COUNTY OF MILWAUKEE

Inter-Office Communication

DATE: May 4, 2011

TO: Supervisor Lee Holloway, Chairman, Milwaukee County Board of Supervisors

FROM: Community Advisory Board for Mental Health
Prepared by Co-Chairs: Barbara Beckert and Paula Lucey, RN

SUBJECT: **REPORT FROM THE COMMUNITY ADVISORY BOARD ON THE CONTINUED ACTIVITIES OF THE BOARD AND ADDITIONAL RECOMMENDATIONS RELATED TO FILE NO. 10-213**

Issue

The Milwaukee County Board created the Community Advisory Board with Resolution No. 10-213. The resolution includes a requirement for the committee to submit a report to the Milwaukee County Board of Supervisors quarterly.

Action Requested

It is requested that the Milwaukee County Board of Supervisors refer the Community Advisory Board's recommendations to the Interim Behavioral Health Division (BHD) Administrator. The Interim BHD Administrator shall include these recommendations in the work and implementation activities of the Mental Redesign Task Force developed by resolution in April. It is further requested that the County Board of Supervisors accept the report as meeting the requirements set forth in File No. 10-213.

Background

This is the third report from the Community Advisory Board which was established in May 2010 by the Milwaukee County Board of Supervisors. The September report to the County Board included recommendations for the 2011 budget which were included in the County Executive's proposed budget, and adopted by the County Board; additional recommendations regarding safety, patient centered care, and linkages to the community were included in the January report.

The Community Advisory Board has continued its efforts to address concerns related to safety, patient centered care, and community linkages and this report contains additional updates and recommendations for policy makers. A list of related meetings is provided as an attachment. We appreciate the support and partnership of Behavioral Health Division staff in moving forward with these recommendations, as well as the support of the County Board, and the active participation of County Board Supervisor Joe Sanfelioppo as a valued member of the CAB.

MILWAUKEE COUNTY AUDIT DEPARTMENT BHD REPORT

ISSUE: The October 2010 report from the County Audit Department indicated that different options are needed to support a small number of aggressive patients who are not appropriately placed ay the Adult Acute Inpatient Hospital. The Audit Report suggested that Community Advisory Board could be a resource for identifying long term strategies and resources to address this model.

RECOMMENDATION: The CAB is committed to working collaboratively with BHD to identify potential strategies. One component of such a strategy should include developing other models for serving people with developmental disabilities and mental illness. Although the audit report does **not** provide any data regarding the disability of the individuals with a pattern of aggressive behavior, we note that when the federal and state governments conducted their investigation of the Milwaukee Mental Health Complex Acute Care Unit in January 2010, the hospital was cited for failing to maintain the safety of 11 of the 17 patients reviewed. Five of these patients had a cognitive disability, including the patient who became pregnant and another patient who had a long history of sexual aggression and was alleged to be the father of the baby. This report includes recommendations for another model for serving people with developmental disabilities which includes a continuum of community based resources. We will continue to work on identifying other strategies and resources. We also recommend that BHD gather additional data about the small number of patients with aggressive behavior so strategies can be targeted to address their disability.

MODELS FOR SERVING PEOPLE WITH DEVELOPMENTAL DISABILITIES

ISSUE: Among the 14,000 people seen at PCS annually, a significant number are people with developmental disabilities – many but not all of these individuals also have a mental illness. Some are enrolled in Family Care. Many are at PCS because of challenging behaviors which some community providers do not have the expertise or support to address, and they may unnecessarily remain at the Mental Health Complex because of difficulty securing appropriate community placements. There is currently limited support to help providers and families address these concerns in the community. Additional supports are needed to ensure that people with developmental disabilities and mental illness are successful living in the community, and to reduce reliance on costly institutional care including Hilltop.

A potential model was presented to the CAB by Paul White, from the University of Wisconsin Waisman Center for Excellence in Developmental Disabilities. Mr. White shared the Dane County Community Ties program, a promising model for serving people with developmental disabilities and complex needs in the community, including people currently served at the Mental Health Complex. Disability Rights Wisconsin (DRW) also hosted a meeting with Mr. White and the three Family Care/Partnership Managed Care Organizations.

RECOMMENDATIONS: The CAB strongly endorses and recommends the following:

- BHD, Disability Services, and community partners to work with the Waisman Center to develop a continuum of services similar to Community Ties for serving people with developmental disabilities and mental illness, and other people with developmental disabilities and complex needs.
- This should include development of person centered behavior support plans, development of intensive supports including training providers on crisis response strategies, use of Environmental adaptations and modifications, a mobile team, and a Safe House. (see attachment for information about Community Ties)
- BHD, Disability Services, the three Family Care/Partnership MCOs, and Disability Rights Wisconsin (the Family Care Ombudsman) should meet to explore how to work together to promote successful life in the community for Family Care members with developmental disabilities and complex needs, reduce admissions to the Mental Health Complex, and accelerate discharge to the community when admissions occur. This will be critically important if the proposed cap on Family Care in the state budget moves forward. If people are not discharged quickly, they will lose their slot in Family Care.
- BHD should track and analyze admissions and discharge of people with developmental disabilities at the Mental Health Complex to better understand why people are being admitted and the areas which need to be addressed to reduce admissions.

MENTAL HEALTH REDESIGN

ISSUE: A number of proposals are under consideration to redesign the adult mental health system in Milwaukee County. The CAB work groups have reviewed the HSRI Public Policy Forum recommendations and also had the opportunity to hear from Chairman Holloway about his proposal. Some CAB members have had the opportunity to speak to the County Board's Special Committee.

RECOMMENDATIONS: There are positive components in all of the proposals and we encourage policy makers to move forward with redesign. The CAB work groups have supported and recommend that the following principles guide the Redesign:

- Efforts to redesign adult mental health in our county should include the overall system – the Milwaukee County system, private hospitals, FQHCs, advocacy organizations, consumer run organizations, and physicians and therapists. A public private partnership, as proposed by the HSRI plan, is needed to move forward with redesign.
- Our current system has an overreliance on costly and traumatizing crisis and inpatient services. We need to shift resources – not decrease them – to increase availability of the community based services and supports that can help people maintain their health and independence, and avoid expensive inpatient and crisis care.
- There is support for expanding partnerships with the private hospitals to serve more people and reduce the number served at the Mental Health Complex. The HSRI report indicated that our number of hospital beds is probably about right – but that there were opportunities to reduce inpatient costs by expanding partnerships with the private

hospitals. In addition, the private hospitals already have Joint Commission certification and less difficulty recruiting staff.

- As noted in our January report, Milwaukee County has an extremely high level of emergency detentions - of the 14,000 visits to PCS last year, approximately 8000 were emergency detentions – people brought to PCS in handcuffs by the police. The second largest county in our state, Dane County, had only 400 EDs. We continue to support the recommendations in the January report including the need for a focused quality improvement effort including data gathering and analysis; training of staff at BHD, private hospitals, and law enforcement; and expansions of alternatives for diversion such as the Crisis Resource Center..
- Redesign must address the culture of care with a commitment to provide person centered, recovery oriented, culturally competent, trauma informed, and integrated delivery model and culture.
- To be successful, any efforts to improve the mental health system must include consumers – meaning people who have experienced mental illness - and advocates, as full partners. The HSRI study indicated that our system has a shockingly high rate of consumer refusal of services. By including consumers and advocates as full partners, we can move towards a system that is more reflective of the needs and preference of those served and that promotes voluntary treatment.

SAFETY WORKGROUP

Listed below are some of the issues discussed by the Safety Work Group and recommendations for addressing them.

RESPONSE TO SEXUAL ASSAULTS

ISSUE: One staff member from the Sexual Assault Treatment Center(SATC) reported anecdotally that they had reports of one client with potential sexual contact/assault who was examined by BHD staff before referral to SATC, and this staff member was concerned that this might be occurring in other cases. BHD staff agreed this is not appropriate as it may destroy evidence. BHD staff indicated they have some conflicts in duty related to regulations that require assessment of any complaint prior to any transfers. Concerns were also discussed regarding the timeliness of communicating with family members or guardians

RECOMMENDATION: When an alleged assault occurs, the patient should immediately be offered the option to go to the SATC and the exam should be done by experts at SATC. BHD staff should review their protocol regarding the response when an allegation of sexual assault occurs, including communication with family member or guardian, and see if changes are needed. SATC staff are available as a resource to discuss protocols. In addition, the CAB recommends that additional training be provided for BHD staff regarding the response when a sexual assault occurs, and SATC staff is a resource for training as well. BHD staff concurs with these recommendations and many have already been implemented. BHD staff report that physicians have been told to not do any physical exam in any potential cases of sexual

contact unless the patient refuses to be transported. Then an assessment is offered for any immediate medical needs.

ISSUE: The group heard perspectives from Community Advisory Board members regarding opportunities to improve the response to allegations of sexual assault at BHD. The CAB includes a number of members with experience in this area including staff from the Sexual Assault Treatment Center and the Healing Center, an attorney from DRW, and county staff including a representative from the Sheriff, an RN, and peer specialists. Concerns were expressed that some law enforcement personnel who respond to allegations of sexual assaults at BHD do not believe the patients. There was also discussion of the benefits of having more female deputies respond to these complaints as many victims are more comfortable speaking to a woman.

RECOMMENDATION: Have training provided to law enforcement. Deb Donovan, from the Sexual Assault Treatment Center (SATC) at Aurora, offered to do a presentation to the leadership at the Sheriff's Department. Discuss with Sheriff Clark the possibility of having more female deputies available to respond and try to honor the victim's choice if they have a preference for a female (or male) deputy.

SECLUSION & RESTRAINTS (S&R)

ISSUE: BHD continues to work on reducing use of seclusions and restraints. However, staff reported that in 2010, the use of S&R in the in-patient units increased. They speculated that this was in response to staff concerns about violence and assaults. BHD has been doing intensive training to address this and recently developed new initiatives that are aimed at dealing with escalating behaviors, with minimal use of restraint and seclusion. A new component is the use of the Broset Violence checklist, which is completed by an RN and then updated throughout the patients stay at the acute unit at BHD. A positive and unique part of the new initiative was the inclusion of a personal safety plan for advance crisis planning. This planning tool is done collaboratively with patients to reflect their preferences in what helps them de-escalate and also the particular use of restraint and seclusion if it becomes necessary. There was also discussion about concerns regarding the use, and possible overuse of chemical restraints.

RECOMMENDATION: Move forward with implementation of the new BHD initiative for responding to escalating behaviors and reducing use of seclusion and restraint. Workgroup members were very enthusiastic about the new tools, particularly the advance planning for crises which includes the patient. It is also important that all staff have training and knowledge about trauma-informed care and understand how the use of S&R can trigger traumatic memories in residents and exacerbate their behaviors. BHD should consult with organizations such as St. Ameliens, who have successfully implemented trauma-informed care concepts in S&R reduction initiatives. BHD should continue carefully reviewing and monitoring its use of chemicals for purposes of S&R as there are strict federal rules regarding their use.

EVALUATING PROGRESS OF SAFETY INITIATIVES

ISSUE: Members of the Workgroup have had several discussions with BHD staff on how to best evaluate progress regarding safety at BHD. There was some agreement that it would be helpful to develop a "Dashboard" of indicators in which progress (or lack thereof) could be easily identified without exposing anything that would breach patient confidentiality. Although these indicator have not yet been defined, there seemed to be agreement that "trending data" might be useful.

RECOMMENDATION: BHD should work with the CAB to agree on a list of indicators that they are willing to routinely report on as a way to evaluate the efficiency of the changes being made to address safety concerns.

MIXED GENDER REPORT

ISSUE: CAB members reviewed the Report on Mixed Gender Patient Care Units and submitted a memo to the board on 3/2/11 commenting on the report and generally supporting the recommendations.

RECOMMENDATION: There are some promising recommendations; however, the manner in which they are implemented is critically important:

- We strongly encourage BHD to include stakeholder input as they move forward.
- The new units should have a focus on treatment that is appropriate for these specialized populations – people with challenging and aggressive behavior and people with additional vulnerability.
- BHD should also consider how to incorporate "therapeutic milieus" within any new models of care (described in our recommendations in the last report).
- It is very important that the Intensive Treatment Unit have a higher staff to patient ratio including staff with specialized training and skills to work with patients with challenging behaviors.
- We must continue to explore other models for serving complex people with challenging behaviors who cycle through the system and are not appropriately placed at Acute Care. To support this, additional data collection and analysis may be needed.

PATIENT CENTERED CARE WORK GROUP

The following issues and recommendations are from the Patient Centered Care work group.

COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE

ISSUE: Milwaukee County is moving forward with CCISC – Comprehensive, Continuous, Integrated System of Care. This evidence based model has as its goal an integrated service

system that can provide high quality, recovery oriented services that are co-occurring capable, person-centered, culturally competent, trauma informed, family involved and include peer to peer services.

RECOMMENDATION: The CAB strongly supports and endorses the CCISC initiative and its focus on person centered recovery oriented care, and increased commitment to finding more effective ways to support and engage complex people. We recommend implementation of CCISC system wide – in the community, acute care, and long term care systems and anticipate significant positive impact from a welcoming, acceptance of people with co-occurring issues on consumers, providers, and the system.

ACCESS TO INTERPRETERS

ISSUE: The CAB had previously expressed concern about the availability of appropriately trained interpreters for deaf and hard of hearing patients and family members. A work group member had offered to assist with identifying additional resources.

UPDATE: A member of the workgroup has been collecting a list of interpreters with specialized credentials to provide to the County, as well as to identify which interpreters meet the new state credentialing law which went into effect in December 2010. As soon as all of the information is updated, this information will be shared with county staff.

GRIEVANCE POLICY UPDATE

ISSUE: As noted in the January report, the grievance policy document is in compliance with the law but complex. The CAB recommended development of an additional "quick reference version" that is very simple and understandable for those with low literacy levels.

UPDATE: The document has been developed by BHD Patients Rights Committee with input from CAB members and is now part of the admissions packet. The Disability Rights Wisconsin brochure is also included in the packet as previously recommended.

COMMUNITY LINKAGES WORK GROUP

The following issues and recommendations are from the Community Linkages work group.

ESTABLISH COMMUNITY ACCESS POINTS

ISSUE: Our mental health and human services system can be confusing and difficult to navigate. People in need of mental health services and supports often face many barriers to accessing help, and as a result may end up relying on expensive crisis care.

RECOMMENDATION: Explore the development of community access points which would be open 24 hours a day and 7 days a week to help link people to services and provide

diversion from PCS. This would provide collaboration and coordination of services. These community access points could be located at sites already operating 24/7, such as the Crisis Resource Center. The CRC could be an ideal site for an initial pilot.

Staff would have the expertise and the computer resources to provide information and referrals. These sites could also be utilized by the police or PCS for assessment and linkage to community resources, reducing the number of folks going to the PCS emergency room.

Staff would assist with appointments to outpatient clinics or other referrals and follow-up with individuals to insure access to services, provide appointment reminders, and identify barriers to treatment and resolutions. Other services would include benefits counseling, and assistance with securing housing.

EXPAND THE CRISIS RESOURCE CENTER MODEL

ISSUE: The Milwaukee Crisis Resource Center (CRC) is a community based, recovery oriented alternative to inpatient hospitalization and emergency department visits, that is not only cost effective, but a better service option for individuals experiencing a psychiatric crisis that does not require medical treatment. In 2010, there were 340 individual admissions to the CRC, and 54% were diverted from a hospital ER or inpatient hospitalization. However, the CRC has very limited capacity with 7 beds and is located on the south side, so can only serve a very small number of those who may benefit from this cost effective diversion. Over 120 people have been turned away this year due to limited space. In addition, the CRC is facing fiscal sustainability challenges due to the low Medicaid reimbursement rate.

RECOMENDATION: The CAB strongly supports the County Board's recommendation to develop a Crisis Resource Center (CRC), including peer support, on the north side of town. We also recommend that Milwaukee County support efforts of the CRC leadership, and advocacy groups, to urge the state to change Medicaid reimbursement rates to maintain adequate funding.

Proposals to DHS for Supporting the CRC:

- Increase the Medicaid rate for the crisis stabilization per diem code S9485 to a level capable of sustaining residential care in an environment that is less restrictive than inpatient care and inappropriate emergency room care.
- Identify a new Medicaid code for acute residential care that would allow the T19 HMOs to include clients served under this code in the T19 HMO contract encounter data.

EXPAND OUTPATIENT SERVICES

ISSUE: We are experiencing a crisis in access to outpatient mental health services. This is due in part to limited number of psychiatrists in the state, and the very limited number who

serve Medicaid patients. In addition, the number of outpatient slots funded by Milwaukee County for uninsured has declined and there is no longer an outpatient mental health clinic on the south side for those receiving outpatient services through Milwaukee County. People literally end up at our county emergency room, because they cannot access outpatient services – this has a very high fiscal cost, as well as a tragic human cost.

RECOMMENDATION: It should be a top priority to maintain and expand our network of outpatient mental health services. As recommended by HSRI, the CAB supports development of a plan to reallocate resources so we can provide more outpatient and community based services and fewer people will be forced to access costly crisis and inpatient care.

We propose these principles for expansion of outpatient care:

- Geographic diversity to improve access.
- Some Walk In Clinic hours to provide access to new clients and to those with an urgent need for assistance.
- A holistic model of services including access to both mental health and substance abuse services, benefits counseling, connections to resources such as housing, peer support. The Bridge Health Clinic (http://www.thebridgehealthclinics.com) is an excellent example of this model.
- Culturally and linguistically appropriate care.
- Partner with Federal Quality Health Clinics (FQHC) to develop outpatient capacity as they receive a better federal reimbursement rate.
- Work with DHS and other stakeholders in the states to hold MCO's accountable for providing adequate access to mental health services in their networks.

DECREASING HOSPITALIZATION

ISSUE: After a psychiatric hospitalizations, people are at risk for readmission if there is not adequate support in the community. In an effort to decrease hospitalization, Optum Health (United Health), in partnership with Grassroots Empowerment and NAMI Greater Milwaukee, has piloted the PeerLink Project. The program matches a Certified Peer Specialist who is successfully managing his or her own recovery with peers in Optum Health who are currently receiving services in inpatient facilities or recently discharged. The goal is to ease the transition of individuals being discharged from hospital settings back into community life and to significantly decrease the need for readmission to the hospital by engaging people prior to the potential need for entry into the inpatient facilities. Results to date have shown a 46% decrease in hospitalization for members involved with the program.

RECOMMENDATION: Pilot use of the PeerLink model for patients discharged from the Acute Care Unit at BHD. Partner with NAMI Greater Milwaukee and Grassroots Empowerment who have been local partners in this project. In addition the above

recommendation about expansion of the community resources and out-patient services will make a significant difference in the number and length of hospitalizations.

HOUSING FIRST

ISSUE: Homelessness or housing insecurity is a large contributor for many people experiencing a mental health crisis. Milwaukee County has made some very positive strides with a public private partnership to develop affordable, accessible housing with supportive services for people with mental illness; however the need still greatly exceeds the supply. The lack of housing also delays discharge from expensive inpatient care, or, when housing is not secured, contributes to costly readmission to the hospital and the "revolving door". The January 26th Point in Time survey of homeless people in Milwaukee County found that in the past six months, 6 – 9% of those discharged from mental health treatment did **not** have a place to stay upon discharge and ended up in shelters or on the street.

RECOMMENDATIONS: The CAB strongly supports the county's efforts to work with the private sector and federal funding to develop additional supportive housing and independent living options, across the county, including in suburban locations. The HSRI report included a recommendation to enhance and emphasize housing supports to offer a greater continuum of housing resources; we support those recommendations as well. A Housing First model will ultimately be a good investment and reduce the overreliance on crisis and inpatient care. The homeless service system should be included as a partner.

Fiscal Impact

At this point, the fiscal impact of these recommendations has not been determined. We request the Administrator of the Behavioral Health Division work with appropriate staff to determine costs of implementation.

Special Note

Paula Lucey has been the co-chair of this board. As Paula Lucey has become the BHD Administrator, she will continue to work with the Community Advisory Board but her participation should not be taken as official endorsement of any of the recommendations. Ms Lucey, as Administrator, will review the referred recommendations for appropriate action.

Respectfully submitted:

Barbara Beckert	Paula Lucey
Milwaukee Office Director	Administrator
Disability Rights Wisconsin	Milwaukee County Behavioral Health Division

cc: County Executive Chris Abele
Antionette Bailey-Thomas, Analyst - DAS
Jennifer Collins, Analyst - County Board
Jodi Mapp, Committee Clerk - County Board

Meetings for Community Advisory Board and Work Groups -January – April 2011

Community Advisory Board Meetings

1/19/11

- Douglas Jenkins, Deputy Director of Audits spoke about the County Audit Department's report on BHD, and discussion of CAB feedback
- Update on Special County Board Committee to Study Construction of a New Behavioral Health Facility, County Supervisor Joe Sanfelippo – CAB member and committee chair
- County Executive Lee Holloway spoke about his vision for the mental health system

2/23/11

- Presentation of Mixed Gender Report by Dr. Mary Kay Luzi and work group members
- Discussion of CAB feedback on the report recommendations

3/21/11

- Presentation by Paul White, University of Wisconsin Waisman Center for Excellence in Developmental Disabilities about models for serving people with developmental disabilities and mental illness or with developmental disabilities and complex needs.
- A meeting was also hosted by DRW with Mr. White and representatives of the three MCOs serving residents of Milwaukee County in Family Care/Partnership programs.

Safety Work Group Meetings

1/26/11

- Presentation by Deb Donovan, of the Sexual Assault Treatment Center at Aurora Sinai Medical Center
- Workgroup members learned about services and statistics regarding sexual assault in Milwaukee, as well as the referral procedures between BHD and SATC.
- Discussed the type of indicators staff could share with workgroup to "measure" improvements in safety at BHD.

2/23/11 Hosted CAB meeting on Mixed Gender Unit report- noted above

3/23/11

- BHD Staff did a presentation on Seclusion & Restraints, as well discussing two new tools being developed to address S&R
- Further discussion on how BHD might develop some sort of "dashboard" of indicators related to tracking safety improvements

4/27/11

- Michelle Cohen, from St. Amelian, did a presentation on their strategies to reduce seclusion & restraint (S&R) with youth.
- Shirin Cabraal, Co-Chair of the Workgroup and an attorney with Disability Rights Wisconsin, did a presentation on the laws regarding S&R.

Community Linkages Work Group Meetings

1/18/11

- Use of Emergency Detentions including overview by Public Defender Dennis Purtell and input from CIT officer
- Lack of outpatient clinics – consumers going to ER departments for med refills
- Concerns re new Managed Care Organization initiative: consumers must be dropped off at clinics 90 minutes before appointment – leads to crowded waiting rooms and unhappy customers

2/25/11

- Outpatient clinic capacity in Milwaukee County
- Disability Benefit Specialists at the Disability Resource Center and elsewhere– too few given the needs in Milwaukee County and financial impact of uninsured
- Medicaid reimbursement for Psychiatrists

3/9/11

- Todd Campbell from the Bridge Health Clinic and Research Center. Provides mental health and substance abuse services. Serves people on Medicaid and uninsured.
- Peter Hoeffel and Serge Blasberg from the Peer Link Program - Overview of the program which is being studied by Yale. Results show a significant decrease in readmission to the hospital for participants.

3/25/11

- Mental Health resources in Milwaukee and current capacity
- Resources utilized by Community Resource Center
- Lack of access to community services are people leave jail – and lack of access to treatment contributes to many ending up in jail

4/3/11 and 4/29/11

- Discussion about recommendation for community services and prioritizing recommendations into 3 tiers:

Patient Centered Care Work Group

1/6/11

- Review and endorsement of HSRI recommendations
- Overview of need for adequate, appropriately trained interpreters for both spoken language and signing. Examples illustrated deficits related to inadequate service provided to Spanish and Hmong speaking individuals, and deaf, leading to suboptimal care.
- Need for expanded list for deaf/hearing impaired interpreters. Denise Johnson will assist them in developing this.
- Recommend interpreters have adequate credentials (mental health specific) and actively participate in the CCISC, PCP, TIC, and Recovery trainings.

2/9/11

- Person Centered Planning and Creating a Recovery Culture
  Speakers: Front line workers including RN, peer specialists. (have had difficulty getting participation from CNA or unit clerk speaker)
  Lalena Lampe, Recovery Coordinator for the State of Wisconsin.
    - update on State training initiatives - Person Centered Planning, Recovery, TIC
    - webcasts = free training

3/21/11 – hosted program with Paul White noted above

4/13/11

- CCISC – Comprehensive, Continuous, Integrated System of Care
- Speaker: CHRISTIE A. CLINE, MD, MBA, PC. Dr. Cline partners with Kenneth Minkoff, M.D..
- Systems Change initiative - co-occurring disorder program enhancement, curriculum development, and staff training.

Waisman Center
University of Wisconsin – Madison
1500 Highland Avenue, Room A109
Phone: 608-263-0271
Fax: 608-265-4101

Community TIES
UW – Waisman Center

A Community Model for Supporting People with Developmental Disabilities and Challenging Behaviors.

Mission

To support behavioral, psychological and emotional needs of persons with developmental disabilities using approaches that assure continued full participation in supported community life.

Discussion

Supported life for persons with developmental disabilities is most effective when it promotes Full Community Membership and assures individual choice (Self Determination). Within this lifestyle most people lead overall meaningful, productive and healthy lifestyles.

Support to some people includes added attention to emotional, behavioral or psychological needs. Such needs, if unmet, are commonly termed “challenging behaviors”. The community team is challenged to, on behalf of the individual, understand and meet these needs. This can sometime present a daunting task. Any “typically developing” individual striving to sustain his/her own emotional health knows this to be difficult enough. Understanding and meeting such needs on behalf of someone else and in this case a person with cognitive and/or communication challenge is most often quite complex.

Challenging behaviors can be expressed overtly (tension, emotional or physical distress) or covertly (withdrawal or isolation). The cause or life situation that may be stimulating the challenging behavior can be wide and varied. Included here is a list of common “stress triggers” for people with developmental disabilities. These stress triggers can occur individually but are often presented in combination.

For some individuals challenging behaviors occur more often or with sufficient intensity to include aggression, destruction or self injury. It is not uncommon for community support teams to consider moving individuals to lifestyles where safety for the individual and others is better assured. This often results in more restrictive locations where community membership and choice is limited. Examples include ICFMRs, Mendota or Winnebago Mental Health Centers. While the immediate safety for the community is met, the more restrictive setting often only serves to increase the number of stress triggers that can result in challenging behaviors. In fact, the challenging behaviors may have been occurring because the supported living program was not the best fit for the individual in the first place. This is, unfortunately, a common life dilemma for people with developmental disabilities.

A suggested blueprint for supporting people with developmental disabilities and challenging behaviors in the community is offered by Community TIES and Dane County Human Services.

I. Develop a supported living model within the County that subscribes to “best practice” standards for Full Community Membership and Self Determination. Apply these standards to all persons with developmental disabilities, including people who present challenging

behaviors. Continue to apply resources and training to this end. Practices that are essential to this model include:

a. Person Centered Planning and a team approach
b. Meaningful relationships
c. Self Directed Services
d. Living, working and recreating in the community
e. Living with only a few house mates
f. Meaningful work and recreational activities
g. Opportunities to explore spirituality

II. When challenging behaviors are of concern look first and foremost to the community support program to assure that it is truly "best practice" as described above. Continually resist pressures to move individuals to, or create, more restrictive settings. Develop a program within the County where additional supports can be added to the existing community lifestyle and only as much as is required. Included here are examples of gradually adding behavioral supports in an effort to assure continued supported community life:

a. Provide a consultant to the existing community team who can offer insights and direction on supporting persons with challenging behaviors
b. Use the Personal Futures Planning style to develop a written plan to support challenging behaviors (behavior support plan). Assure that the wording is straightforward and that the plan is accessible to all direct providers.
c. Offer training and support to direct providers on sensibilities in developing relationships with people who present challenging behaviors.
d. Build in more intensive supports that assure safety within the existing community support program. This effort sometimes includes the judicious use of Restrictive Measures. Reduce the need for these supports as the individual learns adaptive alternatives to the challenging behaviors.
e. Provide learning opportunities to direct providers on positive behavioral supports and dealing with potentially dangerous challenging behaviors.
f. Assure that psychiatric consultation with expertise in disability issues is available to people when needed.
g. Develop a crisis response that offers an alternative to unnecessary stays in psychiatric hospitals, mental health centers or jail. Crisis response includes:

    - Accelerated access to a behavioral consultant
    - Emergency psychiatry
    - Crisis response staff providing support in the community setting
    - Short term stay "crisis home" in the community

    The response should assure either continued participation in community life or a quick return to the supported living program.

The Community TIES model can also be a cost effective approach. While providing supports as described above will require additional funding, it can be less costly than extended stays in more restrictive settings where the per diem rates if often quite high. Additionally the pro-active orientation of the approach offered here will lessen the need of more restrictive and expensive supports over time.

Written by Paul White, Administrator
Community TIES
UW-Waisman Center
April 18, 2011