Whole Person Care For Consumers With Co-Occurring I/DD And SUD: How Monarch Developed A Specialized Treatment Model For A Historically Underserved Population

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Dr. Gutierrez 0:11
Hello everyone and welcome to "Whole Person Care For Consumers With Co-Occurring I/DD And SUD: How Monarch Developed A Specialized Treatment Model For A Historically Underserved Population" presented by RECADEMY and *OPEN MINDS*. My name is Rick Gutierrez and I'm a Senior Associate with *OPEN MINDS*. I've spent more than two decades in clinical and operational leadership roles serving individuals with intellectual and developmental disabilities, behavioral health conditions, and complex support needs. My experience spans clinical practice, program development, network management, crisis services, and large-scale operational leadership, with a particular focus on improving access to care for vulnerable and underserved populations. Today's discussion focuses on a population that is often overlooked in conversations about substance use disorder treatment, individuals with co-occurring intellectual and developmental disabilities, and substance use disorders. While significant progress has been made in expanding access to evidence-based addiction treatment, many traditional treatment models were not designed with this population in mind. As a result, individuals with IDD and SUD frequently experience fragmented care, limited access to specialized services, poor treatment engagement, and worse outcomes. At the same time, provider organizations are being asked to serve increasingly complex populations while navigating workforce shortages, operational challenges, and growing expectations around outcomes and whole person care. The reality is that there are very few established treatment models specifically designed to address the unique needs of individuals with co-occurring IDD and substance use disorders. That's what makes today's conversation so important. We're joined by an organization that recognized this gap and decided to do something about it. And I'm pleased to welcome Todd Posey, Vice President of Clinical Best Practice at Monarch. Todd has spent his career working in behavioral health, substance use disorder treatment, and clinical leadership across a variety of treatment settings. At Monarch, Todd has helped lead the development of an innovative

treatment model specifically designed for individuals with co-occurring intellectual and developmental disabilities and substance use disorders. What began as an effort to address a significant service gap has evolved into a nationally recognized resource that has attracted interest from provider organizations, researchers, and clinicians across the country. Today, Todd is going to walk us through how Monarch identified the need developed a model, engaged its workforce, and created practical tools that organizations can use to better serve this population. Todd, thank you for joining us today.

Todd Posey 3:04
Well, thanks for inviting me. I appreciate the opportunity to talk to you a bit today. I want to start with telling you a little bit about Monarch, tell the listeners a little bit about Monarch. We are a nonprofit. We've been around for quite a while under the IDD umbrella. And then around 2012 is when Monarch branched into substance abuse and behavioral health services with mental health reform in North Carolina. And we currently serve people in 99 of North Carolina's 100 counties. We have facilities across much of the state, more than 120 facilities. Many of them are group homes serving the IDD population. We have around 6,000, excuse me, 1,600 staff members delivering services to behavioral health in outpatient crisis, residential and community based settings. We also, in addition to having 16 brick and mortar clinics to provide outpatient therapy and psychiatry, we have two mobile clinics up in the northeastern part of North Carolina that serve six very rural counties, one of which has no medical doctors in the whole county. But our clinic has been serving there for about 3 years now. We are accredited by the Joint Commission. We're one of the first organizations of our type to be accredited by the Joint Commission and one of the largest surveys they've ever done. We really focus on promoting wellness, on recovery, helping people regain or gain independence for the first time and long-term community integration. So I mentioned the lion's share of the history goes back to the arc of Stanley County in the central part of the state. Albemarle is the city there and expanded into behavioral health services. We are earning a reputation for innovation and definitely focus on person-centered care. We have a number of workforce development initiatives and have come a long way in becoming data driven over the last several years. In 2023, actually may have been 2022, but we were approached by the state about a grant. They were looking at providing treatment for the underserved population of those duly diagnosed with IDD and substance use disorders. And we began exploring it. And one of the things we found out right off the bat with Peggy Terhune, she's our CEO, and I independently were researching this, and we found nothing. We couldn't find anything that anybody anywhere was providing treatment for this population. And, you know, because of this, North Carolina and some other states decided to use some federal dollars to fund grants to come up with treatment for this population. And I know in other states, there's been a push in the last couple of years providing grant funds for training for staff and they've called upon us to share these materials. So that's, you know, kind of been a trend in the field that the recognition of this population and the critical needs. But as you can imagine, so many barriers to service for this population, physical barriers, cultural barriers, just all kinds of

things that prevented them from getting the kinds of services that they need. And it's kind of sad to me in this day and time, some of the physical barriers that folks still experience. I won't go into all the details, but just within a couple years ago at a hospital, my father was getting services and I was there with him for his appointment and they brought a gentleman came into the waiting room obviously had traumatic brain injury, was in a large motorized wheelchair, and several other people in the waiting room and me had to rearrange the waiting room for this gentleman to get in and get services. You know, there's no way he was the first person with a traumatic brain injury to have to come in there. but yet they were totally unprepared for that. And, you know, a lot of people with intellectual developmental disabilities have mobility issues, have things like that that prevent them from coming. So that's a big issue too. But also, as we'll get into the, you know, cognitive level, things are not geared and designed to reach them. So all these barriers, all these difficulties in getting services and people end up being left out. They may not fit in the traditional models that treatment models that are available. People make assumptions about their ability to participate in treatment. We've also discovered over the years that, you know, clinicians often don't feel comfortable working with people with IDD issues because they're not trained to do so. Many of the graduate programs don't provide any training, you know, required training, in working with that population. And so the clinicians really feel unprepared. And I've had therapists tell me, well, I've never worked with anybody with an intellectual developmental disability. And I tell them, well, you have, you just probably didn't know it. If they were high functioning and they didn't tell you, you wouldn't have reason to know. And if they're of a certain age, they may not have known because back in the day, there weren't services available, widely available to identify people who are in need of IDD services and to diagnose people who were struggling with those kinds of issues. And, but they're out there and we see them, we just may not know it. And, but it's important to be prepared and it's important to, you know, rise to the challenge to serve this population. This statement really sticks out because I consulted with a colleague of mine who works with the Duke Addictions Program and we were talking about this and I reached out to him to see if he knew of anybody who was providing services for this population. And he said he wasn't aware of anything. And at the end of the conversation, this really stuck with me. He said, Todd, I really hope that you guys apply for this grant because if you don't do this, who will? And that really became a motivation to me. If we don't build it, if we don't do this, who's going to do it? Because as I said, there's very little out there. We had difficulty finding anything. But we ended up applying for the grant. We were awarded it and were able to put together these materials. As I mentioned before, you know, just the absence of established models really reinforced and underscored the need for, you know, putting something together for, you know, being innovative, thinking differently, not thinking traditionally and working toward coming up with these materials. And initially this grant was for treatment as well. But as we got into it, the state came back to us and they said, look, there is just such a need for this. If you'll come up with materials and disseminate it, that's the biggest thing we want right now. So if you can develop these materials, push them out, and that was one of the requirements of the grant, we had to disseminate it across the state of North Carolina. But,

you know, it was intended to improve care for us across North Carolina, but it really ended up going beyond. In putting this together, we focused on adapting traditional substance use disorder concepts. I reached out. I have credentials in treating substance use disorder. I'm a licensed clinical addiction specialist. And I reached out. We had at the time 10 or 12 other therapists in our organization who had credentials to treat substance use disorders. And I reached out to them and asked, can you shoot me back? Can you send me the 8 or 10 or 12 recovery topics that anybody really interested in recovery should understand? Just what are the basics that anybody should know? And they gave me their list. I got my list together, and you know, we we came up with these with these materials and I'll tell a little bit more about the how in just a minute. But focusing on now, you know, one of the things that we encountered from talking with professionals in the field, I mentioned I talked with a colleague and mentor at the Duke Addictions Program. I talked with a psychiatrist who specialized in IDD, the IDD population at UNC Chapel Hill and got some tips and suggestions from them and, you know, about the importance of adapting the materials for the cognitive abilities, the importance of having materials that they could take home with them, having a summary that very basic summary of the topic that they could take home with them. The importance of having structure to the sessions, having family members and caregivers involved. In fact, we actually designed these materials so that a caregiver or family member could actually go over it with a person. You don't really have to be a professional. It's great if a therapist will use these materials to work with someone with co-occurring IDD SUD, but it's really not necessary and it can still be a great tool to help the person. But, you know, making sure that we could have this replicated and just have, the term I'm looking for is escaping me, but you know, so we could have a, you know, ready package that we could drop in the hands of therapist and they could run with it. Turnkey, that was the, we could have a turnkey package that we could drop in their hands, it would be done and they could move forward with it. We came up with 14 modules and each module has multiple components. Each module is only focused on one topic, keeping it simple, avoiding abstract, thinking and the abstract concepts, really sticking to things that are very concrete. But next slide, I'll talk a little bit about a piece that really excites me. Peggy, this whole thing was our CEO, this whole thing was her brainchild. And her idea was, let's get together a work group of people with lived experience. And she got together a work group of about 15 people. Some of them had IDD issues themselves, or they were caregivers or family members, and they are the work group that helped us shape these materials. And we met for a couple of months every Monday night. And I would bring to them these topics that I mentioned earlier that our substance abuse therapist had come up with and that I had compiled this list of topics. And I would give them an overview of the topic and then they would teach us how to communicate it. And out of that, we learned so much and several of the topics they came up with. The very first topic is we begin talking to them about, you know, substance use, drugs, and they're like, well, medications are drugs and we take a lot of medication. So we stepped back and created a brand new unit. It was our first module on what is medicine and the importance of taking medication as prescribed and not mixing it with drugs or alcohol. But we met with them and

they really gave us a lot of helpful hints and tips. When we're invited to train on these materials, we have a couple of slides of things that they said, hey, these are things we want people to know about us. And one of the things that I thought was probably the most awesome, was they said, well, you know, tell therapists to assume that we're competent because after all, we assume they are. But they really were, you know, underscored the idea and the truth that people with intellectual and developmental disabilities, at the end of the day, they're just people and they have the same types of desires and hopes and dreams that everybody else does. And the more that we can look at them as people and less like a population with a problem, then the better off we are in helping them. You know, one of the things they communicated to us is, as I mentioned before, making sure things are very concrete and not abstract, but at the same time, they were very sensitive to things being juvenile and they didn't want to be talked down to. They didn't want to be treated as children. And that makes total sense. And those things really shaped these materials and, as I said, from what I've described, we learned a lot more from them than what they learned from us. It was an incredible experience for me. I did not have a lot of experience working with the population. But Peggy did. That was the reason why she spearheaded this. Her background is in IDD services. Mine is in substance abuse treatment brought together our expertise along with this work group to produce this. And I was just in awe of them from week to week as I learned from them and learned a lot about their abilities. I probably learned more about their abilities than I did their disabilities. And, you know, they're people. They live in neighborhoods, just like we do, probably live in your neighborhood. They live in mine. You know, some of them live independently. They have relationships. They work jobs. You know, and it's really important that we understand that and grasp that. Another thing that they pointed out that they were very sensitive to, and I think this says a lot about how people approach them, but they said, you know, don't be afraid of us. We're not going to hurt you. That was something that they really emphasized. But I think there is a lot of fear and trepidation from professionals when they work with a population that's new to them. And it's really important to get outside of our comfort zone and to be exposed to populations we've not worked with before so we can gain expertise in doing so. How do we come up with an accessible, a practical, clinical appropriate treatment guide, treatment materials for people with co-occurring substance use disorders and IDD? And what we came up with was coming up with this or producing a free and interactive learning curriculum that's structured into approachable and replicable modules. We decided from the beginning that since the grant was paying for these materials, that we would make them available free of charge and they are available on our website. We do require people to register a little later. There's a link to the website. But you do have to register, but registration is free. We just like to be able to track the downloads. But one interesting piece of this is that we worked with media partners who kind of helped us in how to best, you know, once we came up with what to communicate and how to communicate it, but how do we then package it? And one of the things that they recommended was that we put together some videos to teach these concepts. They're very short. I don't think any of them are even 3 minutes long. Most of them are under 2 minutes. Our media partners also suggested that instead of using live actors, that we

use animated characters. And the rationale being that animated characters can connect with a broader range and more diverse range of people, you know, culturally, ethnically, and every other way that there, it's easier to connect with an animated figure than it is a human being who may look very different than I look or than you look. So, and at the same time, we're a little concerned that because of our work group and not wanting things to appear juvenile or like, are they going to think this is juvenile? They didn't and they loved it. They loved the videos. You know, even as we those were produced and we would show them to them, they made some suggestions for changes and edits in the videos and they really had a huge role in crafting it. One thing I want to say too, and I'm kind of skipping back. But one thing that Peggy insisted upon and got the state to agree on with this grant, she said, you know, we're putting together this work group of people with lived experience to help us and they need to be paid. We don't expect them to do this for free. And the state agreed. And so they were paid an hourly stipend for meeting with us and, you know, helping us shape these materials and putting this together. So that was an awesome piece of this. This is actually screen captures from our web page. You see here the link where you could access it on the right side is once you get your login, you register and get your login, you can access the videos. There's also a facilitator's guide. There is also a psycho-ed piece, there's a discussion piece, there's an activity piece, and then there's a summary, a handout. All of it's full color. You can see here, these are screenshots from the original animated videos that were produced. There are 14 of them. And the two characters are Tasha and Eddie. Eddie is there with his doctor in number one, medicine and alcohol, and that's Tasha in #2, what is addiction? But they are the stars of our video, the stars of these materials. Yeah, some things that made this very usable and made this model different is that we we didn't assume standardized cognitive processing and so we didn't require that it have that that there was a lot of self-directed insight. We really made it again very concrete. We avoided the abstract, we kept it simple with one recovery topic per unit, per module. And it's very flexible. It's practical. Now, we focus primarily on alcohol because that is primarily the substance that is most problematic with the population, with any population alcohol is. But the materials are readily adaptable to other substances. One of the things we also did with this, and I don't think we included this on the slides, but there is an evidence-informed screening tool that was informed by some existing screening tools, the DAST, the CRAFT. We examined those and we pulled some of the ideas from there and brought them to our group and they helped us come up with a very basic screening tool that can be used to initiate the conversation and determine if more information and a deeper assessment is needed. But, you know, really the focus was and the plan was how do we get rid of barriers? How do we have something turnkey that we can put in the hands of providers, put in the hands of family members, of, you know, case managers, of whoever, to get this information out to the people who need it. And we give it away. We do ask that people not make money off of it, that they don't sell it or try to do anything like that, but it's all downloadable for free on the website. So strategies that really helped with this and helped us with not just, you know, training our staff, but also training those on the outside. Strong executive sponsorship and clinical leadership. You know, our CEO spearheaded this. I don't think it gets

any stronger executive sponsorship than the CEO taking a personal interest in this and she was the driving force behind it and is, you know, the lion's share of the success of this goes to her. You know, and she freed up my time to be able to focus on this project and to work with her on this. But, you know, we had organizational commitment. We, you know, through this and it's kind of a norm for us that, you know, the ongoing learning that, you know, we're lifelong learners and, you know, focusing on that cross-disciplinary collaboration, as I said, is in both in putting this together and in pushing this out. You know, Peggy by trade is an occupational therapist. She presented these materials to the state occupational therapy conference a couple of years ago. I've presented it at substance use treatment provider conferences. You know, we've really worked to make it appeal to multiple disciplines in order to get this out. And, you know, a lot of the activities, and we talk about the cross-disciplinary collaboration, a lot of the activities in the materials, Peggy as an occupational therapist came up with and we considered the special needs of this population. One of them, I was working on a script for relaxation techniques. And one of the things that I came across was the importance of bilateral stimulation for this population for people with intellectual and developmental disabilities and how helpful that is for them. So I chose one that did bilateral stimulation for the progressive muscle relaxation. Many of those scripts don't do it, you know, they do both arms, they do both legs, but this allowed for the bilateral stimulation. So we took a lot of those things into consideration to really tailor this to help the people who needed it. You know, we both internally, externally support ongoing workforce training. I've been multiple places to outside agencies, helping train their staff in working with this population and in using these materials. And I think that last bullet point is huge, that we prioritize the practical implementation over the theoretical complexity. And one of the things that I say when I train this, and it's even stated in the facilitator's guide, we explain these terms for the people, it's targeted, not for the professionals who use it. So if you look at these materials, you may see some of the concepts explained in terms that are not what you're used to, but it's on purpose to help them understand, not to help us as professionals to understand, but to put it in terms that work for them. It's really been amazing to see how, even though we really haven't done much in the way of marketing, we do have a section on our website that features these materials, but how through word of mouth and other ways that interest in this has spread. In 2023, we received the Innovation Award from North Carolina's Eye to Eye Center for Integrative Health. And just from there, you know, we started, excuse me, rolling it out across the state of North Carolina in webinars. We did a national webinar for NatCon because of the interest there, they invited us to present at the National Council and then they invited us to NatCon in 2024 to present and then people from there begin reaching out to us. And it was interesting, it was my first time at NatCon. There were about 5,000 people there. I'd never been. And I was a little disappointed that there were only about 200 people in my presentation when I presented these materials. And I was talking to a lady afterwards and she said, you don't understand. She said, I've been coming here for more than 10 years and this is the biggest crowd I've ever seen with any topic that had to do with IDD. So that was rewarding to know that. But University of Minnesota contacted us that summer and did a journal article on us. We've had contacts from

other states asking us to come train. I've done most of those and tailor it to to fit the needs of the organization. And so most of the growth has been organic, word of mouth, people who come to a conference and see it and then go back to their organization and take it. But I think that really speaks to the fact that there's not anything out there and that this may very well be the first of its kind. As far as we can tell, as far as a lot of people outside of our organization have told me that this may very well be the first thing of its kind that specifically targets this population and their specific needs. We've kind of touched on some of these things before, you know, making it practical, you know, and by making it practical, that made it accessible. Keeping it simple for our workforce, that cross-disciplinary collaboration that enabled us to come up with the product, you know, the structure of the modules, and, you know, there's a fair amount of repetition, but that's intentional. You know, with any population, repetition in learning is helpful in retaining information, but it's also important, particularly important with those who may have cognitive issues. Incremental implementation. This is not something we have, you know, forced across the board. We make it available to our therapist. We make it available to outside organizations. As I mentioned, we incorporated family and caregivers from the beginning in coming up with the materials, but we also made the materials in such a way that they could take it and run with it. And they could use these materials with the people in their lives and our commitment to sharing this resource and not charging people for it.

Dr. Gutierrez 33:56
All right, Todd, thank you so much for this very informative discussion. You and Peggy and the team over at Monarch, I'm just mesmerized by your intentionality all along the way and, you know, getting the lived experience of the folks that you're serving and making the content accessible to this community, I think is really remarkable. And I was just excited to be able to see that you all are kind of being the trailblazers in helping to support people with IDD and substance use disorder. I do think that people, organizations, providers still struggle with figuring out how to serve this community. So there's some questions for you. What operational capabilities become most important when building treatment models for populations traditional systems were not designed to support?

Todd Posey 34:37
Sure, I think a few things. One, flexibility and a willingness to step outside of your comfort zone. I think those are critical pieces. I think a mindset, and as Peggy, our CEO, says, look for ways to say yes. You know, it can be easy to come up with reasons why we can't do something, and instead, she often says, look for ways to say yes, look for ways we can make this happen. And I think lastly, lead with your strengths, stay true to your organizational values, and be operationally consistent with your strategic growth plan. I think all of these things have coincided to help make this a success and for us to be able to make this happen.

Dr. Gutierrez 35:44
Wonderful. You highlighted this during the talk, which was, you know, the potential discomfort or lack of confidence that providers might experience and kind of shying away from doing this kind of specialized treatment model. I'm curious, what leadership strategies most effectively support workforce readiness and long-term adoption?

Todd Posey 36:05
I think, you know, one of the big ones we've already touched on, executive buy-in. Our CEO spearheaded this initiative. She co-authored these materials. This was her brainchild. And I'm not saying that that level of buy-in is what is required, but if the senior leadership is not on board, it's not likely to work out. There has to be that buy-in on the senior management level. And I think another key piece of this is delegation and empowerment of staff. You know, while Peggy is an excellent trainer in her own right, and has trained and co-trained these materials in several settings. She's largely delegated much of the training to me, both internally and externally. And this is just one example, but she empowered me to have high level discussions with leaders and other organizations that are seeking information to run with training them when requested. And, you know, again, this is just one example, but when you delegate, you multiply your ability to develop your own workforce, to help others with, you know, developing theirs. And because when you delegate, it doesn't require you to have your finger in every slice of the pie. You're able to really exponentially increase your influence when you delegate and allow others to, you know, use their strengths and skills.

Dr. Gutierrez 37:31
I love that. I love the whole idea of being strength-based and kind of leveraging those strengths in the workforce. That's awesome. You know, I can't help but wonder, you know, Monarch is a larger organization. And for those people that are watching this and, you know, coming from an organization maybe that doesn't have the financial resources or the operational infrastructure to support a highly specialized treatment program, I have this question. How should leaders think about scalability, sustainability, and access when developing programs for high complexity populations?

Todd Posey 38:00
One of the big things is to start small. Use small tests of change or pilot new initiatives at a single site or a single program. We do that all the time. You know, we recently made an operational change. We did it in one clinic to see how it was going to work and, now that we saw it was successful, we're going to spread it out to the rest of the clinics. And we do things like that all the time. Let's test this here in this small way. Let's do it with this program or do it with this clinic. And that allows you to learn your lessons, to fix the glitches, resolve your problems, to overcome your barriers before you scale it up. And that makes for a much smoother rollout when you learn those lessons by starting small, then it's not as painful to iron out those bumps and those

wrinkles, you know, if you've rolled it out large scale and then have to kind of back up and punt. I think another one, thinking creatively and non-traditionally, you know, we intentionally develop this material so staff at all levels can facilitate it. So it's not going to be dependent upon having a licensed therapist that's billing, you know, a fee for service.

Dr. Gutierrez 39:04
I love a pilot program. That's good.

Todd Posey 39:27
Yep, you know, you can use it that way. We hope that they will. You know, when we do the training, we also include some information about, you know, if you're doing this as a group therapy and, you know, keeping the session short, you don't need an hour and a half for these sessions because of often having the cognitive issues to deal with, use smaller chunks. Well, most payers will pay for a group therapy that is at least 26 minutes long. So knowing those things about your payers. So what is the minimum length that a group session needs to be? What's the minimum length that an individual therapy session has to be? So, you know, looking at those things and kind of thinking, working non-traditionally to see how you can make it work, even if there's not a specific billing code that you can use to pay for this.

Dr. Gutierrez 40:25
That's incredible. You guys really have thought about this from all different angles and I really respect that and I think it's incredible how you guys have put all this together. I'm curious, looking ahead, what system level changes are needed to improve treatment access and long-term outcomes for consumers with co-occurring IDD and SUD?

Todd Posey 40:42
I think there are a couple things. I think one of the big things would be to see graduate counseling programs provide education and training and working with the IDD population. That is a huge shortcoming that it's really not touched on in most programs. And this really needs to become more mainstream instead of an afterthought or instead of something that the providers have to chase on their own. The other thing I think is more flexibility and funding, you know, payers being willing to be more flexible to provide creative approaches to treatment. And I think that flexibility would ideally include the ability to bundle services. So, you know, you're already doing these services with somebody. So can we bundle this in with it and get a slightly enhanced rate that would enable us to do it? I think another key piece is, and this is probably going to be a ways down the road, but research to support the development of reliable, normed, and validated tools to measure treatment outcomes with this population because I could not find anything that had been. And, you know, there are some tools out there, but they've not been validated with this population and normed with this population for us to be able to use it and to

know if the data means anything. So I think that would be huge, to be able to have some reliable norm validated tools to measure outcomes.

Dr. Gutierrez 42:25
Yeah, that's important. It makes a lot of sense. So Todd, thank you so much for this very informative webinar in illuminating this important treatment options for people with IDD and substance use disorder. As Todd shared earlier, these resources are available for free. So to learn more and to gather these resources, head on over to understanding.monarchnc.org. And to learn more about upcoming webinars and resources, visit recademy.com.