

## Effective Interagency Collaboration for People with Co-Occurring Mental Illness and Developmental Disabilities

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In a recent NASDDDS Project Technical Report (April 2003), the estimate is that 20-35% of all persons with mental retardation have a diagnosable psychiatric disorder. As a result, most states now acknowledge the importance of comprehensive and coordinated systems of care to meet the needs of individuals with co-occurring disorders. Mental retardation professionals recognize the need for the clinical expertise available in the mental health system to assist those individuals whose mental illness impacts their ability to live and work successfully with others. Unfortunately, barriers are frequently cited regarding access of one system to the other.

Connecticut has a framework for collaboration between the separate mental retardation and mental health agencies that is proving to be successful. While barriers still exist in terms of adequacy of financial resources, and a lack of clinically trained and available practitioners, significant strides have been made in access to mental health inpatient services and to follow-up community outpatient services.

There are lessons learned that may be useful to future policy discussions:

Recognize the limitations of formal interagency agreements.

The recent survey jointly issued by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the National Association of State Mental Health Program Directors (NASMHPD) identified key components associated with successful service delivery. While 75% of the reporting states indicated they had a formal interagency agreement for services for individuals who have co-occurring conditions, 43% reported that these agreements were less than effective. A similar level of ineffectiveness was reported about regional or local collaboration.

Realize the importance of interagency relationships among key professionals.

The success of formal agreements is more reliant upon ongoing communication, collaboration and the achievement of professional respect. At both the state level and the regional level, we have found improvement in the areas of clinical consultation, joint planning, inpatient services, restoration training and outpatient treatment where there are long standing professional relationships.

Ensure regular communication at the state and regional levels.

Opportunities for sharing databases, reviewing clinical status, interagency problem solving, and joint planning allow the formal agreements to be effectively operationalized. It also allows for joint agency ownership of the desires for a successful life of each person collaboratively served by both agencies. The unique nature of the individual and what network of supports will enhance the chances for successful community living become the focus of interagency discussion.

Ensure that key administrators at the state and local level have an orientation to their sister agency.

When Connecticut formalized its Memorandum of Agreement (MOA), sessions were planned for all state and regional level staff responsible for implementation. Training in the specifics of the MOA was coupled with an orientation to each agency's mission, eligibility criteria, guiding principles and statutory authority.

This provided an excellent opportunity to understand the different premises, service delivery approaches and limitations of both agencies. As an example, the existence of a Waiting List for individuals with mental

retardation brought greater understanding to mental health professionals of a major barrier to timely discharge from psychiatric facilities for people still living at home with their families.

Our mental retardation professionals learned that what was sometimes perceived as discriminatory practices were not. In this state, public mental health resources are dedicated to those people with significant, chronic mental illness and community supports are often more acute and intermittent. The mental retardation orientation to comprehensive long-term support is a departure from the mental health service delivery approach. Our service delivery orientation led us to expect service interventions that were not necessarily available to the general population accessing mental health services.

Respond effectively to the organizational needs of both agencies and respect service and budgetary constraints.

Through the interagency relationship, DMR became aware of the frustration of the mental health agency in supporting necessary psychiatric admissions, because of untimely, unresponsive discharge planning of individuals while in acute mental health inpatient settings. As a result, people continued to be hospitalized in expensive settings long past their readiness for discharge. Their continued presence created a burden for the hospitals, lack of access for others in need of intervention, and prolonged unnecessary hospitalization for individuals with mental retardation.

The department's response was to:

- Work with its provider community to cooperatively plan timely discharges for individuals returning to a funded residential setting.
- Create a tracking system to help bring managerial attention to the problem.
- Streamline eligibility determinations for individuals not previously served by DMR.
- Strengthen collaboration with the children's agency to better plan community alternatives for adolescents who had co-occurring mental illness and mental retardation.
- Develop a transitional program for adults who could not return to their family's home.

These initiatives have significantly reduced the length of stay for individuals with co-occurring diagnoses in both private and public psychiatric settings.

Collaborate and train.

There has been great opportunity for training between agency professionals that benefit community service development. Mental retardation professionals have benefited from trainings on psychiatric interventions, clinical assessment tools and medication utilization. Mental health professionals have gained expertise from positive behavior support in-services. Interagency case conferences are used as both a training opportunity and a chance to collaborate effectively for individuals who present challenges while using generic treatment and support approaches.

No particular strategy will prove successful in all cases. Connecticut still struggles to meet the needs of some of its citizens with co-occurring conditions. The availability of community services and the necessary resources in sufficient quantity to fund these supports remain a barrier to effective support for some of these individuals. However, effective collaboration and communication have furthered our efforts to expand the availability of psychiatric interventions allowing more people to live successfully in community settings.