Federal Substance Abuse and Mental Health Service Administration

Recovery Support Services Meeting

Transforming to a Recovery-Oriented System of Care: The Connecticut ATR Experience

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A Healthcare Service Agency

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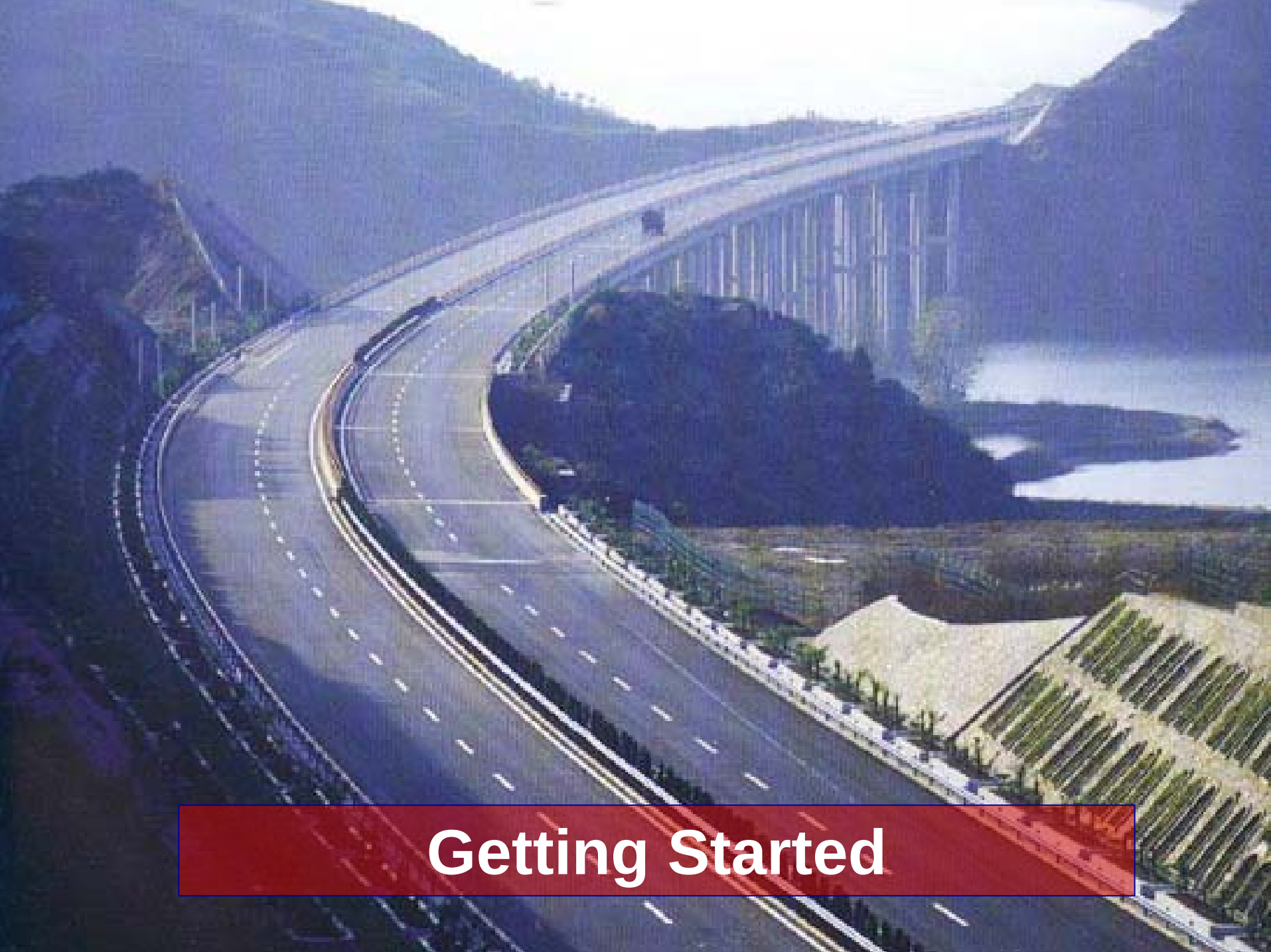


Getting Started

DMHAS' Systemic Approach to Recovery

- Develop core values and principles
- Establish conceptual and policy framework
- Build competencies and skills
- Change programs and service structures
- Align fiscal resources and administrative policies in support of recovery
- Monitor, evaluate and adjust

Recovery Core Values

Direction

- Equal opportunity for wellness
- Recovery encompasses all phases of care
- Entire systems to support recovery
- Input at every level
- Recovery-based outcome measures
- New nomenclature
- System wide training culturally diverse, relevant and competent services
- Consumers review funding
- Commitment to Peer Support and to Consumer-Operated services
- Participation on Boards, Committees, and other decision-making bodies
- Financial support for consumer involvement

Recovery Core Values

Participation

- No wrong door
- Entry at any time
- Choice is respected
- Right to participate
- Person defines goals

Programming

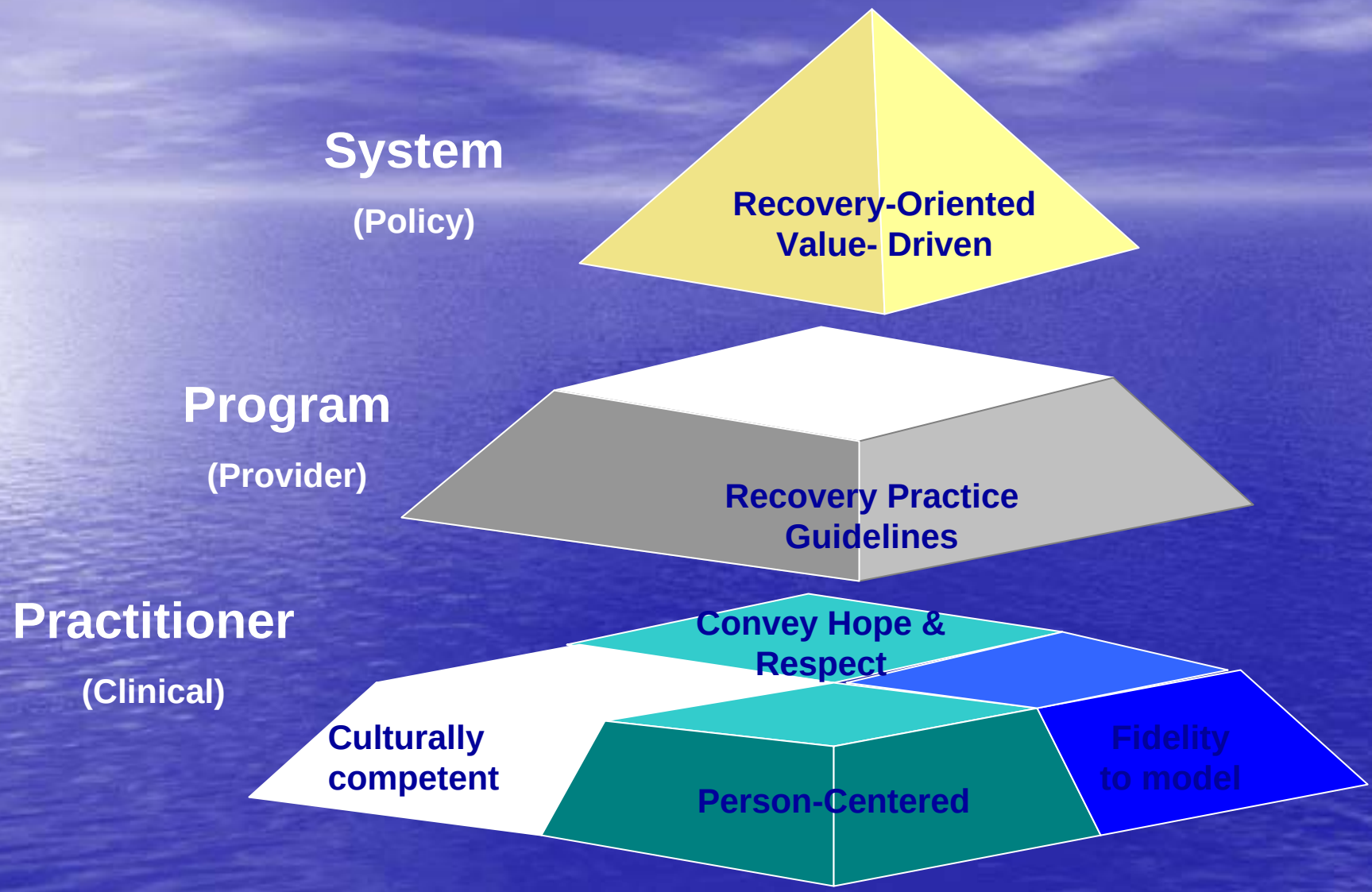
- Individually tailored care
- Culturally competent care
- Staff know resources

Funding-Operations

- No outcomes, no income
- Person selects provider
- Protection from undue influence
- Providers don't oversee themselves
- Providers compete for business

Strategy 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 providers to recovery-oriented performance outcomes in non-punitive manner


System
(Policy)
Recovery-Oriented
Value- Driven
Program
(Provider)
Recovery Practice
Guidelines
Practitioner
(Clinical)
Convey Hope &
Respect
Culturally
competent
Person-Centered
Fidelity
to model

Commissioner's Policy Statement # 83

"Promoting a Recovery-Oriented Service System"

- Defines recovery
- Establishes objectives for recovery-oriented system
- Commits DMHAS to statewide systems transformation

Signing the Commissioners Policy on Recovery

September 16, 2002

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."*

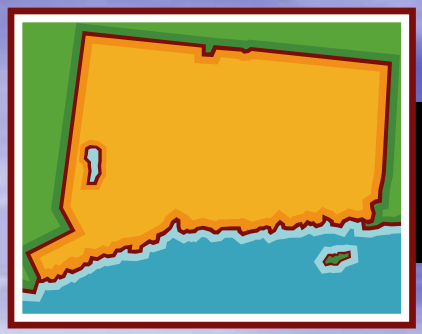

Many Paths to Recovery

ACCESS TO RECOVERY (ATR)

- Connecticut: 1 of 14 states awarded grant
- $22.8 million over 3 yrs.
- Non-traditional supports
- People exercise genuine and informed choice regarding all services
- Purchasing power influences provider actions
  - People vote with their feet

How Does ATR Fit Into CT's Larger Picture?

- ATR is not just another program, it represents a significant investment in the promotion and enhancement of the Department's overarching goal of a recovery-oriented system of care
- Our focus with ATR is on true systems change
- ATR builds upon a combination of previously undertaken steps and programs



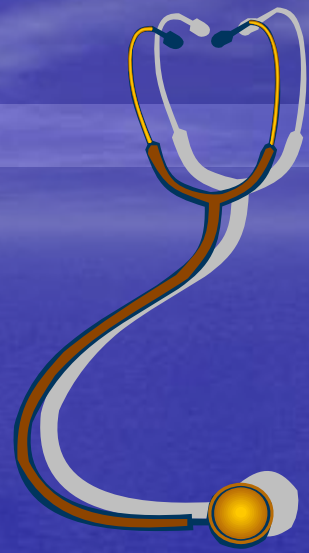
Connecticut's ATR Model

- High degree of collaboration with other targeted state agencies
- Five regional networks - a total of 36 clinical and 130 recovery providers (including peer and faith-based) to ensure client choice
- One lead agency in each network assisting with implementation, certification of providers, auditing, etc.

Collaborative Agencies & Programs

- Department of Correction
- Judicial Branch
- Department of Children and Families
- Department of Social Services
- Primary Healthcare Sites (Hospital ED & FQHC Sites)
- DMHAS-funded Outreach &
- Engagement Urban Initiatives

Clinical Services



- Evaluation
- Brief Treatment
- Ambulatory Detoxification
- Intensive Outpatient (IOP)
- Methadone Maintenance
- Recently implemented: an evidenced based model of IOP for individuals using cocaine and/or methamphetamines

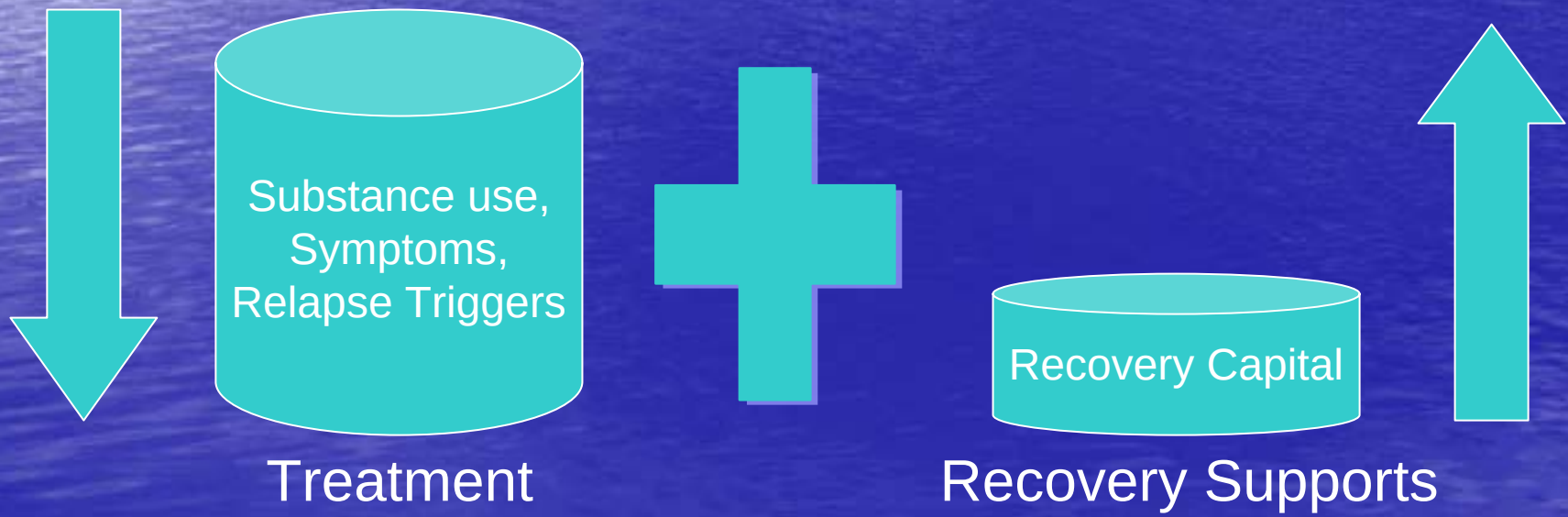
Recovery Support Services

- Short-term Housing
- Case Management
- Childcare
- Transportation
- Vocational/Educational Services
- Basic Needs (food, clothing, personal care)
- Faith-based Services
- Peer-based Services

Two thirds of CT's ATR service budget is invested in Recovery Support Services, not clinical services.

What are Recovery Support Services?

Complement the focus of treatment, outreach, engagement, and other strategies and interventions to assist people in establishing an environment supportive of recovery and in gaining the skills and resources needed to initiate and maintain recovery.



Recovery Capital is . . .

“the quantity and quality of both internal and external resources that a person can bring to bear on the initiation and maintenance of recovery” (W. White, 2006)

In contrast to people who achieve “natural” recovery (without care), most people with addictive disorders entering treatment have never had much recovery capital or have dramatically depleted such capital by the time they seek help.

Recovery Support Services aim to:

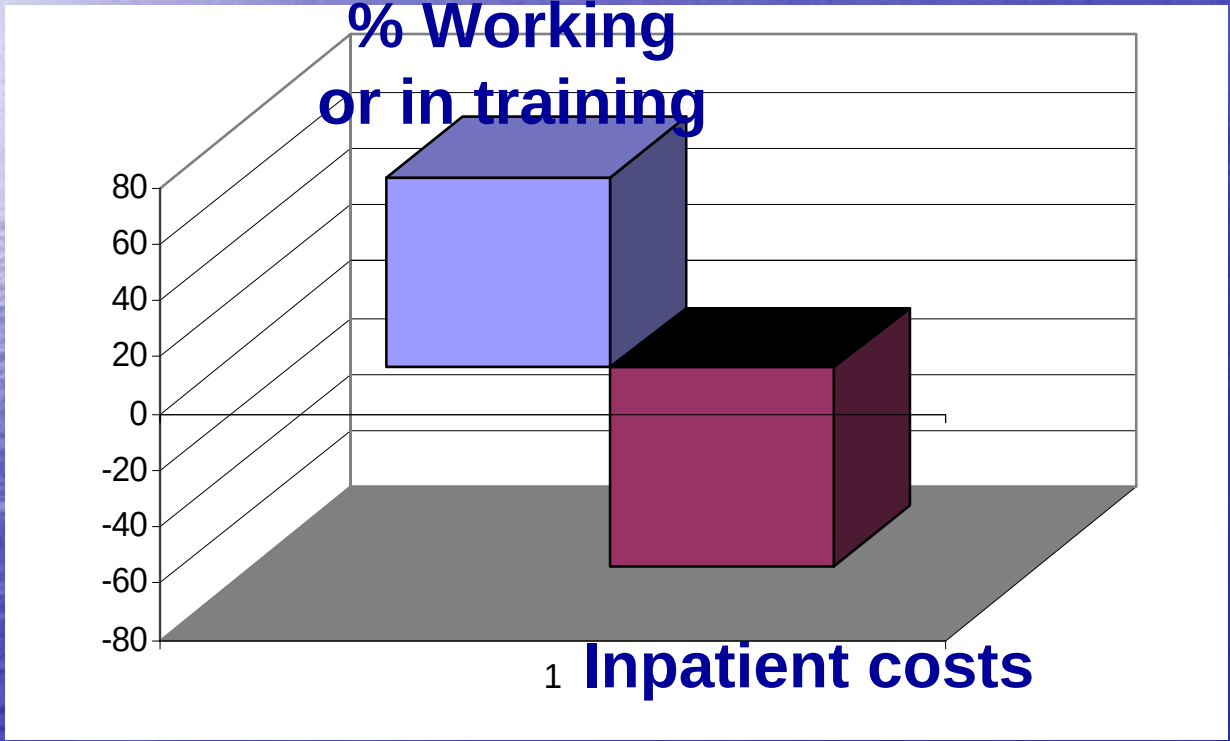
1) remove personal and environmental obstacles to recovery (e.g., through the provision of child care or transportation)
2) enhance identification of and participation in the recovery community (e.g., through connecting people to treatment and to 12-step and other mutual support/recovery-oriented groups)
3) enhance the person's "recovery capital" (e.g., by assisting people in addressing their basic needs, gaining employment, going back to school, forming sober social relationships, etc.)

Year To Date

August 3, 2004 – December 31, 2006

- Over 15,000 Unduplicated Individuals Served
- Received over 94,000 service level authorizations (clinical and/or recovery support services)
- Next GPRA upload (1/31/2007), we anticipate over 17,000 individuals served

More people working and in housing, less inpatient costs



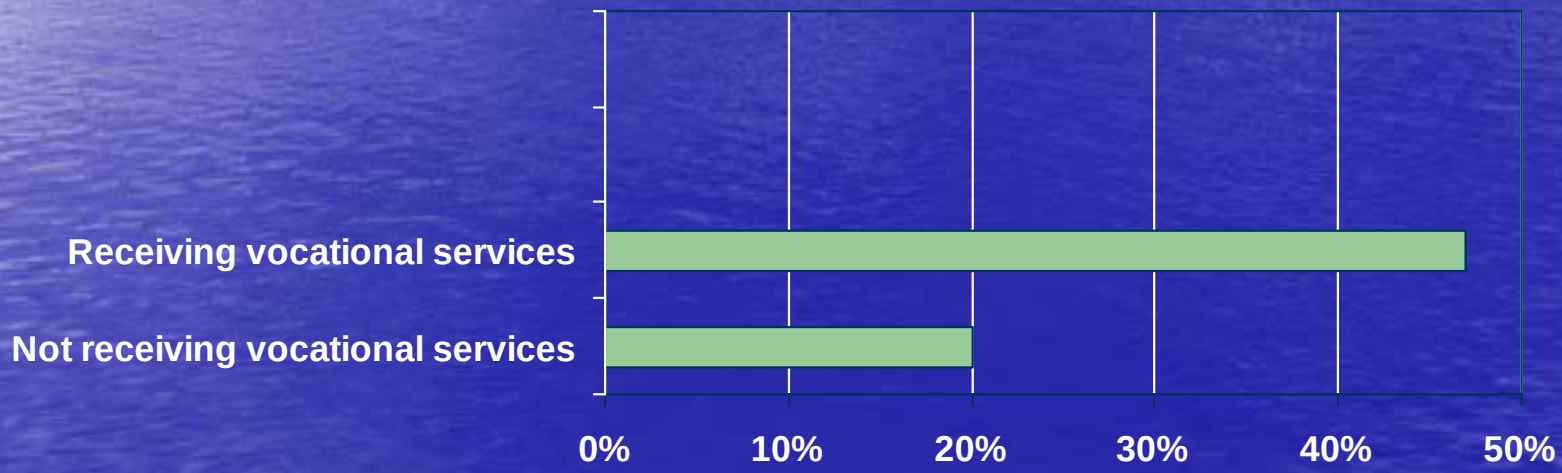
DMHAS established new supportive housing units for over 550 people with psychiatric or substance use disorders. Over 60% of these people are now working or in training, and their inpatient costs have decreased 70%.

Based on a Corporation for Supportive Housing study, these supportive housing units are projected to generate over $140 million in direct and indirect economic benefits for the state.

Putting People to Work

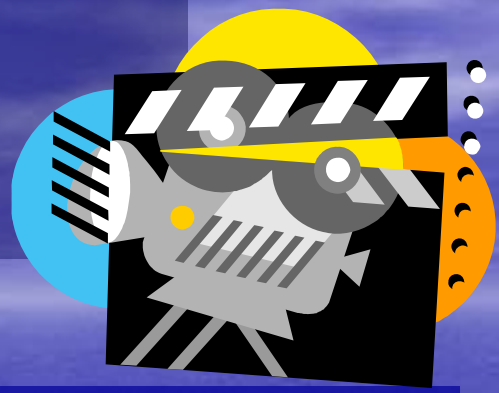
Enhancing Employment and Self-Sufficiency through Vocational Rehabilitation

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



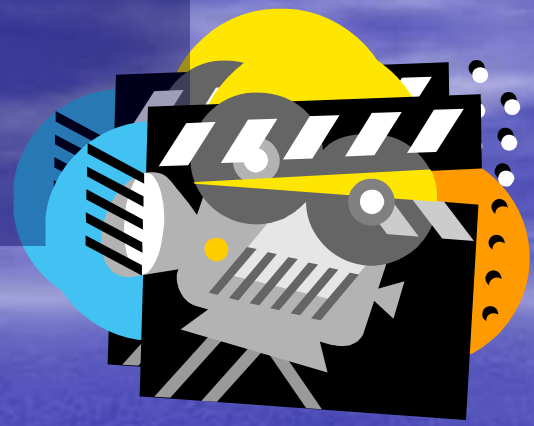
It pays!!

Client Vignettes



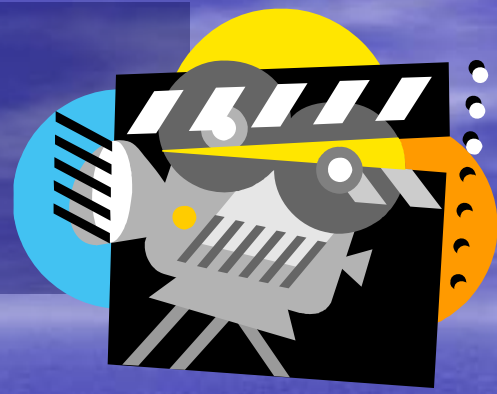
"Mary" prior to discharge from York Correctional Institute for Women, met with an ATR case manager to review discharge plans. "Mary", through informed choice, selected an intensive outpatient program from a list of providers and a faith-based housing provider from a list of housing providers. Additionally, the ATR case manager assisted "Mary" with transportation from the correctional facility to her housing provider. Once in the community, the housing provider submitted a request on behalf of "Mary" for food, clothing, personal care items and bus passes to attend her IOP program and look for employment.

Client Vignettes



“Jim” was referred from the Judicial Branch-Probation Division, with a history of crack, cocaine, and alcohol abuse. As an important milestone in his recovery, he was returning to work as an electrical contractor. **ATR** paid for textbooks required for the Electrical Code Review Contractor Course and for the course itself. **ATR** also assisted “Jim” in purchasing the electrical contractor tools required for employment.

Client Vignettes



“Karen” has been receiving substance abuse treatment funded by **non-ATR** sources since May 2005. She is becoming self-sufficient and is now in classes at the Stone Academy, with **ATR** covering textbook costs.

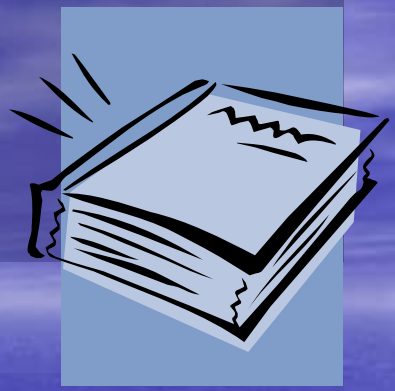
“Frank” requested and is receiving **ATR** financial assistance to cover the cost of a Faith-based Men's Retreat where people support each other in their recovery.

“Patti” is attending Hairdressing school, requested and received **ATR** assistance in purchasing hairdressing supplies needed for her courses. Her treatment is being funded by the General Assistance funds.

Challenges

- Developing administrative infrastructure
- A voucher program requires an agency to have infrastructure to support the necessary administrative processes, including appropriate documentation of delivering the service
- Many grassroots organizations, including faith-based organizations, struggle with the paperwork that is required of a voucher (fee for service) program

Lessons Learned

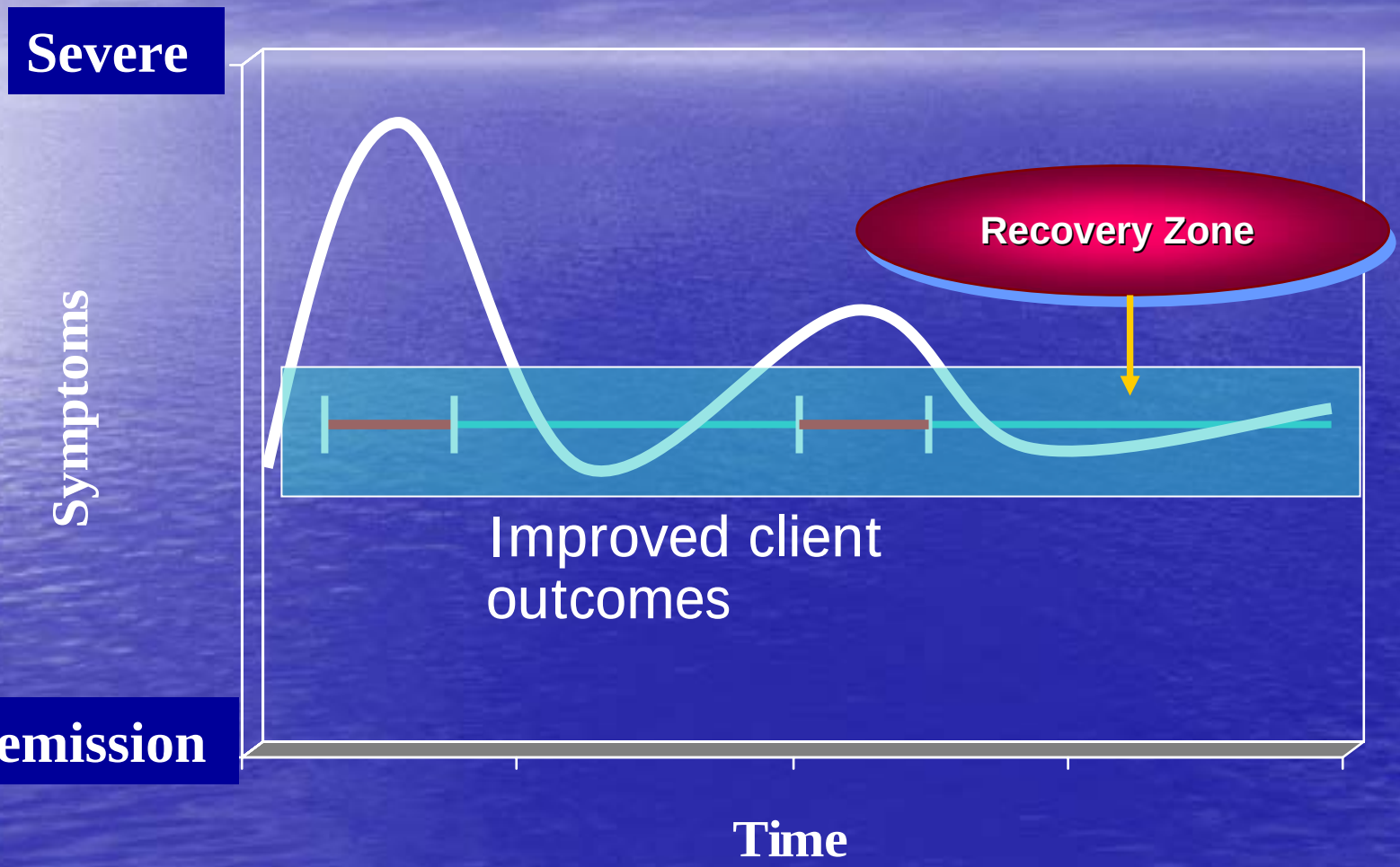


- ATR represents a major service system change that takes time and commitment from all entities
- Need to support Recovery Support Service (RSS) providers in building infrastructure to collect and maintain client, program, and administrative level data and documentation
- Some RSS providers over-extended themselves on their ATR business and ignored other potential revenue streams

ATR's Impact on the CT System

- Expands clinical continuum of care to include Cocaine/Meth. IOP and Brief Treatment Services
- Expands recovery services continuum to include an array of peer- and faith-based services
- Adds new "non-traditional" provider base (peer- and faith-based)
- Offers extension of ATR processes and services within CT's General Assistance BHP (I.e, housing provider credentialing application, expansion of basic needs, etc.)
- Helps to improve continuity of care and maximize existing capacity of system.

Helping People Move into Recovery Zone



NEXT STEPS:

SUSTAINING **ATR** IN CONNECTICUT

- Enhance credentialing process for on-going monitoring of quality of care, performance, and resource efficiency;
- Consider formal regional networks for integrated prevention, intervention, treatment, and recovery support services;
- Determine comparative effectiveness of recovery support services, including a cost effectiveness analysis; and
- Explore the feasibility of expanding recovery support services within its existing General Assistance Behavioral Health and Basic Needs Programs and within State General Funds

***In addition to those outcomes already expected by ATR*, recovery support services may lead to positive outcomes in the following domains:**

- Sense of personal hope for recovery
- Work searches and applications submitted
- Work activities, including volunteer positions
- Educational searches and applications submitted
- Educational activities (academic and alternative educational and skill building pursuits)
- Friendships and social connections
- Time spent in self-selected valued social roles, including giving back to others
- Time spent in self-selected pro-social community-based activities
- Acquisition of symptom/illness self-management skills

Take Home Messages

- *Creating recovery-oriented care requires service system changes at all levels*
- *Non-traditional services help people get better, “many paths to recovery”*

FOR FURTHER INFORMATION

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