literature but modified for the situation in Savannah.

The RRTC and Dennis Moore at Wright State University were contracted to provide SABHC and CCDS with technical assistance in exploring treatment models, development of viable long-term approaches for providing substance use disorder and mental illness treatment, and identification of training needs associated with the project. The overall goal is to explore program development options that can be integrated into the present structure and current program philosophy of existing programs.

II. Objectives of the Report

This report is intended to provide an overview and analysis of planned services, potential program models, and training needs relative to establishment of a new program to serve the substance dependence or mental health needs of persons with DD/MR in this county.

III. Key Participants in Consultation Visit

Catherine McRae - SABHC
Faythe Merkert - CCDS
Wayne Bland - Recovery Place
Mia Carbone - CCDS

IV. Background

SABHC: Catherine McRae is the C.E.O. of this organization, and she has held this position since December, 2003. She has been in the Savannah area for approximately 25 years. In 2003, SABHC was certified by CARF for five service areas, CCDS is also certified by CARF. For some time, providers in this geographic area have struggled to provide appropriate services to clients who experience MR/DD in addition to substance use or mental health disorders. The services available in Savannah have been inadequate for this population, and this matches reports received by Wright State from several state systems throughout the county. Several individuals

with MR/DD currently utilize Union Mission services, and these individuals would be appropriate referrals to the new program.

Recovery Place: Wayne Bland is the owner and Executive Director of Recovery Place, a comprehensive substance use disorder treatment program and one component of SABHC. The active client census of Recovery Place exceeds 800 persons at any given time. Mr. Bland has a wide background in public service, and this includes coordinating services at a children's hospital where a number of children and adults with MR were involved with services. His treatment facility entered into a collaborative agreement with CCDS approximately five years ago to serve MR/DD persons, but a lack of adequate funding resulted in the discontinuation of this effort.

CCDS: Faythe Merkert is the Executive Director of this community provider of services for persons diagnosed as MR/DD. CCDS has a mission to provide appropriate support services to their clientele while engaging with the community at every opportunity. Their services value and promote competitive, community-based employment over sheltered work, but they recognize that some clients are impaired by substance abuse to the degree that they cannot successfully participate in the community. CCDS estimates that up to 25 persons enrolled in their programs may have significant problems with substance abuse, and mental illness and during the course of the two day consultation meeting a list of eight of the most problematic clients was generated who clearly require substance use disorder treatment.

Utilizing the grant in aid funding for this project, CCDS has hired Mia Carbone to serve as Program Coordinator for the new program. Prior to this position, Ms. Carbone was the South Eastern Regional Manager for the DD state office. She also has previous experience in working with persons who have MR/DD and mental illness. These previous experiences include working with intake and assessment, support coordination, and crisis intervention. Ms. Carbone stated that her goals for the new program would include a viable program with realistic caseloads and adequate time to do other development work necessary for the long-term stability and success of this endeavor.

Nature of collaboration in this project.

An apparent strength of this project is the degree of cooperation, shared experience, and trust that the partners have for one another. They have spent a number of years tackling common problems, and this has engendered strong working relationships. To further elaborate organizational and collaboration issues, The Wilder Collaboration Factors Inventory (Mattessich et al., 2001) was administered to all attendees at the planning session (McCrae, Merkert, Bland, Carbone). This questionnaire was designed to assist community planners in understanding the nature of their collaborative relationships, as well as point out areas of strength and areas needing improvement. Overall, the combined scores from these four individuals indicated that there are high levels of cooperation among the three respective agencies represented at the meeting. In addition, the attendees all recognized the importance and priority of the project goals. The factors scoring highest in collaboration were "*unique purpose*", "*shared vision*", "*members share a stake in both process and outcome*" and "*established informal relationships and communication links*". The factors scoring lowest (least collaborative) were "*history of collaboration or cooperation in the community*", "*development of clear roles and policy*"

guidelines", and "sufficient funds, staff, materials, and time".

Following discussion of the above findings with the group, they decided that "cooperation" on a common goal might be a more fitting description of this arrangement than a true "collaborative" endeavor. This in itself is neither positive nor negative regarding the outcome of the project, but it does have some implications for management and policy. It is suggested that in consideration of the discussion, it might be best for partners to consider the reporting and management structure that is best - especially considering that the grant in aid goes to SABHC, but service delivery personnel will be employed by and housed at CCDS.

To the person, the attendees expressed concern that regardless of the organizational structure at the local level, it will be regional and state policies, guidelines, and funding requirements that will have the greatest impact on the success or failure of the project. They are concerned that existing health care reimbursement policies in Georgia do not have sufficient flexibility and sensitivity to account for the service needs of the target population or the funding requirements of the partner agencies.

Program Design - Initial Concepts

Over the course of two days of on site consultation, the providers, as well as this consultant, discussed and elaborated their ideas for how the program might work. The following is this consultant's interpretation of the collective vision:

The "ideal" program envisioned at this time would include informal referrals of clients to this specialized program. Mia Carbone or another case manager would then meet with the referral source, the person being referred, and when appropriate, the family of the person being referred. Ms. Carbone would then identify other services that may be required (e.g., Mental Health, Substance Abuse or MR/DD), and processes would be initiated to qualify the person for those services (e.g., Medicaid waiver for DD eligibility or diagnosis of co-existing conditions qualifying for substance dependence or mental health services). The services would be offered and initiated in such a way that they would not jeopardize employment where applicable. Clinical services would be offered by the agency that has the authorization to bill for related services, with CCDS providing support to those other agencies.

Although based at CCDS, the services provided by Ms. Carbone and other staff of this project may or may not be delivered at the CCDS facility. In many cases, the services may be supplemental to other community services already in process. This approach follows the concept of "community inclusion" for persons with MR/DD. Another key ingredient to this program would be technical assistance and support for other community providers that are involved with the enrolled individual's case (such as SABHC clinicians).

An additional component of this program would be technical assistance to community providers, including outreach and case-finding. Specifically, the project would assist other community agencies in better addressing immediate accessibility needs of clients with low cognitive functioning, in addition to assisting agencies in identifying other persons who may be cognitively impaired and would benefit from the specialized and enhanced services. Coordinators from each participating agency (or a "coordinating council" of providers) would meet periodically for

purposes of case finding, brain storming solutions, or planning training or other events to strengthen the overall program.

Services in this specialized program ideally would be time-unlimited, in the sense that community and recovery support would be offered over a period of time that is commensurate with the severity of problem and associated needs. Persons do not "recover" from mental retardation or developmental disability, and therefore alcohol/drug or mental health interventions may require that cases remain open for a longer duration than is typical with other populations.

V. Possible Barriers, Challenges, and Potential Solutions identified by participants to accomplishing the above program vision

Barriers: Program Eligibility

Qualifying someone for service at CCDS may require a Medicaid waiver for MR if the person is not already in this system. This potentially excludes those who have not applied for the waiver, and some persons may not desire to do so. Some persons in the "borderline" cognitive area who are still substantially cognitively impaired with an IQ above 70 will not qualify at MR/DD, as American Psychological Services (or state regulations) will prohibit reimbursement for services to these individuals. Reimbursement for client services may also be difficult if they are enrolled in a partner system.

Solutions:

Qualify clients for services in other service systems where indicated, and CCDS case managers provide technical assistance and support to the other community programs for free. Identify other long term strategies for billing for these support services during the feasibility period of the program (it's first year of operation).

Meet with state officials to discuss the impact of "silo effect" funding, where persons with co-existing conditions do not qualify for needed services in adjacent service sectors. Advocate with state officials and Medicaid to qualify persons with low cognitive functioning and co-existing alcohol-drug or mental health problems for a different or specially defined DD Medicaid waiver.

Develop tracking system to determine the number of persons who are referred to or who could benefit from this specialized program. Expand case finding and collaborative efforts with substance abuse and mental health systems to identify persons who could potentially qualify for and benefit from these services.

Utilize "informal assessment" at point of referral, with more detailed assessment provided by reimbursed providers, thereby reducing fiscal, clinical and administrative burden for referring agencies.

Involve clients regardless of primary diagnosis so long as they can benefit from the service. Base program eligibility criteria on the functioning of an individual, not on the diagnosis.

Qualify eligible clients in all relevant service systems for billing purposes as soon as possible in the referral process.

Barrier: Silo effects

Accomplishing the goals of this project is difficult from both political and funding perspectives due to necessity of involving multiple, public health care systems (alcohol/drug-mental health-MR/DD) even though they are all in the same State Department.

Solutions:

Involve regional and state representatives in the planning and evaluation of this program to familiarize them with the problems inherent in service provision within the current policies and regulations.

Educate state officials on the unique needs of this population and the possibility for this project to serve as a state, and perhaps a national, model.

Barrier: Diversity of needs of clientele

Potentially, a wide range of service needs and levels of disability severity may be referred to this program. For example, the regional hospital clientele likely will require substantially greater service demands (with concomitantly greater behavioral issues) than persons who are currently attending CCDS and are employed.

Solutions:

Begin the program by enrolling the most readily available clients who have immediate needs relative to their current community placement - starting with active clients of CCDS services (up to 25 persons). Follow with case identification for persons using MH services in SABHC who might qualify (8 currently identified). Eventually expand the program to include regional hospital residents, and persons referred to Recovery Place who are not presently served by the DD system.

Barriers: Duration of services

Clients may not have availability of longer-term recovery services beyond the time frames of normal alcohol and drug treatment.

Case management services may not be reimbursed under current policies for the primary service provider if they are in the alcohol/drug or MR/DD system.

Solutions:

Investigator qualifying clientele in systems that reimburse for long term case management.

Establish support groups, recovery groups, and other recovery services utilizing MOA's between agencies that qualify for reimbursement and others that may be providing services.

Barrier: Housing

Sober housing alternatives are limited in the greater Savannah area, and persons with MR/DD may not qualify for existing services or units may not be available for a long time.

Solutions:

Include housing authorities and agencies in the collaborative or project advisory group.

Obtain housing units through SABHC, rehab the facilities and utilize some of space for program participants.

Additional Potential Challenges identified by consultant based on experiences with other sites:

1. More ready access to psychiatric and medication consultation for potential program participants.
2. An important sub-population that might benefit from specialized services of this nature may be residents of regional hospitals with MR/DD, but the program will require time to mature (and perhaps expand) before these individuals may be successfully treated by this program.
3. Performance criteria imposed by the state on the program (number of clients and outcomes expected) may not match the reality of the program development or client service needs, especially in regard to case duration and successful closures.

VI. Recommendations

The following recommendations are provided in consideration of the discussions during the consultation.

1. Suggested Program Model

Due to the nature of the target population of clients, as well as the collaborative nature and distribution of services in the community, it is recommended that the evidence-based practice of the "Interdisciplinary Dual Disorder Treatment" (IDDT), also known as the Dartmouth Model, be utilized with some modifications in this project. Although originally developed for persons with severe mental illness and substance dependence, the model lends itself well to persons with dual conditions that include MR/DD. The specific local modifications to the IDDT model for this program may be similar to how the CAM program in Dayton, Ohio, has modified their program to serve persons with substance dependence and any severe, co-existing disability. The particular principles in IDDT that have relevance for the Savannah project include nearly all of the core ideas, especially an approach utilizing a multidisciplinary team, stage-wise interventions, time-unlimited services, assertive outreach, pharmacological treatment, and family psycho-education. Further information can be provided on this model, as well as details on the modifications that were completed in Dayton. (See training recommendations below.)

2. Conduct Feasibility Phase First

The funding provided to pilot this program is modest relative to the needs of the clientele;

however, there is a real potential for creating a model of service that can become self-perpetuating over time. In addition, the proposed program has solid potential for addressing the needs of what is arguably one of the most difficult to serve populations in need of alcohol/drug or mental health services in the country. It is therefore recommended that the partners spend the first year conducting a "feasibility" program, which means that they should proceed with establishing services for a limited number of clients while carefully evaluating and discussing the progression of the project. The number of potential barriers to this project also suggests that a feasibility period will allow for further exploration of the greatest impediments to program success. Additional activities suggested for the feasibility phase include the following:

1. Hire an additional case manager now so that Mia and the case manager can more efficiently undergo training experiences while building a team. This will also allow for Mia to work on the other aspects of developing the program.
2. Start a group based on existing CCDS clients, while also developing a more extensive list of potential clients and referral sources.
3. Meet regularly and frequently to work on protocols, procedures, and the above identified barriers. Engage all partners in assisting with the development of policy, intake protocols, eligibility criteria, and program components.
4. Determine early what data collection will be employed, and collect data on all clients. Collect data from case managers and treatment program personnel also, even if only surveys of their satisfaction with the cooperative arrangements.
5. Meet with state officials to discuss funding issues. Establish MOA's among partners on billing plans as needed.
6. Submit a CSAT State Technical Assistance Request to aid the new program in reaching its goals. This topic and the intended interventions are very congruent with CSAT philosophy and program interests.

3. Suggested Training:

1. IDDT model training - It is suggested that Dr. Robert Drake at Dartmouth University be contacted to identify potential training options available through his organization. Dr. Drake's organization has extensive experience in training community sites to adopt an IDDT approach to services. They are also versed in site fidelity assessment in order to gauge the degree to which individual or site adaptations are necessary in order for IDDT models to be effective. This training would address the rationale and necessity of an IDDT systems approach, and allow the partners to assess how they can best use these principles locally.
2. CAM model training - It is further suggested that a site visit to Dayton would be beneficial by key program personnel in order to visit the CAM program. The CAM program adheres to the IDDT model, and they provide substance dependence and mental health services specifically to persons with disabilities, including persons with developmental disabilities and/or mental retardation. The CAM training would provide project staff with hands-on experience in one of the only sites nationally that is serving a similar population in an integrated setting. This would include formal training, involvement in staffing and treatment planning, shadowing case managers, and

interviewing clients at various stages of recovery. This training activity would address aspects of how an IDDT team actually works together to provide services to the target population. It would be more applied and less theoretical than the first suggested training activity.

3. Savannah training for AOD or MH personnel. Specific techniques, approaches, and adaptations could be discussed that would entirely focus on persons with MR/DD. One of the most difficult aspects of providing alcohol/drug or mental health services is modifying cognitive-behavioral approaches for persons with serious cognitive deficits. An excellent trainer would be Jerry Annand, M.S., from Portland, Oregon. He has recently published a text on alcohol/drug treatment for persons with DD/MR, and he has extensive experience in directly providing group and individual counseling for this population. Mr. Annand also could train persons with MR/DD clinical backgrounds in how to address substance abuse issues, including how to identify and address denial, minimization, and enabling. This training activity would provide clinicians with very specific approaches and techniques for delivery of group, individual, and case management services.