

State Best Practices and Innovative Program Examples

Council of State Governments
Coronado, California

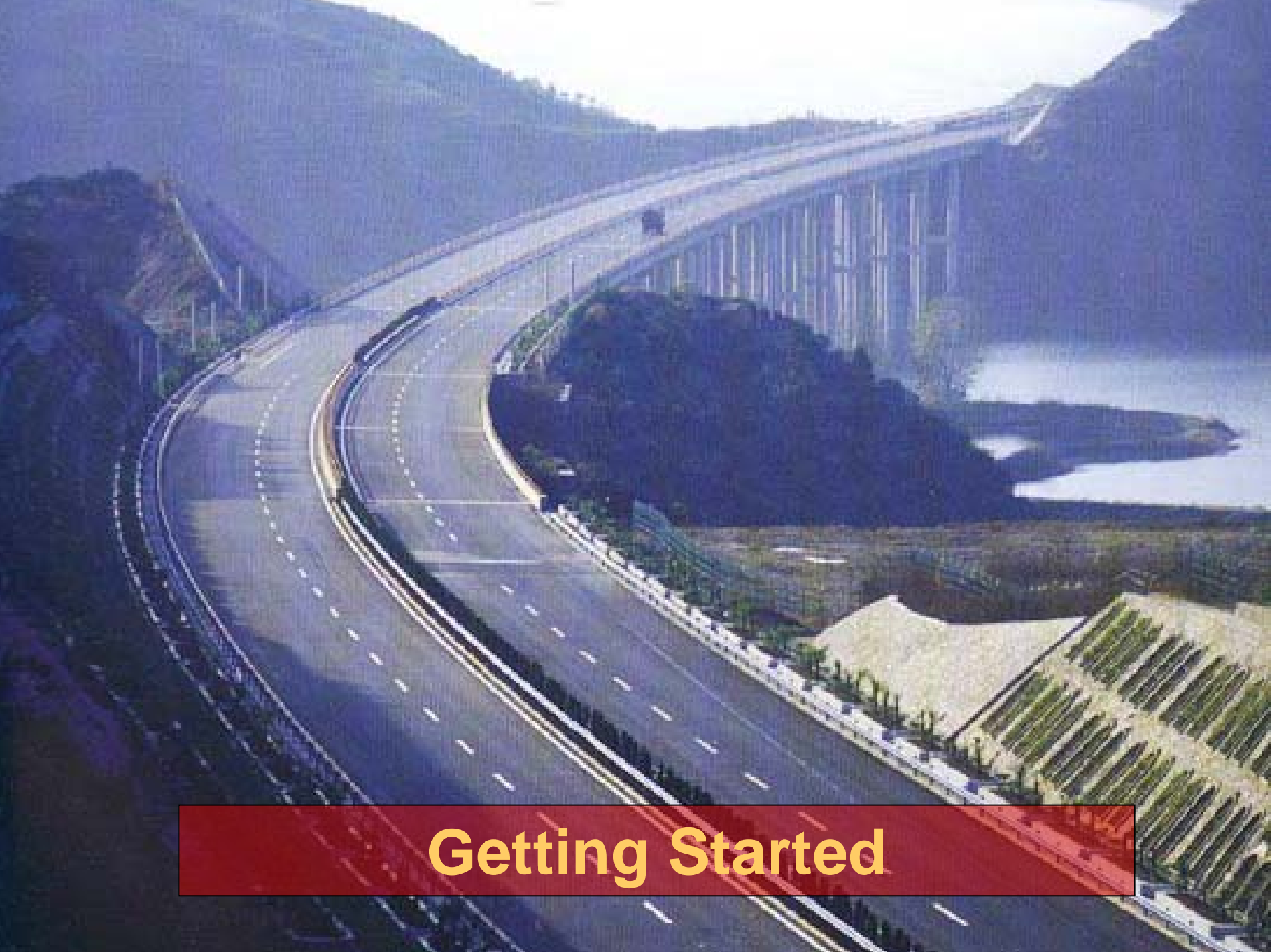
Thomas A Kirk, Jr., Ph.D., Commissioner
Connecticut Department of Mental Health and Addiction Services

June 1, 2006



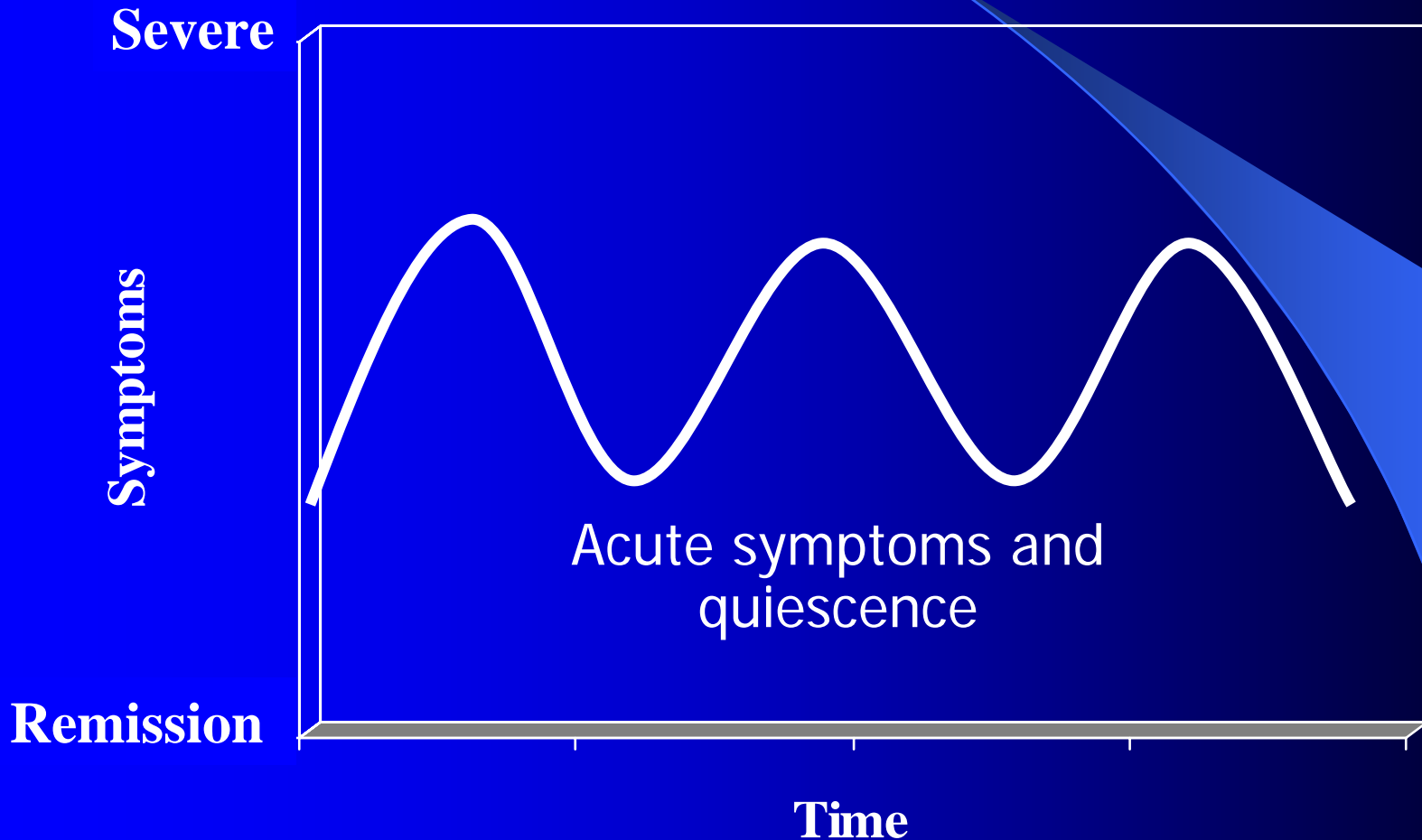
Connecticut Department of Mental Health and Addiction Services
A Healthcare Services Agency





Getting Started

“Natural history” of serious mental illness



Acute and Quiescent Phase Symptoms of Schizophrenia

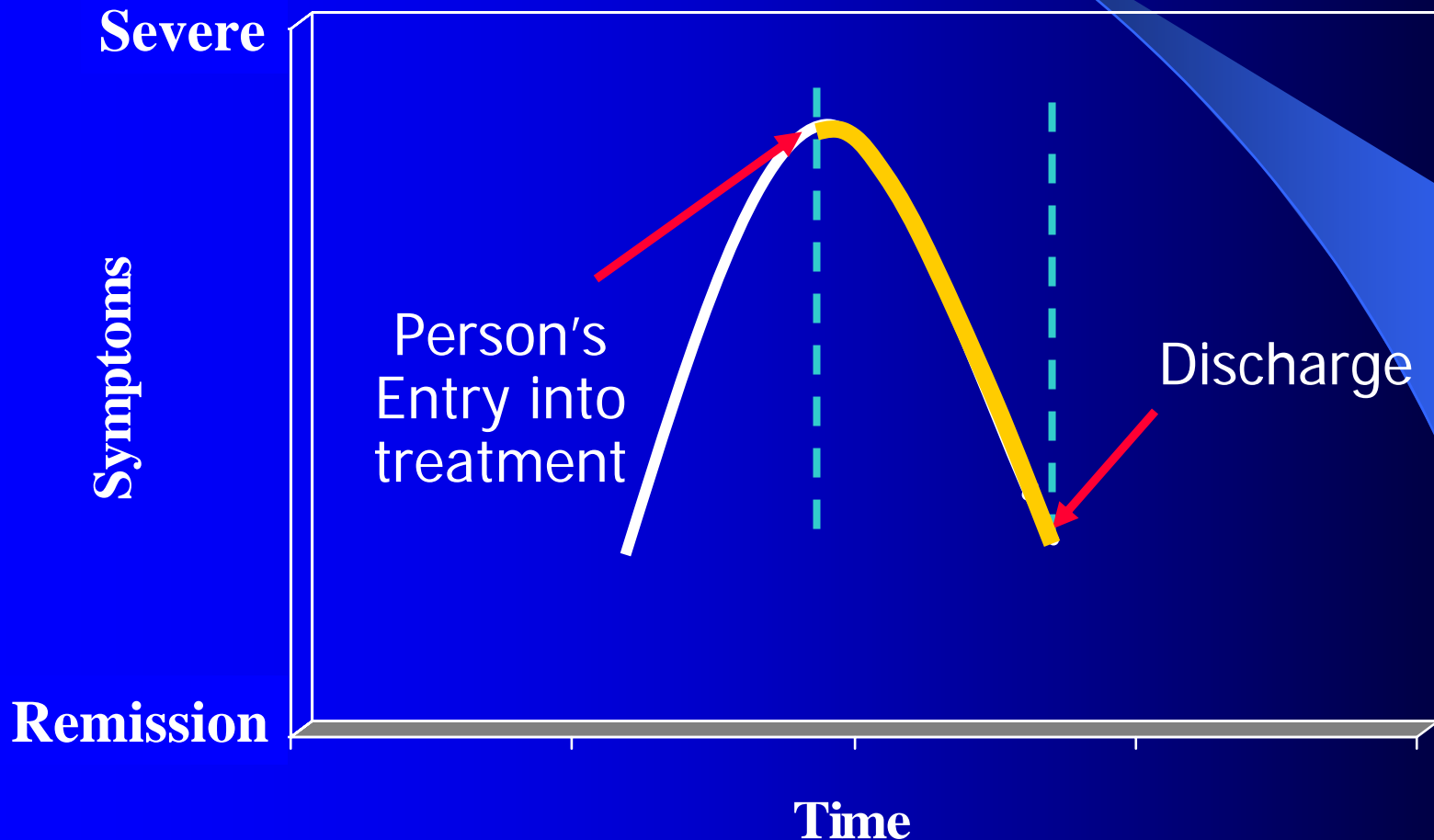
Positive Symptoms (acute phase)

- Hallucinations
- Delusions
- Bizarre behavior
- Thought disorder

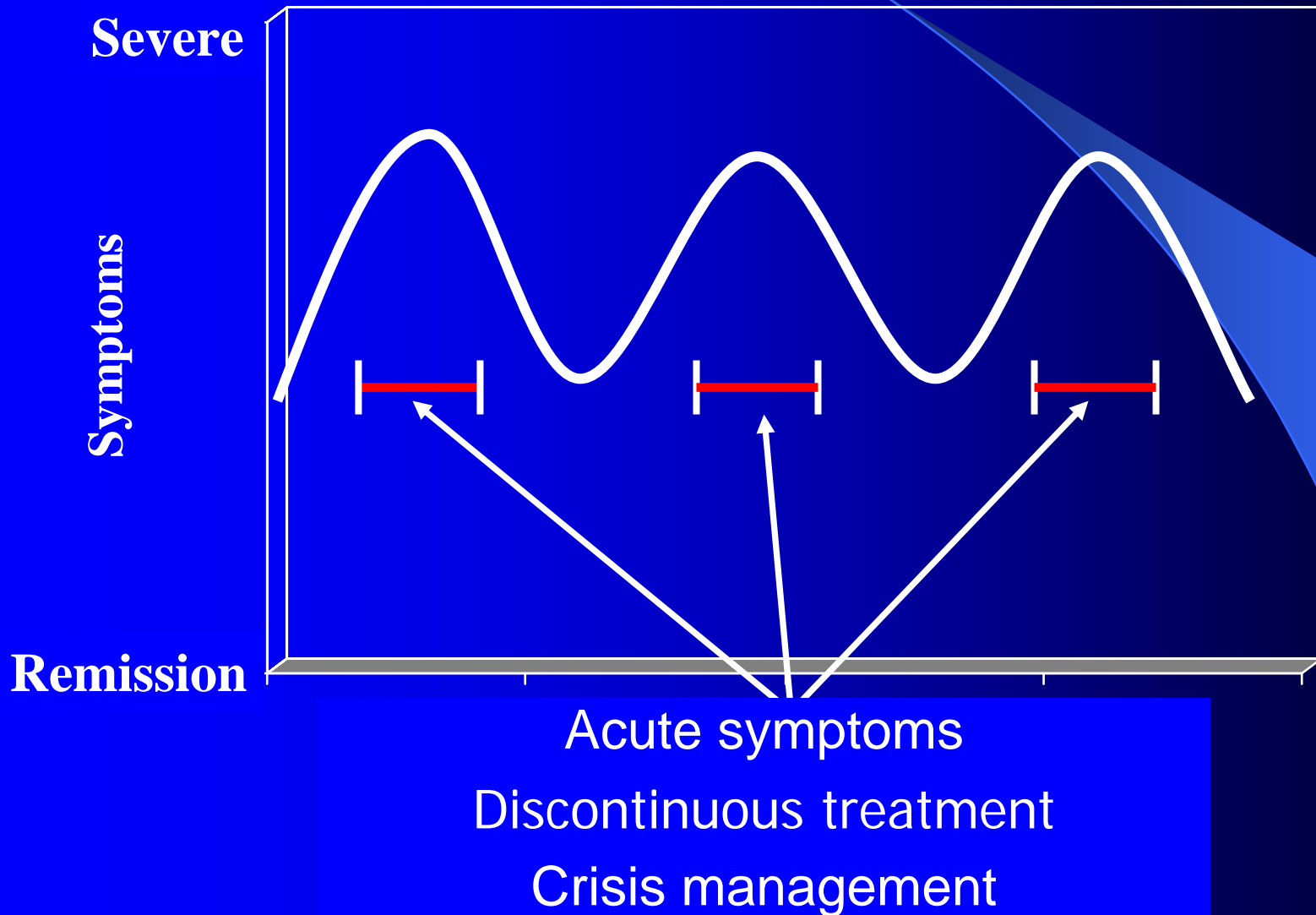
Negative Symptoms (quiescent phase)

- Flatten affect
- Poverty of speech
- Apathy
- Social inattentiveness
and isolation

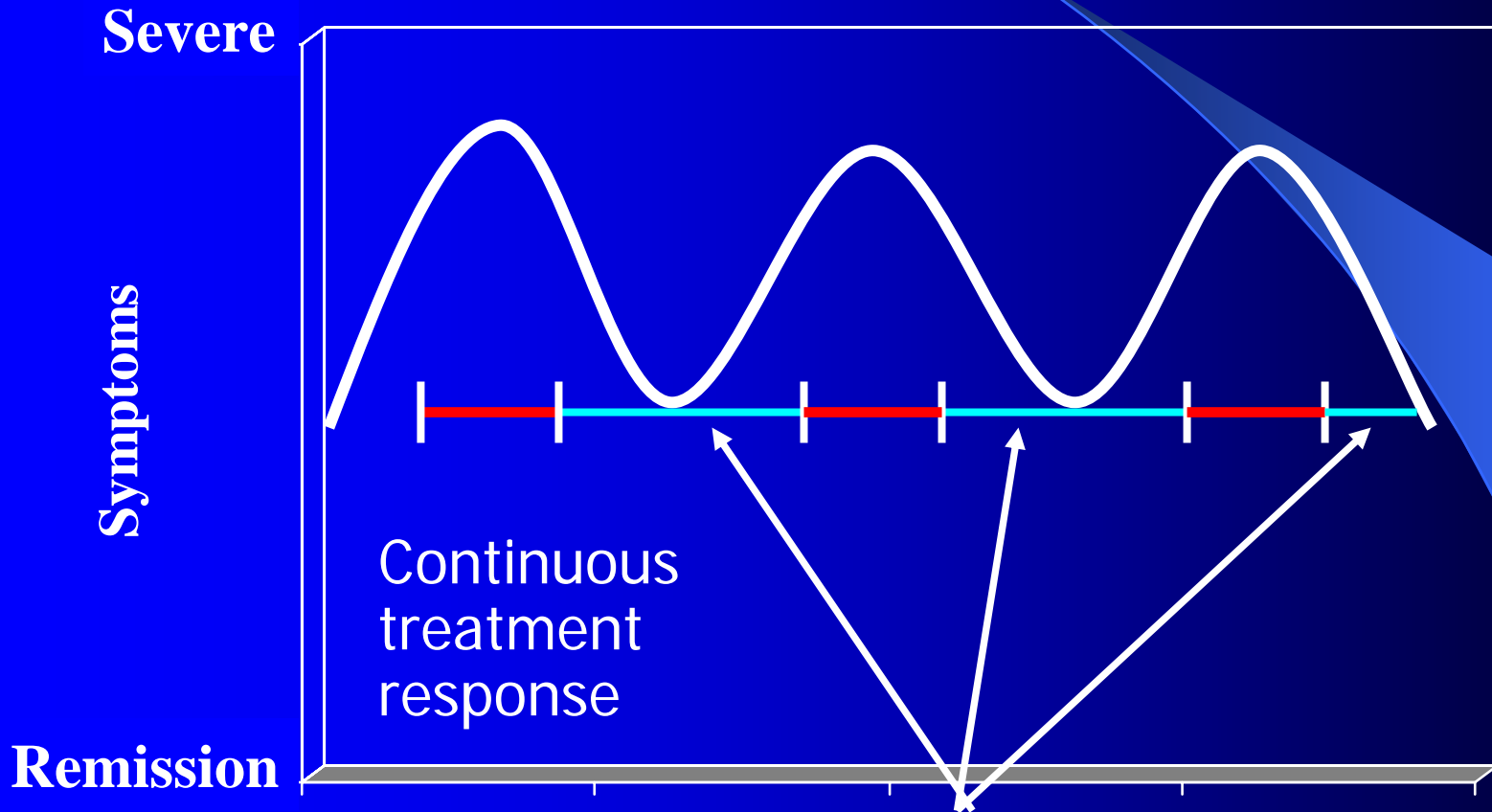
Mental illness as too often viewed by the funder and/or service provider



Typical service response

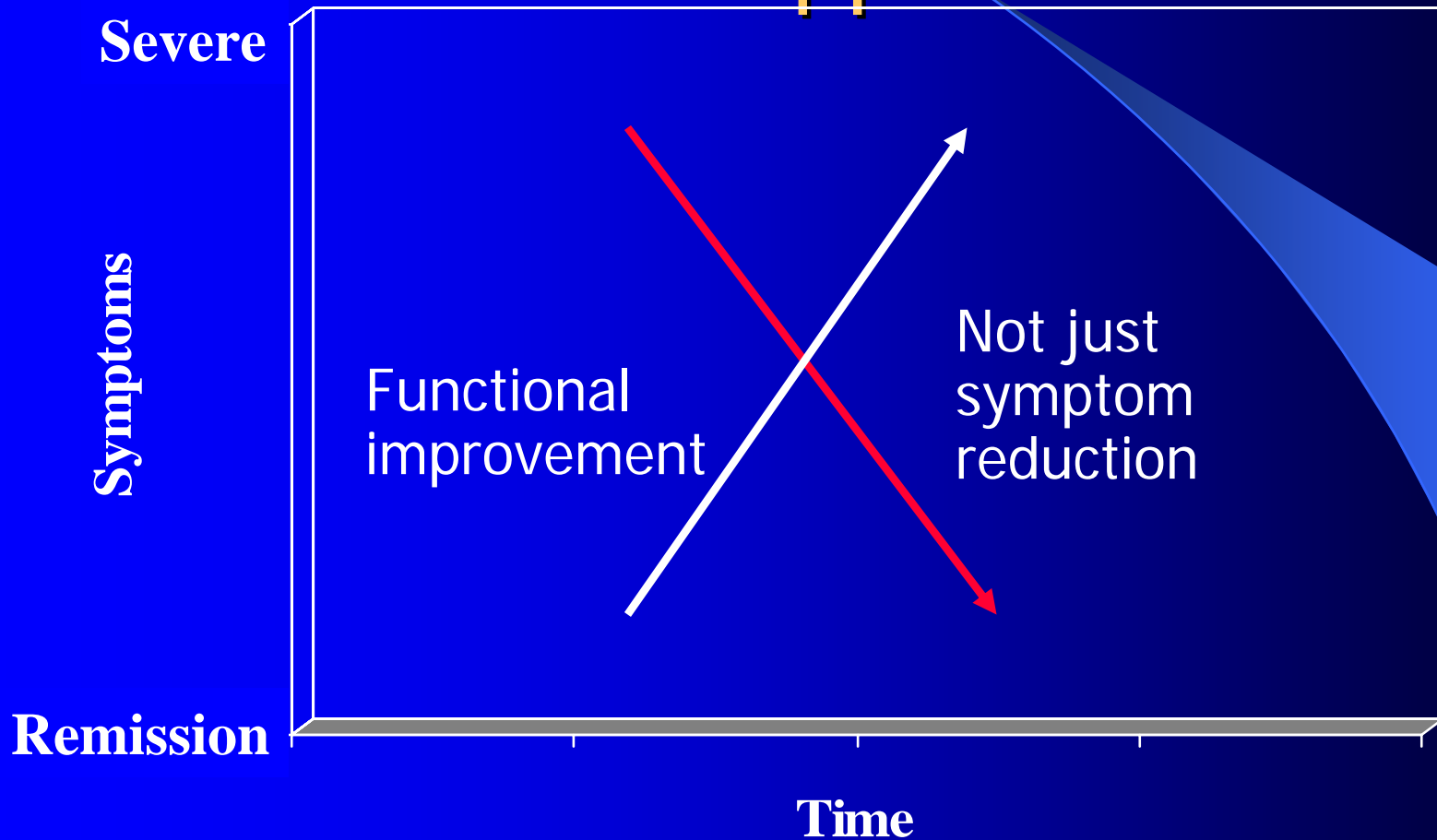


Recovery-oriented response



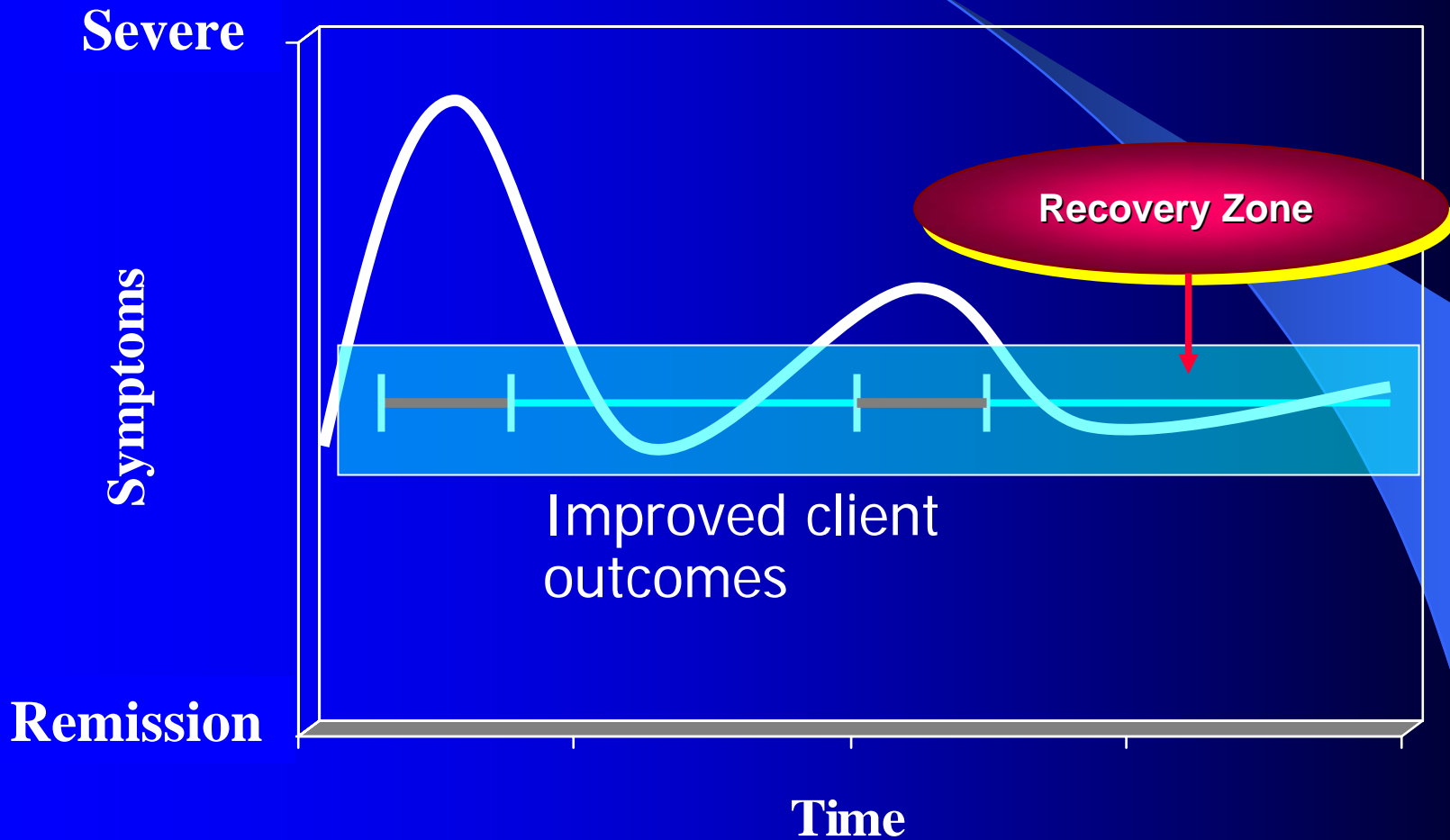
Promote Self Care, Rehabilitation

What should the provider strive to achieve and the funder support?



Recovery-Oriented Model

Helping People Move into Recovery Zone



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

Not All Best Practices are Evidence-Based Practices



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



1 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



2

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

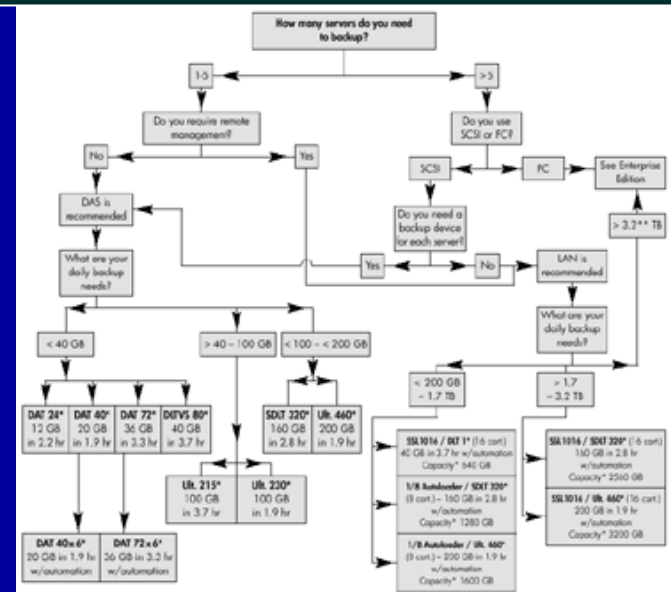


3

Standardized Pharmacological Treatment

- Issue/Problem
 - Medications – often essential to recovery
 - Wide variations in practice
 - Practice guidelines not followed
- Solution
 - “MedMAP” or “Medication Algorithms”

Medication Decision Tree Protocol



(Make any sense to you?)

4 Family Psychoeducation

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



5 Supported Employment

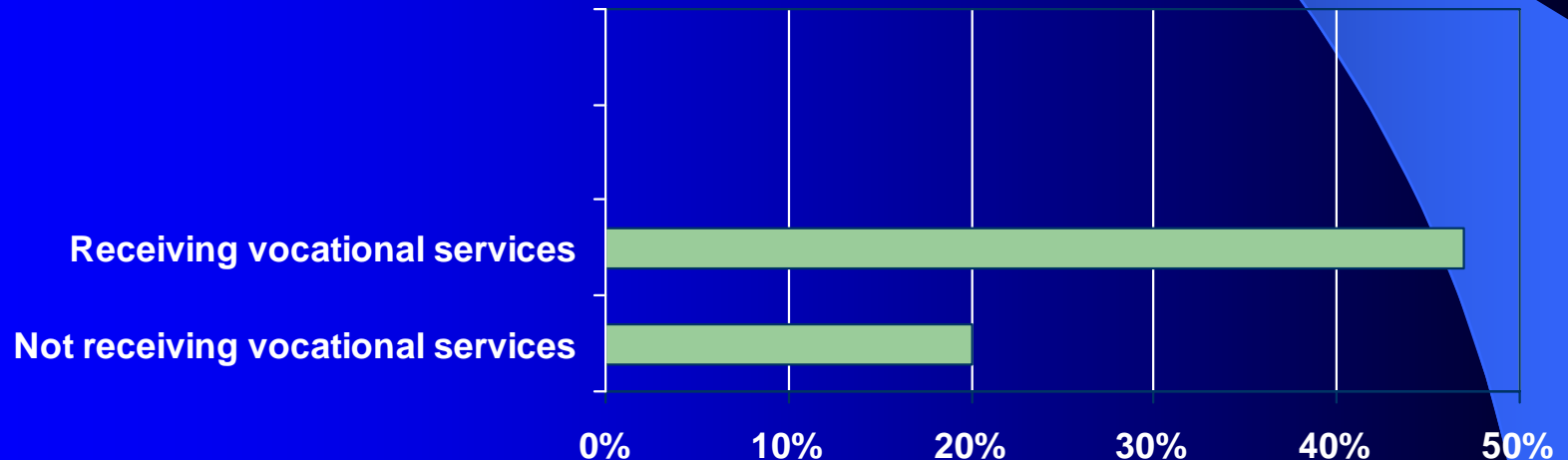
- In a recovery-oriented system:
 - Work helps people heal
 - You don't have to be healed to work



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.



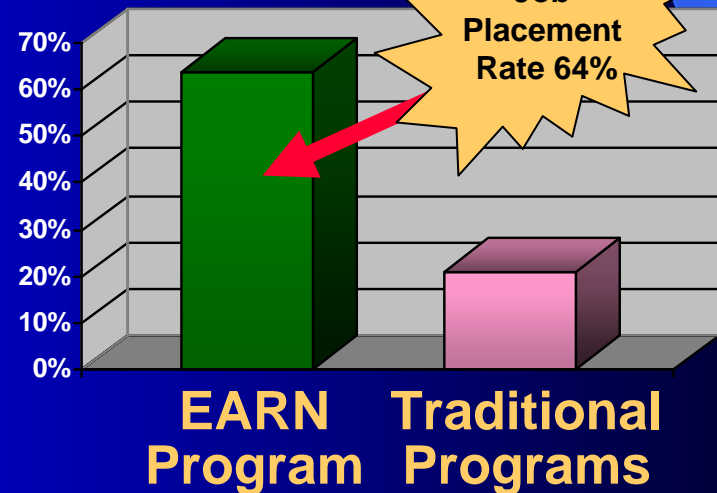
It pays!!

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



6

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



The image features the text "Innovative Programs" in a bold, 3D, sans-serif font. The text is rendered in a gradient of yellow and orange, giving it a three-dimensional appearance. It is set against a dark blue background that transitions to a lighter blue at the top. A bright blue spotlight beam illuminates the text from the right side, creating a strong contrast and highlighting the words. The overall composition is dynamic and modern.

**Innovative
Programs**

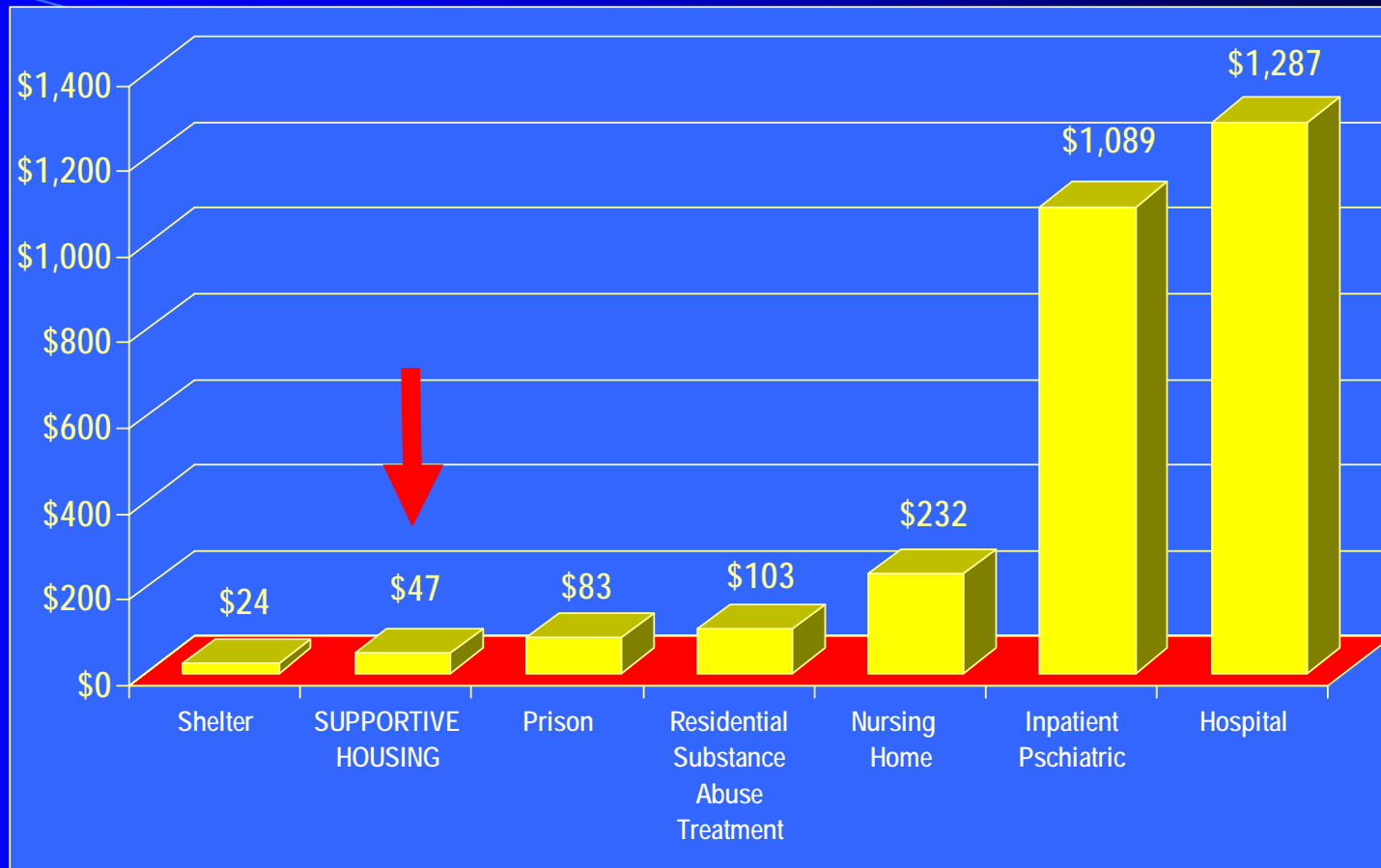
Supportive Housing



- 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

Jail Diversion and Community Re-entry

Reduces:

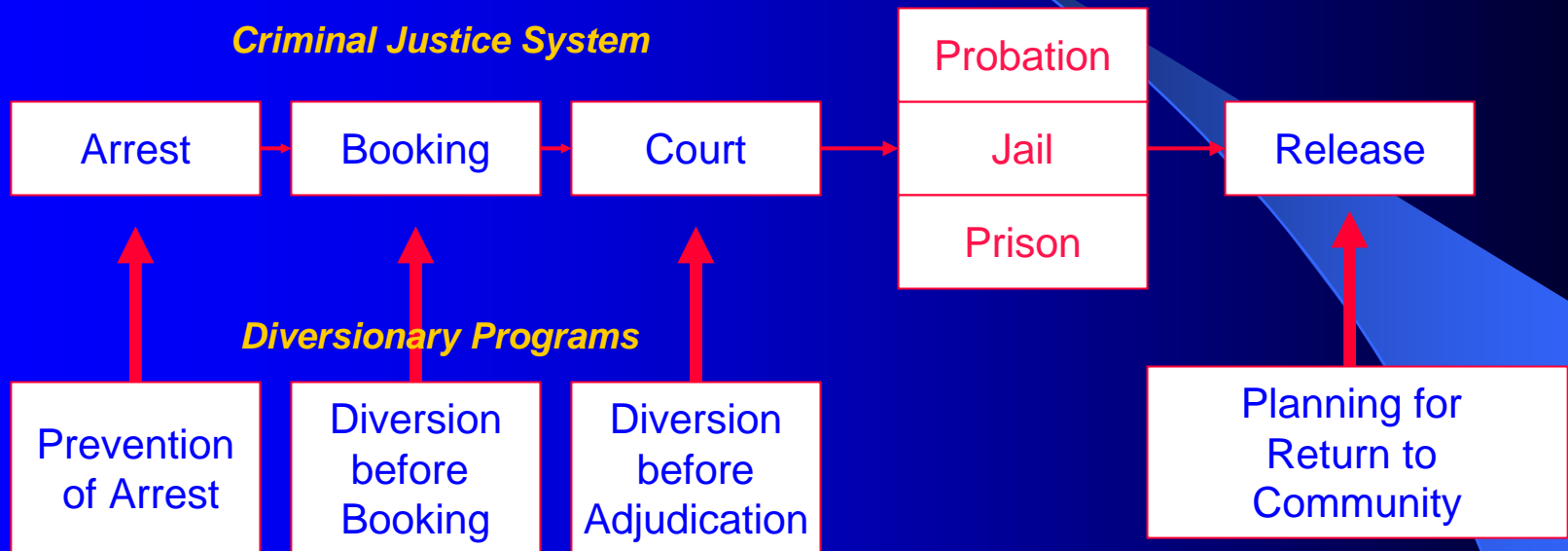
- incarceration rates
- recidivism

Enhances:

- public safety
- humane alternatives
- options for judges
- efficiency of criminal justice system
- cost effectiveness



Phases of Diversion/Re-Entry



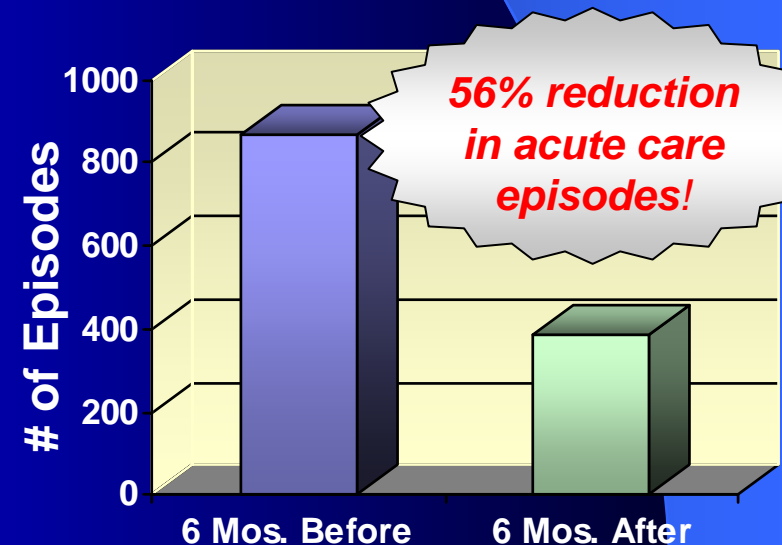
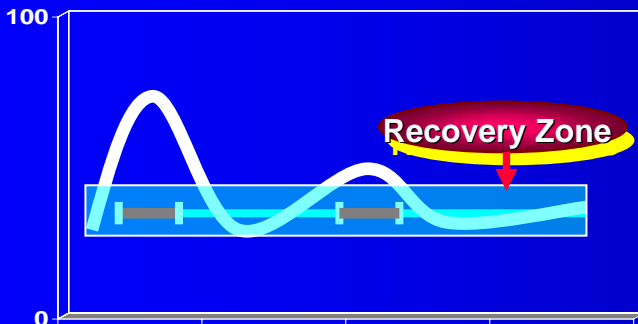
← *The earlier the diversion is in the process the better*

Effectiveness of Intervention More Likely

Violation of Rights Less Likely

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

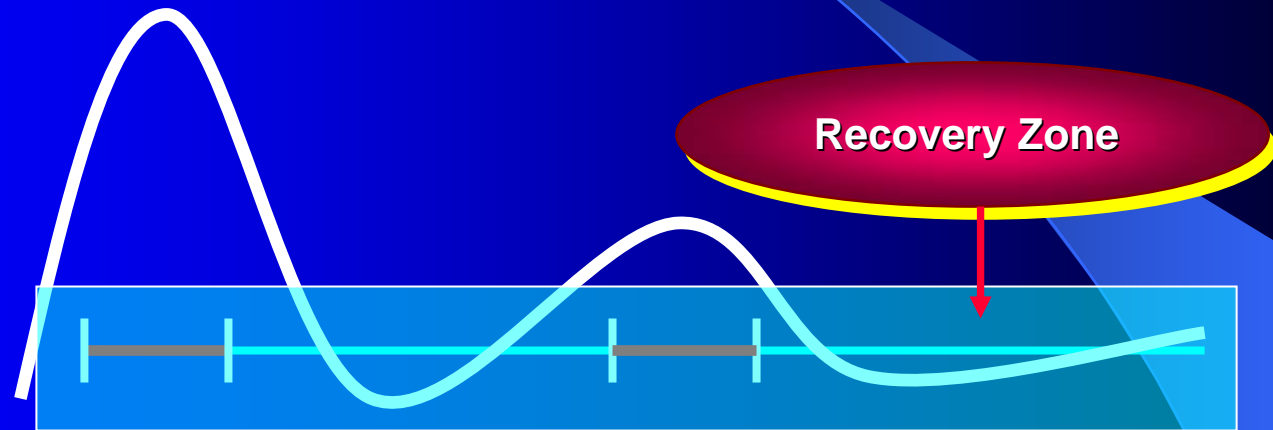


Sample Recovery Zone Sustainer Strategies

- 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

Severe



Improved recovery
outcomes for the
person

Remission



Many Paths to Recovery

**Implementing
a
Recovery-oriented
System of Care**



Organizational and workforce Development



Factors Influencing Quality and Outcomes in Recovery



1.0	1.0	1.0	1.0	1.000
0.8	0.7	0.7	0.6	0.235
1.0	0.7	0.7	0.6	0.294
0.8	1.0	1.0	0.6	0.480

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?

CONTACT INFORMATION

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Connecticut Department of Mental Health and Addiction Services
A Healthcare Services Agency

**Additional
General
Information**

System
(Policy)

**Recovery-Oriented
Value-Driven**

Program
(Provider)

**Best Practices
and Innovative
Programs**

**Organizational
and Programmatic
Design**

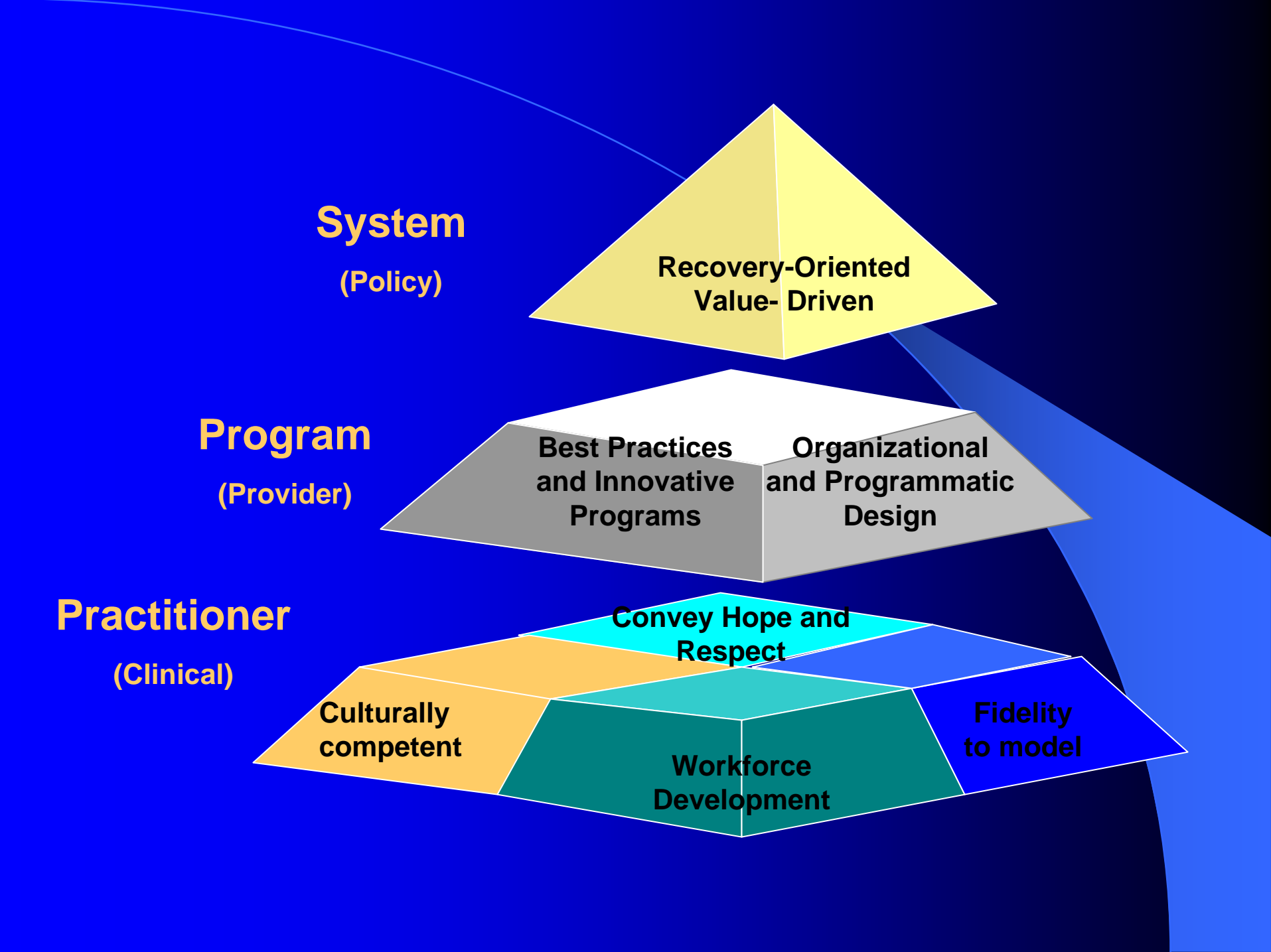
Practitioner
(Clinical)

**Convey Hope and
Respect**

**Culturally
competent**

**Workforce
Development**

**Fidelity
to model**



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"

"Be looked at as whole people"

"Looking forward to life"

Strategies for Change



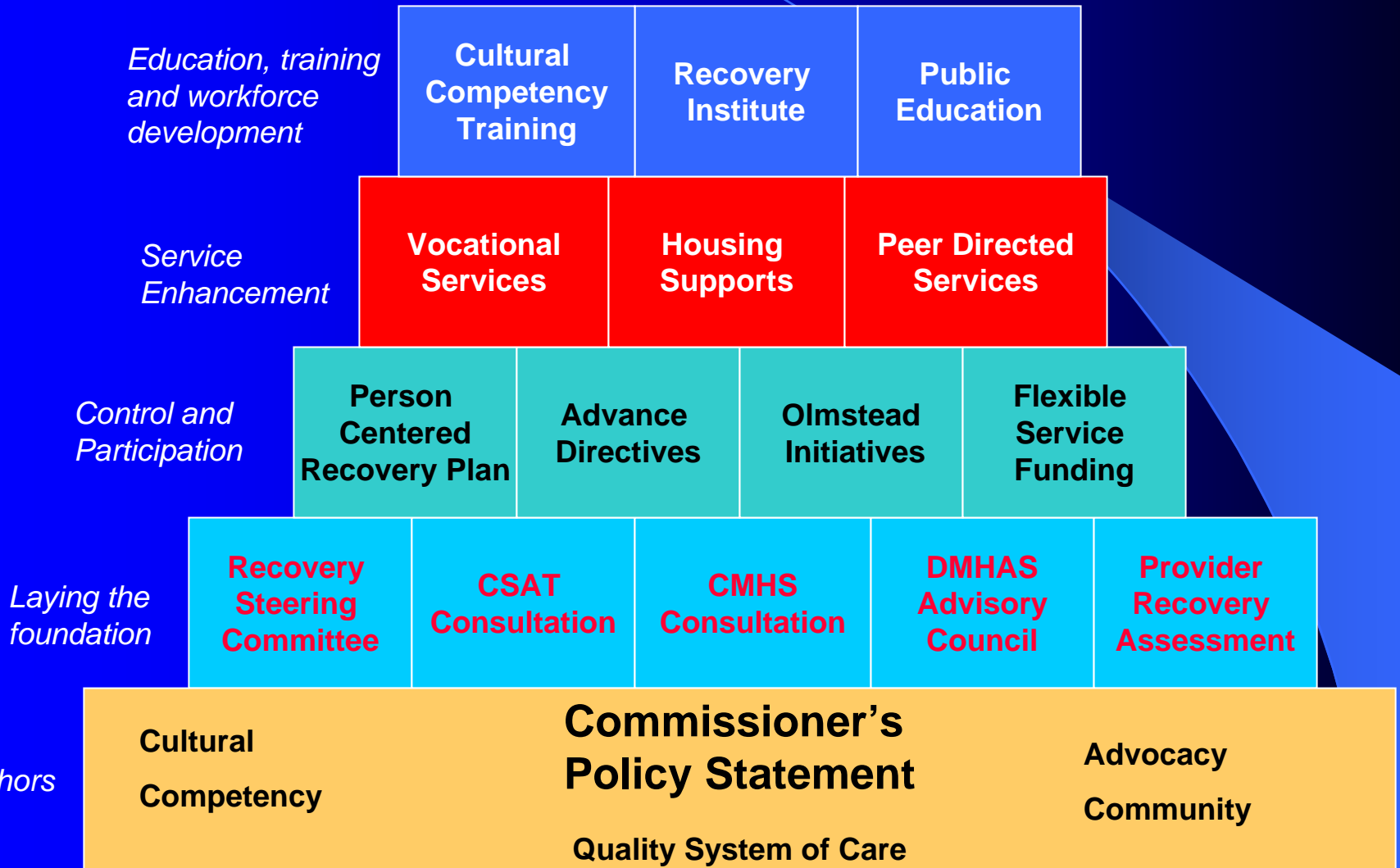
- Multi-year implementation process
- Big tent approach to consensus building
- Use technology transfer strategies to Identify develop, implement and sustain “best practices”
- Incorporate existing initiatives
- Re-orient all systems to support recovery
- Transition to recovery-oriented performance outcomes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

Implementation Plan: Examples

	Phase I	Phase II	Phase III
Philosophical/ Conceptual	<ul style="list-style-type: none"> • Build Consensus on Definitions 	<ul style="list-style-type: none"> • Identify Implications • Dog & Pony Shows 	<ul style="list-style-type: none"> • Address stigma within other systems and the community
Competencies, Skills & Programs	<ul style="list-style-type: none"> • Evaluate Approaches • Baseline Assessment 	<ul style="list-style-type: none"> • Skills Training • “Centers of Excellence” (Pilot Recovery Practices) 	<ul style="list-style-type: none"> • Advanced training • TA/Knowledge Transfer
Fiscal/ Administrative	<ul style="list-style-type: none"> • Identify Barriers & Incentives 	<ul style="list-style-type: none"> • Solution-focused workgroups • Develop Fiscal Support 	<ul style="list-style-type: none"> • Performance Measures • Implement Policy/Resource Changes

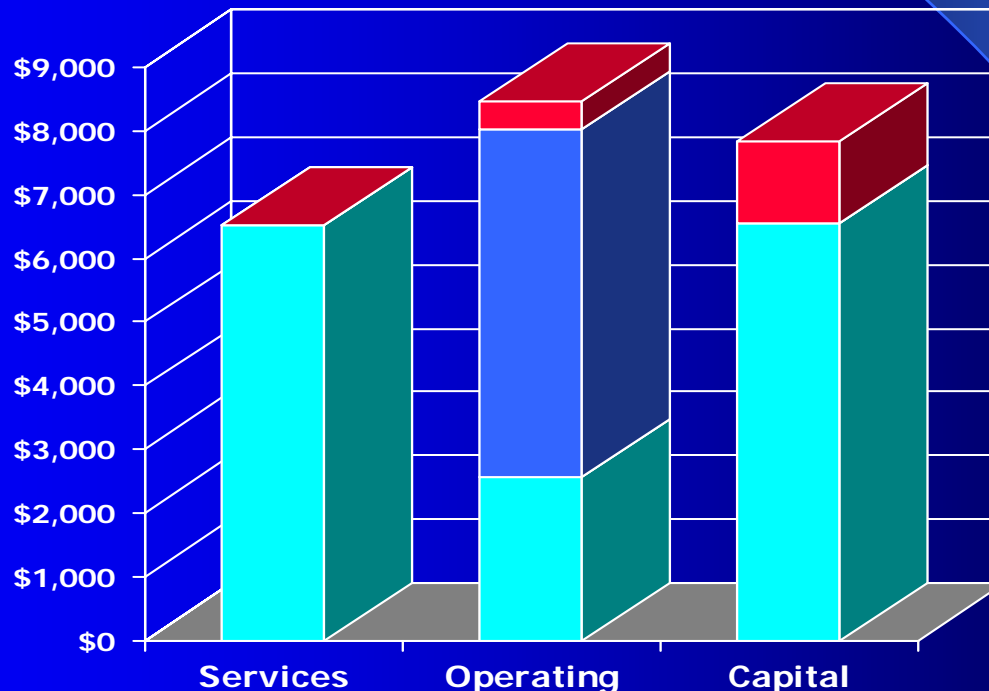
Utilize a consensus process throughout the implementation

Building the System



Leveraging Supportive Housing

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



■ State & CHFA ■ Federal ■ Private

CHFA = CT
Housing Finance
Authority

The Connecticut Experience