

Recommendations for a Comprehensive Crisis Prevention and Intervention Plan to Address the Needs of Individuals with IDD and Behavioral Health Needs

“Ability to support persons with diagnoses of substantial behavioral disorders in combination with intellectual/developmental disabilities is widely perceived “to be a critical measure of a community service system’s capacity to act as an effective alternative to institutional care.”

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Facts:

Studies of prevalence of individuals with co-occurring IDD and mental illness range from 25% to over 35% of the DD population. These individuals also tend to be a high risk/high cost population group which indicates a need for focused attention. Researchers have found that as many as one third or more of all people with I/DD have significant behavioral, mental, or personality disorders requiring mental health services (Nezu, Nezu, & Gill-Weiss, 2006).

Combine the MI prevalence with those with other severe behavioral challenges and the impact to the system is significant.

- 1. Increase the capacity of the system to support people in communities to prevent crisis: 65% of people who show up at START crisis programs have no connection to or a limited connection to community based services and supports. 50-85% of people showing up for services have had no public or private health care coverage. Many people are waiting close to a decade for interventions, worsening later crisis. This includes but is not limited to:**
 - Needing specialty providers who understand evidence based interventions that work for individuals who are diagnosed with both IDD and behavioral needs and the need to treat the person as whole and not a series of diagnosis.
 - needing providers/programs who can address child and adolescent crisis in residential as well as community settings
 - training/support for families to support their family member in the family home
 - fixes for Personal Care issues, adult care issues, and other problems that may have the result of further limiting access to long term care and housing for people with complex needs

- 2. Increase the ability of providers, both residential and non-residential, to sustain individuals in place.**
 - MCOs should work with their provider networks to identify residential providers willing to invest in the ID/MI population through RFA/RFI process including use of enhanced rates to incentivize.

- Ensure competency of staff serving individuals with IDD/MI or severe behavioral challenges by requiring a competency based training curriculum and ongoing coaching to ensure true understanding.
- Consider the use of bridge funding to support providers when an individual goes into crisis so that the person is able to maintain their residential setting after the crisis.

3. Increase the clinical capacity of the system.

- Identify billing mechanisms for psychologists to support development and monitoring of Positive Behavior Support plans for individuals outside of the Innovations waiver.
- Consideration of how telepsychology could assist in widening the psychologist capacity.
- Enhance the knowledge of psychiatrists working with individuals with IDD and behavioral health challenges.

4. Require that all individuals served by NC START receive consistent and ongoing care coordination of IDD, MH, medical/dental, behavioral, and other health issues; not just through a crisis period. (There seems to be a parallel between loss of case management for this population group and an increase in loss of residential settings and increased referrals.)

5. Ensure access to walk-in centers, Facility Based Crisis centers, and Three-way community hospital beds for individuals with IDD and behavioral health needs. This involves ensuring that expertise in the area of ID/MI is available in these settings. Those centers should be open 24 hours and allow for immediate connections to a psychiatrist, not waiting months for appointments.

6. Expand NC START with the goal of enhancing the existing system of care. NC START is designed to support individuals with mental illness or severe behavioral challenges who also happen to have an intellectual or developmental disability. They provide services that cross service delivery systems; i.e. MH, IDD and are instrumental in breaking down silos. They are not a segregated system. Expansion of NC START will:

- Improve the ability of residential providers to sustain individuals in place through increased consultation, training and education.
- Increase/enhance knowledge of service providers through training and education, as well as direct consultation, regarding clinical issues, systems of support and resources for individuals with IDD and behavioral health needs.

- Increase/improve the clinical knowledge of stakeholders; e.g. MCOs, providers, clinicians, through increased access to NC START clinical expertise regarding the population.
 - Increase response time to individuals in crisis
 - Reduce emergency department waiting times/Length of Stay
 - Increase hospital and developmental center diversion (Note: since the NC START Central moratorium on accepting new cases there has been an increase in referrals to Murdoch for therapeutic respite.)
 - Note without a NC START for children, develop community capacity for a similar model for individuals not served by NCSTART due to age or other capacity barriers.
7. **Allow for a service that mimics Case Management for individuals in crisis that follows and navigates them through the complicated system.** Allow that service to check in post crisis on follow up and ensure stability (see notes from MH Oversight on 2.24).
 8. See the whole person and develop a system that recognizes people are not siloed, even though our system is likely to remain in silos for some time: People have inter related needs for physical/medical, dental, mental health, addiction, and developmental care.
 9. **Ensure we are not siloed in approach to crisis,** recognize available traditional MH services for individuals with IDD and vice versa, ensure enough capacity and training is in both areas to allow for effective service delivery.
 10. **Coordinate MCO efforts** with the state Crisis Solutions Initiative, local Community Collaboratives (crosses into DJJ, etc.) be sure everyone knows what one another is doing and what local needs and resources are.
 11. **Work in local communities to train first responders and LEOs, CIT officers, ED docs, etc.** on typical needs and presentation of individuals with IDD/MH issues.
 12. **Ensure all services provided comply with the Americans with Disabilities Act:** this statement includes many issues, but in particular address access for individuals with mobility devices, those who are deaf and hard of hearing, those who need access to interpreters, etc.