State Best Practices and Innovative Program Examples
Council of State Governments
Coronado, California

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Connecticut Department of Mental Health and Addiction Services

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Connecticut Department of Mental Health and Addiction Services
A Healthcare Services Agency
“Natural history” of serious mental illness

Symptoms

Severe

Remission

Time

Acute symptoms and quiescence
Acute and Quiescent Phase 
Symptoms of Schizophrenia

Positive Symptoms (acute phase)
- Hallucinations
- Delusions
- Bizarre behavior
- Thought disorder

Negative Symptoms (quiescent phase)
- Flatten affect
- Poverty of speech
- Apathy
- Social inattentiveness and isolation
Mental illness as too often viewed by the funder and/or service provider.
Typical service response

- Acute symptoms
- Discontinuous treatment
- Crisis management

Severe

Symptoms

Remission
Recovery-oriented response

Severe

Symptoms

Continuous treatment response

Remission

Promote Self Care, Rehabilitation
What should the provider strive to achieve and the funder support?

- Functional improvement
- Not just symptom reduction

Symptoms
- Severe
- Remission

Recovery-Oriented Model
Helping People Move into Recovery Zone

Severe

Remission

Symptoms

Improved client outcomes

Time
Recovery Defined

“We endorse a broad vision of recovery that involves a process of restoring or developing a positive and meaningful sense of identity apart from one’s condition and a meaningful sense of belonging while rebuilding a life despite or within the limitations imposed by that condition.”
A Recovery-Oriented System

“A recovery oriented system of care identifies and builds upon each individual’s assets, strengths, and areas of health and competence to support achieving a sense of mastery over his or her condition while regaining a meaningful, constructive, sense of membership in the broader community.”
Best Practices
Evidence-Informed Not All Best Practices are Evidence-Based Practices

Evidence-Based

Evidence-Supported

Evidence-Informed

Evidence-Suggested
SAMHSA Toolkits

National Evidence Based Practices Project

1. ACT - Assertive community treatment
2. Illness management and recovery skills
3. Standardized pharmacological treatment
4. Family psychoeducation
5. Supported employment
6. IDDT - Integrated dual diagnosis treatment, for co-occurring mental illness and substance use disorders
Assertive Community Treatment

- Comprehensive services
- Provided by Interdisciplinary Team
- 1:10 staff/client ratio
- 10-12 staff to 100 clients
- In the community – not in office or clinic
- 24 hour – 7 day week access
Illness Management and Recovery

- Weekly individual or group educational sessions
- Over 3-6 months
- 9 topic areas:
  - Recovery Strategies
  - Practical Facts about Mental Illness
  - The Stress-Vulnerability Model and Strategies for Treatment
  - Building Social Support
  - Using Medication Effectively
  - Recovery Strategies
  - Reducing Relapses
  - Coping with Stress
  - Coping with Problems and Symptoms
  - Getting Your Needs Met in the Mental Health System
Standardized Pharmacological Treatment

- Issue/Problem
  - Medications – often essential to recovery
  - Wide variations in practice
  - Practice guidelines not followed

- Solution
  - “MedMAP” or “Medication Algorithms”

(Make any sense to you?)
Family Psychoeducation

- Helps reduce inpatient readmissions
- Helps families cope
- Increases clinician understanding of family dynamics and how to foster recovery
5 Supported Employment

- In a recovery-oriented system:
  - Work helps people heal
  - You don’t have to be healed to work
Putting People to Work

Enhancing Employment and Self-Sufficiency through Vocational Rehabilitation

The likelihood that a person served by DMHAS will become gainfully employed is more than doubled when he/she receives vocational rehabilitation.

It pays!! It pays!! It pays!!
EARN Program
The Employment and Recovery Network

- **Individual Placement and Support (ISP) Model**
  - Integrated employment and clinical supports
  - Zero exclusion policy
  - Individualized goal planning
  - Rapid job search
  - Time-unlimited supports
  - Employer education and support
  - Ongoing work-based assessments

Job Placement Rate 64%
Integrated Dual Disorders Treatment

For Co-occurring Psychiatric and Substance Use Disorders

- 80 – 20 Rule
- High risk for the person and the community
- Costly and not well treated in traditional systems
- Successful treatment strategies exist
Innovative Programs
Supportive Housing

- Affordable housing linked to flexible, accessible supportive services that help people live more stable, productive lives.

- Tenant pays no more than 30%-50% of household income towards rent, and ideally no more than 30%, and has individual lease or similar agreement.

- There is a working partnership that includes ongoing communication between supportive services providers, property owners or managers, and/or housing subsidy programs.
Supportive Housing Costs

Cost of Supportive Housing in Connecticut compared to alternative forms of care used by homeless people with behavioral health needs.

Cost - per day per person

- Shelter: $24
- SUPPORTIVE HOUSING: $47
- Prison: $83
- Residential Substance Abuse Treatment: $103
- Nursing Home: $232
- Inpatient Psychiatric: $1,089
- Hospital: $1,287

SHELTER SUPPORTIVE HOUSING PRISON RESIDENTIAL SUBSTANCE ABUSE TREATMENT NURSING HOME INPATIENT PSYCHIATRIC HOSPITAL
Jail Diversion and Community Re-entry

Reduces:
- incarceration rates
- recidivism

Enhances:
- public safety
- humane alternatives
- options for judges
- efficiency of criminal justice system
- cost effectiveness
Phases of Diversion/Re-Entry

**Criminal Justice System**

- Arrest
- Booking
- Court
- Probation
- Jail
- Prison
- Release

**Diversionary Programs**

- Prevention of Arrest
- Diversion before Booking
- Diversion before Adjudication
- Planning for Return to Community

*The earlier the diversion is in the process the better*

- Effectiveness of Intervention More Likely
- Violation of Rights Less Likely

Graphic courtesy: David L. Bazelon Center for Mental Health Law, Washington, DC
Specialized Intensive Supports

- ASO identifies people with 3 or more acute hospital admissions within 90 days
- Recovery manager initiates contact while person is still in hospital
- Recovery plan developed to fill support gaps
- Recovery manager helps with transition to community care

56% reduction in acute care episodes!
Sample Recovery Zone
Sustainer Strategies

- Peer to Peer grant awards
- Trained Peers in healthcare settings
- Recovery Followup telephone calls
- “Citizenship” Training
- Elders in Recovery
- “Advocacy Unlimited” Training
Helping People Move into and Flourish within the Recovery Zone

Improved recovery outcomes for the person

Severe

Remission

Recovery Zone
Many Paths to Recovery
Implementing a Recovery-Oriented System of Care
Organizational and Workforce Development
Factors Influencing Quality and Outcomes in Recovery

<table>
<thead>
<tr>
<th>Best Practices &amp; Innovative Programs</th>
<th>Workforce Prep</th>
<th>Organizational Factors</th>
<th>External Factors</th>
<th>Quality/Outcomes</th>
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Key Policy Issues/Questions

- Do you want bricks and mortar or people living communities with natural supports?
- Should we focus on healthcare costs or on the cost of disability and disease?
- How do we widen and reinforce the Recovery Zone for people with disabilities?
- Should mental health be “The Agenda” or part of “Every Agenda?”
- Are we talking about spending more or less, or spending differently?
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Additional General Information
Recovery-Oriented Value-Driven Practitioner (Clinical) Program (Provider) System (Policy)

Culturally competent Workforce Development Fidelity to model

Convey Hope and Respect Organizational and Programmatic Design

Best Practices and Innovative Programs
Voices of Recovery

"Having hope"

"Getting well/ getting better"

"Having same rights as others"

"Making choices"

"Doing everyday things"

"Making changes, having goals"

"Staying clean and sober"

"Starting over again"

"Looking forward to life"

"Be looked at as whole people"

"Getting well and getting better"
Strategies for Change

- Multi-year implementation process
- Big tent approach to consensus building
- Use technology transfer strategies to identify, develop, implement and sustain “best practices”
- Incorporate existing initiatives
- Re-orient all systems to support recovery
- Transition to recovery-oriented performance outcomes in a non-punitive approach
## Implementation Plan: Examples

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<th>Phase I</th>
<th>Phase II</th>
<th>Phase III</th>
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<tbody>
<tr>
<td><strong>Philosophical/Conceptual</strong></td>
<td>• Build Consensus on Definitions</td>
<td>• Identify Implications</td>
<td>• Address stigma within other systems and the community</td>
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<td></td>
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<td>• Dog &amp; Pony Shows</td>
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<td><strong>Competencies, Skills &amp; Programs</strong></td>
<td>• Evaluate Approaches</td>
<td>• Skills Training</td>
<td>• Advanced training</td>
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<td></td>
<td>• Baseline Assessment</td>
<td>• “Centers of Excellence” (Pilot Recovery Practices)</td>
<td>• TA/Knowledge Transfer</td>
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<td><strong>Fiscal/Administrative</strong></td>
<td>• Identify Barriers &amp; Incentives</td>
<td>• Solution-focused workgroups</td>
<td>• Performance Measures</td>
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<td>• Develop Fiscal Support</td>
<td>• Implement Policy/Resource Changes</td>
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Utilize a consensus process throughout the implementation
Building the System

Education, training and workforce development
Service Enhancement
Control and Participation
Laying the foundation
Anchors

Cultural Competency Training
Recovery Institute
Public Education

Vocational Services
Housing Supports
Peer Directed Services

Person Centered Recovery Plan
Advance Directives
Olmstead Initiatives
Flexible Service Funding

Recovery Steering Committee
CSAT Consultation
CMHS Consultation
DMHAS Advisory Council
Provider Recovery Assessment

Commissioner’s Policy Statement

Quality System of Care

Advocacy
Community
Leveraging Supportive Housing

State, Federal and private-sector investments - per unit, per year - Services, operating subsidies and capital development

The Connecticut Experience