

CT MHT Excellence in Mental Health Care Workgroup (#5)

Wednesday, April 12, 2006

9:30 – 11:30 a.m.

Convener: Lauren Siembab

Major Topics/Discussion Points:

Presentation on evidence-based practices by DCF, including benefit to cost ratios calculated by Washington Institute for Social Policy (e.g., for each dollar spent on FFT, \$13.25 saved in other costs), and processes of and barriers to effective implementation. This is a possible interface area with Workgroup #7. Major issue in implementation (as opposed to workforce development) is the need for resources and infrastructure to support practices.

Review of completed and ongoing research projects on areas of interest, including studies on recovery, resilience, and consumer-driven services; identifying and eliminating health care disparities; efficacy, effectiveness, and limitations of psychotropic medications; trauma-sensitive interventions; strengths-based case management; interventions for adults with co-occurring disorders and those involved with the criminal justice population. Most of these studies have been funded externally (by federal and foundation sources).

What might be facilitative of further, and clinical and policy-relevant, research would be infrastructure support to put into place a data management system that includes rigorous assessments of outcomes that then are accessible to investigators. This could exponentially increase the pay off of research and evaluation activities for the system of care. Workgroup #6 may be addressing this need, and is encouraged to explore the utility of the AKAZA system out of Cambridge currently being considered as part of the National Governor's Association Infrastructure Grant. Another web-based system is being used by homelessness providers coordinated by the Connecticut Coalition to End Homelessness.

What about capacity? What can be done about the backlogs and wait times in the hospitals and emergency rooms? Access is a big problem. How can infrastructure dollars be used to increase capacity? Not just hospitals, but housing, the elderly, etc. Need for interface and continuity across programs, agencies, and episodes. Workgroup #6 is looking at some tools for this (e.g., electronic medical record). But also a focus on quality can increase capacity by maximizing available resources.

Potential first priority area: *getting the right services and supports to the right people, across the life plan, at the right time and within the least restrictive and expensive settings*; may need to be combined with managed approach to multiple need/multiple agency/multiple system clients who use disproportionate share of resources; also requires defunding interventions that cost more than they produce.

One prong would be identifying multiple system/multiple need clients, carrying out root cause analysis of how people end up such circumstances, and fixing these gaps/problems as we manage the care of such folks across agencies, systems, etc. Another prong would be to attend to increasing quality of services for less high utilizing clients who still would benefit more and require less care over time if they were served with higher quality services now. This can be done, in part, by being outcome-driven and basing this on client/family's own goals rather than on clinically-driven goals.

Potential second priority area: Housing, housing, housing, housing, and more housing.

Additional Barriers/Problems Identified:

Additional Ideas/Recommendations:

Transformation Activities in Connecticut Discussed in the Meeting:

To Do/Tasks: begin to draft paragraphs on issues described above

Next Meetings: Wednesday, April 26th, 2006. 9:30 – 11:30 a.m.