Healthy People, Healthy Communities; Let's Make It Happen!

BRIEFING BOOK

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

Revised February 2009

Thomas A. Kirk, Jr., Ph.D., Commissioner

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INTRODUCTION
SNAPSHOT OF THE DMHAS SERVICE SYSTEM

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS)
Thomas A. Kirk, Jr., Ph.D., Commissioner
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- DMHAS is a ***healthcare agency*** committed to improving the quality of life for Connecticut residents by providing a highly effective range of mental health and substance use prevention, health promotion, treatment, and recovery support services.
- DMHAS administers ***a recovery-oriented system of care*** with clinical and rehabilitative services that focus on the individual. A recovery-oriented system of care provides the fundamental supports needed for individuals to participate fully in community life. Services promote and support independent living, employment, socialization, and community integration.
- DMHAS provides ***services to adults 18 years and older*** through a system of state-operated services and more than 170 private, non-profit community providers.
- DMHAS ***employs approximately 4,000 people*** located in five regions throughout the state
- ***Over 90,000 individuals receive care*** annually in the DMHAS service system. In addition, thousands of citizens benefit from prevention and health promotion services.
- DMHAS operated hospitals:

  Connecticut Valley Hospital in Middletown is a 543-bed facility with three divisions: General Psychiatry, 181 beds; Forensic Services, 252 beds; and Addiction Services, 110 beds.

  Cedarcrest Hospital operates two campuses. Cedar Ridge in Newington is a 103-bed facility that provides intermediate psychiatric care and Blue Hills Hospital in Hartford is a 42-bed facility that provides detoxification and residential substance use services.
- ***14 Local Mental Health Authorities*** that provide a range of residential and outpatient services are operated or funded by DMHAS.
- DMHAS' ***FY 09 Current Services Budget is approximately $590 million***. The Department receives approximately $20 Million in federal block grant funds and was awarded ***over $155 million in federal grant funds*** between 1997 and 2008. Major grant awards are for Mental Health Transformation; Access to Recovery I and II (substance use), Co-occurring (mental health and substance use), prevention of underage drinking, and suicide prevention.
- DMHAS administers the behavioral healthcare benefit for General Assistance recipients under the ***General Assistance Behavioral Health Program***.
- Significant ***progress has been made*** in many important policy and system development areas during the past several years. Nevertheless, ***DMHAS continues to address many complex challenges***.

ACCESS TO CARE

I. BACKGROUND

Connecticut's public sector behavioral health system is striving to eliminate problems with access to care that sometimes make it difficult for people to be admitted to treatment or to move through the continuum of inpatient and outpatient services in a timely manner. Much like a traffic jam, if there is a backup at one or more points in the system, timely access to the appropriate level of care can be impeded.

These periodic access issues are the result of interconnected problems that make it difficult for people to obtain the type of care they need, when they need it, and for the right duration of time. For example, sometimes people become "stranded" in general hospital emergency departments because community service options are not available and inpatient treatment beds are filled to capacity. Similarly, people ready for discharge can become stuck in hospitals because the community (clinical, rehabilitation, residential, vocational, or housing) services and supports which they need are overwhelmed by referrals. It should be noted however, that problems with access to care are most visible, and clamor for solutions is loudest, when people with psychiatric or substance use disorders become stuck in hospital emergency departments.

II. HIGHLIGHTS/ACCOMPLISHMENTS

In order to address these problems, DMHAS has established several initiatives:

- In November 2005, the Department began using a new diversion model in general hospitals called Alternatives to Hospitalization (ATH). This model is being used to redirect people with psychiatric and substance use disorders from inpatient care.
  - First developed at St. Francis and Hartford hospitals, ATH services are now operating in the following thirteen Connecticut hospitals: Bridgeport, Stamford, Hall Brooke, Charlotte Hungerford, St Vincent's, Hartford, John Dempsey, St. Francis, Waterbury, Backus, Middlesex, Manchester, and Danbury.
  - Since its inception, ATH has been used to intervene with hundreds of emergency room patients, diverting 49 percent to more appropriate, less costly levels of care.
  - Under the ATH initiative, Case Managers assist hospitals in making connections to ongoing treatment and support services.
  - Using the ATH diversion model, DMHAS has saved approximately $1.3 million in mental health inpatient service costs. These funds have been re-invested to develop much needed residential rehabilitation programs for people with co-occurring psychiatric and substance use disorders.
- DMHAS established a Transition Pilot Program at CVH to increase the number and improve the timeliness of discharges from the hospital. The pilot team develops strategies to assist community providers that need specialized training in behavioral planning and rehabilitative techniques to address the community placement needs of patients with difficult behaviors.
- DMHAS has contracted for **29 inpatient psychiatric beds within 11 general hospitals** and one private psychiatric hospital. This includes 27 acute care beds and two (2) intermediate-stay beds.
- Using discretionary discharge funds, the Department has contracted with community providers to develop **highly individualized support services for people with special needs being discharged from state hospitals**.
- A pilot program has been created to offer two state-operated mental health facilities control of admissions to local state inpatient beds. Previously, the state inpatient units had been

- Through its network of state-operated and private non-profit community-based agencies, the Department continues to employ **Peer Support** staff (i.e., people who understand psychiatric conditions based upon first hand experience). Peers work at warm-lines, drop-in centers, and psychosocial rehabilitation programs offering assistance to individuals, who, in the absence of such support, would experience more frequent and severe problems, some of which would likely result in relapse and hospitalization.

III. CHALLENGES

- **Insufficient funding to support long-term residential specialty programs,** including those for people with serious mental illness and co-morbid medical conditions that would decrease reliance on nursing homes for this population.
- **Insufficient** f**unding for Supervised Housing** that provides on-site 24/7 support to individuals who are unable to live independently.
- **General Hospitals deny admission to some patients** because: 1) the person has no health insurance or entitlements; 2) insurance or entitlement benefits are seen as inadequate to cover the patients' needs (e.g., anticipated long length of stay); 3) reimbursement rates are too low; or 4) the patient may have the potential for violence, etc**.**

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

INFORMATION . . . *foundation for good policy*

The Department of Mental Health and Addiction Services

A Healthcare Service Agency

M. Jodi Rell
Governor

January 25, 2008

Thomas A. Kirk, Jr., Ph.D.
Commissioner

Out Of The Emergency Department And Into Treatment

Gridlock in Connecticut's healthcare system contributes to lengthy waits in hospital emergency departments, particularly for people with mental health and/or substance use disorders who have encountered waits of days, and even weeks, in emergency rooms before receiving appropriate care placements. Individuals with mental health and/or substance use issues often seek help at the Emergency Departments when their natural supports are exhausted and other options are not available. DMHAS has implemented a number of initiatives in the past 24 months to fight the problem of gridlock. One such initiative, the ***Alternatives to Hospitalization Project (ATH)***, assists persons receiving State Administered General Assistance who express suicidal thoughts upon arriving at the emergency room.

Data revealed that people were being unnecessarily referred to costly inpatient mental health units when they actually needed less costly and more appropriate substance use treatment.

ATH
Fights Gridlock and gets people the right kind of care for their needs!

A SIMPLE CONCEPT WITH FANTASTIC RESULTS:
Case managers assist hospitals in helping to make and sustain treatment connections and initiate contact with patients in the ED.

Since ATH started at Saint Francis and Hartford Hospital emergency departments in November 2005:

- **Over 425 interventions** were made at those hospital EDs.
- **49% were diverted** to a more appropriate, less costly level of care
- **78% were diverted to substance use treatment settings,** including residential detox, rehab or outpatient levels of care. An additional 3% accessed community-based sober or recovery houses.
- **Only 12% declined treatment** services.
- **98%** of individuals diverted had a **primary substance use disorder** as the identified focus for treatment

"The Alternative to Hospitalization collaborative with DMHAS, Capital Region, ABH and Saint Francis Hospital and Medical Center has resulted in length of stays in more appropriate level of care for patients suffering from substance use disorders."

Surita Rao, MD, Chairman and Director, Behavioral Health, and Diane Achenbach-Zatorski, LCSW, Director, Social Services, Behavioral Health, Saint Francis Hospital and Medical Center

NOW OPERATING

- **Bridgeport Hospital**
- **Charlotte Hungerford**
- **Hall Brooke Behavioral Health Services**
- **St. Vincent's Medical center**
- **Hartford Hospital**
- **John Dempsey Hospital**
- **St. Francis Hospital & Medical Center**
- **Waterbury Hospital**

COMING SOON!

Seven other hospitals are at various stages of weighing the utility of the approach and/or of designing the preliminary steps to implement the ATH strategy in their facility.

Given the favorable response in the Hartford area and the continuing gridlock throughout the state, DMHAS is expanding ATH statewide, beginning in large urban areas. Staffs from the DMHAS Regional Teams, local mobile crisis teams, and Advanced Behavioral Health are working collaboratively with hospitals throughout the state to introduce the project to many others looking for assistance in accessing care.

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To view previous issues visit www.ct.gov/dmhas/infobriefs

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The Department of Mental Health and Addiction Services
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M. Jodi Rell
Governor

May 3, 2007

Thomas A. Kirk, Jr., Ph.D.
Commissioner

BETTER CARE = BETTER VALUE

There is an "80% rule" that often is applied to the public mental health and substance use systems of care which is 20% of the people in the system use 80% of its resources. While those numbers may not be entirely accurate, the notion is generally true that just a few people, whose mental health or substance use problems are very serious and poorly managed, cycle frequently in and out of costly detoxification and other acute services. Besides using a disproportionate share of limited public resources, recovery is inhibited for people caught in this cycle because their treatment needs are not being sufficiently met.

DMHAS has initiated the innovative **General Assistance Intensive Case Management Program (GAICM)** to bring improved care to individuals with frequent admissions to acute care by applying managed care technology that helps to better connect people with the care they need. GAICM is currently available only to people who are receiving or are eligible for General Assistance. Its success suggests that all individuals who meet the profile would benefit from this intensive case management service.

How does it work?

- People who have 4 admissions to detox or other acute services within a six-month period are identified through centralized "utilization management."
- A recovery specialist is assigned and meets with the person while they are still in the detox or hospital setting.
- The recovery specialist and regional staff work with the person to help them access treatment, stabilize their lives, return to work, and eventually take steps to move off public assistance.
- The combination of regional outreach teams with centralized, statewide data and care management helps to ensure that no one "falls through the cracks."

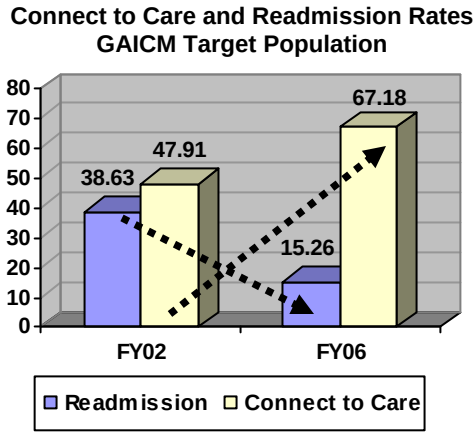
THE BENEFITS OF THE GAICM PROGRAM ARE EVIDENT!

- More individuals in need of case management services identified and assigned.
- Fewer individuals have multiple readmissions into acute or crisis levels of care.
- Increased numbers of individuals are connecting to lower levels of care.

There has been a **55% decrease in the number of individuals with multiple (4+) acute care admissions** since the beginning of the program—an indicator of its success. **80+% of these individuals receive interventions**, compared to 50% at the beginning of the program.

GAICM recently began an intervention with individuals who are being released from jails and prisons. **Support services will help impact recidivism rates**

1,000+ individuals received over 62 thousand support sessions totaling over 30 thousand hours in FY06



50% fewer "non-compliant" discharges from treatment (against medical advice, absent without leave, refused care, etc.)

89% either maintained or improved their level of functioning while in services.

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To view previous issues visit *http://www.dmhas.state.ct.us/infobriefs/index.htm*.

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M. Jodi Rell
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March 1, 2007

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Commissioner

Hartford Project Attacks Gridlock

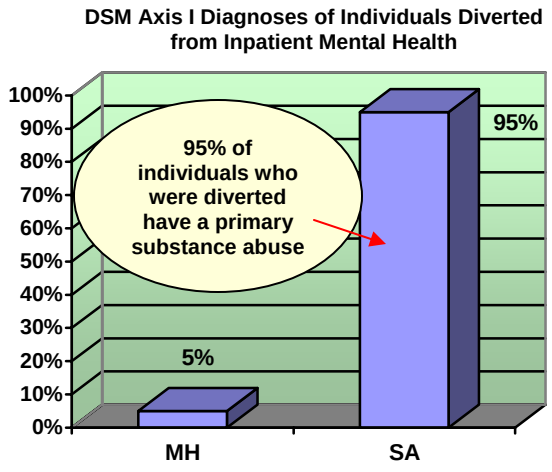
The problem of gridlock in CT's overall healthcare system contributes to lengthy waits for people with mental health and/or substance use disorders who seek care in general hospital emergency departments. DMHAS has implemented a number of initiatives to fight this problem, including:

- ***Acute Care Contracts*** with 12 general hospitals for psychiatric care serving approximately 600 individuals
- $***3.4 million Hospital Discharge Fund*** provides intensive community supports that help people transition from state hospitals and remain in the community
- ***16 new acute care beds*** at Capitol Region Mental Health Center in Hartford
- ***8 new acute care beds*** at Connecticut Mental Health Center in New Haven
- ***Two new 15-bed intensive residential units*** *in New Britain and New Haven*
- ***Hartford Alternative to Hospitalization Project*** identifies individual needs and provides more effective treatment placements

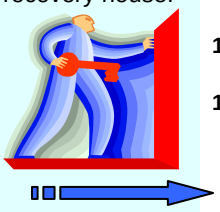
Hartford Alternative to Hospitalization Project (ATH): Beginning in November 2005, DMHAS implemented the ***ATH*** at Saint Francis and Hartford Hospital emergency departments for persons receiving State Administered General Assistance. In ATH, individuals who express suicidal thoughts upon arriving at the emergency rooms are referred to substance abuse treatment (usually residential care) rather than to an inpatient mental health program if, after clearing from the effects of substance use, they no longer feel suicidal.

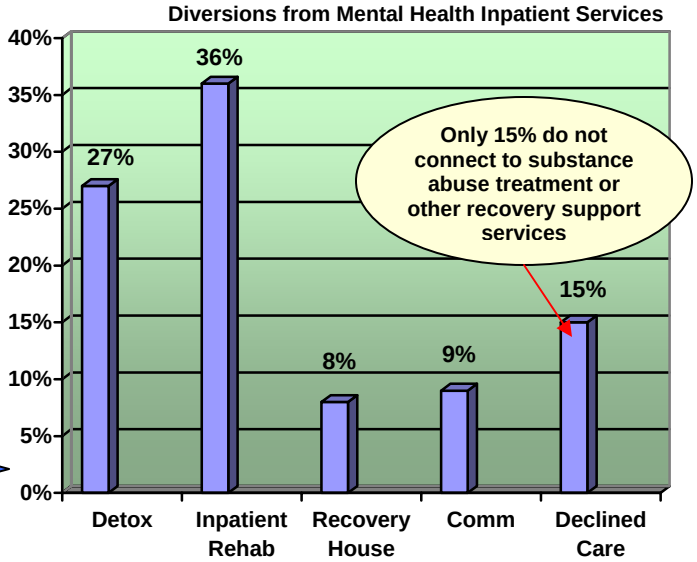
Dramatic results indicate that ideally the program should be replicated statewide!

- Interventions were made with **over 300 people** seeking care at emergency departments.
- **60% diverted** to more appropriate, less costly levels of care.
- **80% were to substance use treatment** settings, including residential detox, rehab or outpatient levels of care. An additional **5% accessed community based sober houses**.
- **Only 15% declined** substance use services.
- **Case managers** have been assigned to help individuals make and sustain treatment connections.
- Emergency room **wait time dropped from an average of 11 hours to 2.5 hours** since the project start-up. *(Time of medical clearance at ED to final disposition to substance use services.)*



Individuals are diverted primarily to residential substance abuse settings (detox and rehab) or to a recovery house.





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Governor

February 22, 2007

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Commissioner

Improving Care AND Good Resource Management

Quality continues to be a driving force behind the DMHAS services and programs in support of recovering persons. **Quality enhances value** by giving **"**more bang for the buck." DMHAS and its partners in the public, private, and academic sectors continuously work to find ways to enhance the value of their work. A good example of this can be found in the ongoing ***Opioid Agonist Treatment Protocol—OATP*** begun out of Connecticut Valley Hospital in April 2001 with funding from the DMHAS administered General Assistance Behavioral Health Program.

OATP Partners

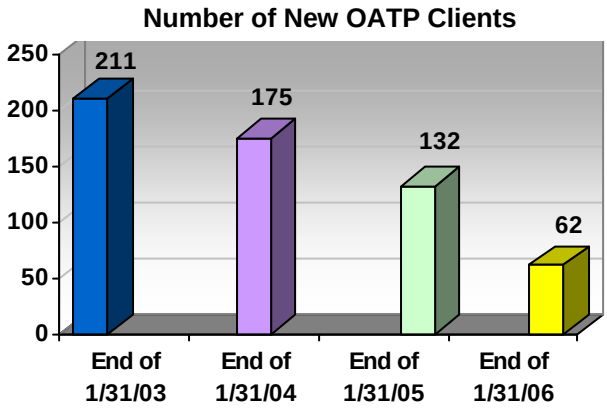
- *DMHAS*
- *Advanced Behavioral Health (ABH)*
- *Residential detoxification providers*
- *Outpatient Medication-Assisted programs such as Methadone Maintenance Clinics.*

On the Eastern Seaboard, including Connecticut, **heroin continues to be a major drug of choice**. OATP offers alternatives to individuals who repeatedly and exclusively use residential detox settings. When a person chooses to participate in OATP, **priority access** is arranged for targeted treatment, whether it is methadone maintenance (a highly effective medication used to treat heroin addiction) or other abstinence based (non-methadone) treatment. **Intensive case management** services provided through OATP are an invaluable conduit to additional supports and supportive housing.

OATP Improves the Outcomes.

- ➔ People participating in OATP have **69% fewer admissions** to costly acute inpatient care, including detox, in the six-month period following initiation.
- ➔ OATP participants discharged from residential detox are **35% more likely to obtain follow-up care** than the individuals who did not participate in OATP.
- ➔ Days between discharge from the OATP inpatient episode and **readmission to acute care went from 30 days to 234 days** on average after 6 months in OATP.
- ➔ **67% of OATP participants are linked to methadone maintenance** (medication-assisted ambulatory care) following participation in the initiative.

One of the most obvious signs of the long-term success of OATP is the decrease in the number of individuals identified as "frequent service users," those heroin dependent individuals who have had four or more admissions in a six-month period. This decrease led to expanding the criteria for participation in OATP to include people with three inpatient admissions in a 90-day period in an effort to intervene earlier.



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December 15, 2005

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MANAGING CARE SUPPORTS RECOVERY

The DMHAS **General Assistance Intensive Case Management Program (GAICM)** is a unique and innovative program that uses an Administrative Services Organization (ASO) to combine managed care tools and technology with community based 'in vivo' case management services. By having the *care management* (clinical utilization management) closely and directly integrated with the *case management* (outreach based services), DMHAS is able to achieve the following:

- *Immediate access to community based case management services offered by a Recovery Specialist. There are no waiting lists or lengthy intake procedures.*
- *Rapid implementation of client-specific individualized recovery plans that follow people through different levels of care.*
- *Increased collaboration with community providers to meet individuals' clinical and support service needs.*

The DMHAS GAICM program combines centralized management and data collection with local community expertise. Program staff, including Recovery Specialists and Mental Health Case Managers, are organized in regional teams and located in offices throughout each region. In some regions, staff is employed by local provider agencies. GAICM staff (Quality System Specialist) work with utilization management clinical staff to determine persons receiving general assistance most in need of recovery support services.

Once identified, regional staff is assigned to work with the person to access treatment, stabilize their lives, return to work, and eventually take steps to move off public assistance. The statewide program combination of regional outreach teams with centralized data collection and management ensures that no one 'falls through the cracks' regardless of behavioral health diagnosis or the person's location.

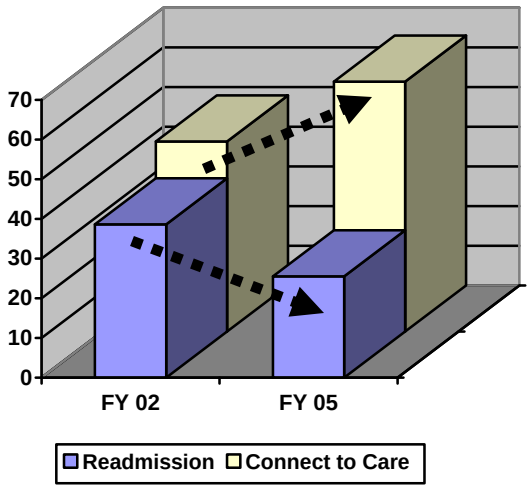
The benefits of the GAICM program are evident:

- More individuals in need of case management services identified and assigned.
- Fewer individuals have multiple readmissions into acute or crisis levels of care.
- Increased numbers of individuals are connecting to lower levels of care.

1100+ individuals received over 61 thousand support sessions totaling over 25 thousand hours in 2005.

89% of the people in the GAICM program either maintained or improved their level of functioning while in services.

Connect to Care and Readmission Rates
GAICM Target Population



There has been a 48% decrease in the number of individuals with multiple (4+) acute care admissions since the beginning of the program.

86% of individuals identified as needing case management receive interventions which compares favorably to 50% beginning of the program

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

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October 25, 2002

The Department of Mental Health and Addiction Services

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John G. Rowland
Governor

Thomas A. Kirk Jr., Ph.D.
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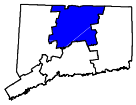


Substance Abuse Treatment Enhancement Project (SATEP)

SATEP is an enhanced system of care in the Greater Hartford area for persons with substance use disorders. It was created in 1998 by the Department of Mental Health and Addiction Services through a comprehensive partnership to address the area's fragmentation of addiction services, its high rates of substance abuse and dependence, and its reliance on hospital emergency departments as entry points for accessing addiction services. SATEP is grounded in a creative program design, a set of guiding principles aimed toward quality care, and the cooperation of state and local organizations dedicated to providing residents with the services they need and want.

Program and System Design

- Added 24hr/7 day/week toll free ACCESS line to call for care
- Introduced new transportation system to reach and link care locations
- Expanded community residential and outpatient programs
- Emphasized culturally competent care to fit Hartford's demographics

SATEP Partners

- *Advanced Behavioral Health*
- *Alcohol and Drug Recovery Centers*
- *Hartford Behavioral Health*
- *Institute Health Care/Institute of Living*
- *Institute for the Hispanic Family*

Other Service System Partners

- *Saint Francis Hospital and Medical Center*
- *DMHAS' Blue Hills Substance Abuse Services*
- *DMHAS' Capital Region Mental Health Services*

- Created Community Advisory Board including persons in recovery to oversee implementation
- Restructured Hartford-based state hospital addiction services
- Provided support for new transitional housing programs, e.g. Alternative Living Centers (ALC) for Women and for Men

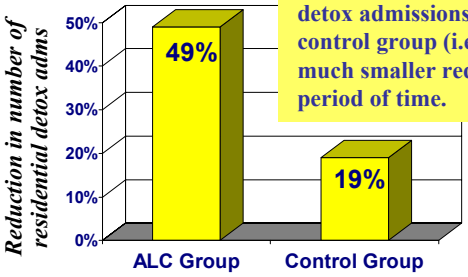
★ Success ★

MORE ACCESS…BETTER CARE DOLLAR SMART

	CY1997	CY2001	Increase
Persons	1,383	2,061	49%
Admissions	2,904	3,090	6%

ADRC Residential Detox Services

SATEP enables more persons to move into the next level of care instead of using detox treatment as a revolving door. So the same level of detox resources can accommodate many other persons.



The Alternative Living Center (ALC) reduced the number of residential detox admissions by 49%. A matched control group (i.e. no ALC) had a much smaller reduction over a similar period of time.

Next Challenges and Opportunities

- ***Continue to promote quality approaches that make best use of existing resources.***
- ***Increase system capacity to meet service needs of new clients.***
- ***Improve linkages with emergency departments for early identification and referral of substance abusing clients.***
- ***Expand Access Line and SATEP recovery model state-wide.***
- ***Strengthen SATEP for increased number of women entering treatment, especially those involved with child welfare system.***

ACCESS TO RECOVERY II

I. BACKGROUND

In June of 2007, DMHAS submitted a comprehensive proposal to the Center for Substance Abuse Treatment (CSAT) in response to a competitive procurement process for Access to Recovery II (ATR). This was not a continuation of ATR I, but rather a separate and distinct competitive procurement process. Connecticut was one of twenty-four grantees made up of states and tribal organizations throughout the country to be awarded the grant. CSAT increased the number of grantees for ATR II; consequently, the funding amounts per grantee were decreased. Connecticut was awarded approximately $14.5 million dollars for this three-year program.

II. HIGHLIGHTS/ACCOMPLISHMENTS

The fact that Connecticut was awarded this highly competitive grant is an accomplishment in and of itself. Now that DMHAS has been awarded this grant, it is the department's responsibility to manage it in such a way that the grant dollars are used in the most cost effective manner while simultaneously achieving excellent outcomes for those who access the services. In order to accomplish this goal, DMHAS has implemented progressive clinical services such as Buprenorphine Treatment Services, Co-occurring Intensive Outpatient Treatment, and Clinical Recovery Management Check-ups. In addition to the clinical services offered, ATR II will offer a variety of recovery support services, such as, Sober Housing, Case Management, Faith-based services, Peer-based services, Transportation, Basic Needs (food, clothing, and personal care items), and Vocational/Educational services.

The first year of this three year grant ended on September 29, 2008. CSAT expected DMHAS to serve 1,514 unduplicated individuals in the first year; DMHAS actually served over 3,000 unduplicated individuals in the first year. All clinical and recovery support services were operational and there was activity from all regions in the state. A significant requirement of the grant is to complete a follow-up interview on all ATR service recipients six months post intake. The minimum follow-up rate for grantees for the follow-up interview is 80%. DMHAS and the Administrative Services Organization (ASO) implemented strategies early in year 1 to ensure the follow-up rate would remain above 80%. DMHAS maintained an exceptionally high follow-up rate throughout the first year (98%) and continues to maintain a rate of 94%.

Client outcomes are an important aspect of the ATR II grant. Thus far, Connecticut has seen improvement in outcome measures based on the intake interview and the six month post intake interview in the following areas:

- Abstinence from alcohol and drugs
- Stable Housing
- Employment and/or vocational/educational programs

III. CHALLENGES

The most significant challenge of the ATR II program is the CSAT requirement that all service recipients must be interviewed six months after their intake. This data collection interview must be completed for all ATR II service recipients and CSAT is requiring a minimum interview of 80% for all grantees. DMHAS has implemented a required document for all ATR II service providers that collect contact information for all service recipients. It asks all service recipients

to list at least two names of individuals that the service provider may contact (with the service recipients permission) if the service provider cannot find the service recipient. Additionally, DMHAS requested technical assistance from CSAT to facilitate training for all ATR II providers on evidence based follow-up techniques that providers can utilize should they not be able to find service recipients.

The six month post intake interview continues to be a challenge despite our current rate of approximately 94%. As the program matures and providers serve more people, it will be increasingly more difficult to maintain a follow-up rate of 94%. The ASO is working with providers to help them obtain the follow-up interview and for those individuals that are no longer with the service provider six months post intake, the ASO will attempt to obtain the follow-up interview. DMHAS and the ASO will continue to make this a priority.

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The Department of Mental Health and Addiction Services
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July 26, 2007

Thomas A. Kirk, Jr., Ph.D.
Commissioner

ATR: A GOOD RETURN ON INVESTMENT

Access to Recovery (ATR) is a **3-year, $22.8 million grant** awarded to Connecticut in 2004 by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). This grant increased substance abuse treatment capacity while ensuring **informed choice** by service participants who self select from a compliment of clinical substance abuse treatment and recovery support services. Unique to this grant is its focus on non-clinical ***services that support recovery*.** The current ATR grant ends on August 2, 2007.

ATR Services & Supports:

- Housing
- Transportation
- Vocational/Educational
- Case Management
- Faith- and Peer-based services
- Basic Needs, (food, clothing, etc.)
- Substance Use Treatment (Intensive outpatient, methadone maintenance, brief treatment)

ATR Works!
"Optimal Outcomes"

As reported upon discharge

- **87% were abstinent from alcohol and drugs**
- **40% increase in employment**

98% reported no arrests, jail or prison time

18,368 People Served to Date!

- 60.1% were Male
- 39.8% were Female
- Mean age 38.1 Years (Ranging 18 – 90yrs.)
- 36.5% White;
- 37.3% African American;
- 15.8% of Hispanic Origin.

"**[With help from ATR]* ***I rebuilt relationships with my family, I've maintained employment, renewed my relationship with God, got engaged, I have rebuilt bridges that were once burnt and have become a productive member of society rather than a menace."

-- *ATR Recipient*

ATR: A Good Return On Investment!

- Less costly recovery supports—e.g. housing, transportation, vocational, basic needs like food and clothing—appeared to be more effective than clinical services (treatment) alone in decreasing use of alcohol and other drugs.
- People were 1.5 times more likely to achieve the Optimal Outcomes (no drug or alcohol use; living independently; gainfully employed; no arrests, jail or prison time) if they received ATR short-term housing support.
- Overall, data reveals the combination of clinical and recovery support services are more predictive of a decrease in substance abuse, jail time/arrests, housing and employment.

What has been accomplished through ATR?

- Served **over 18,000 unduplicated individuals,** surpassing the proposed target number of 17,000
- **Over 6,000** assisted with congregate sober housing or independent housing
- **Over 7,000** selected faith-based services
- Reached **new individuals,** with 40% of ATR recipients having no prior history within the DMHAS system
- Established **5 regional networks** to provide a full continuum of clinical and recovery support services, with **32 clinical substance abuse treatment** and **86 recovery support providers**.

For more information, contact William Halsey at william.halsey@po.state.ct.us .
To view previous issues visit www.ct.gov/dmhas/infobriefs .

CO-OCCURRING DISORDERS

I. BACKGROUND

Co-occurring disorders (CODs) are the combination of two or more disorders, at least one of which relates to the use of alcohol and/or other drugs and one of which is a mental disorder (e.g., schizophrenia, major depression, bipolar disorder). A rich literature of studies documents the high rates of co-occurring disorders within populations seeking treatment (U.S. Dept. of Health & Human Services-DHHS, 2006); psychiatric and addiction problems are as likely to co-occur in the same individuals as to exist independently of one another. This population is usually described by the "four quadrant model": Quadrant I includes individuals with less severe mental and addictive disorders; Quadrant II includes individuals with severe mental illnesses (SMI) and less severe addictive disorders (i.e., substance abuse); Quadrant III includes individuals with severe addictive disorders (i.e., substance dependence) and less severe mental illnesses; and Quadrant IV includes individuals with SMI and substance dependence disorders. A significant number of persons served in CT's publicly funded behavioral healthcare system have co-occurring disorders.

Over 25 years ago, experts in the behavioral health field reached the conclusion that treatment in parallel and separate mental health and addiction treatment systems is remarkably ineffective for people with co-occurring disorders. Today, it is common for people with co-occurring disorders to have poor outcomes, but a growing body of research confirms improved outcomes for this population are achieved within integrated models of care (DHHS, 2005). However, there continue to be structural, fiscal, regulatory, professional, and practical barriers to implementing integrated psychiatric and addiction treatment. The infrastructures put in place separately within both fields years ago with a vision of enhancing quality of care now constitute obstacles to achieving that goal. It is important that the State of Connecticut's system be highly responsive to the multiple and complex needs of persons and families experiencing co-occurring psychiatric and substance use disorders.

II. HIGHLIGHTS/ACCOMPLISHMENTS

Connecticut has taken significant and important steps over the last several years to increase the system's capacity to provide accessible, effective, comprehensive, integrated, and evidence-based services for adults with co-occurring disorders. Specifically, in the last year DMHAS:

- Certified 11 Intensive Outpatient Programs (IOPs) across eight agencies as **Co-Occurring Enhanced IOPs,** using the *DMHAS Co-Occurring Enhanced Program Guidelines* developed in 2007 through a statewide workgroup process; these sites are granted a 25% rate increase using the federally funded Access to Recovery II (ATR) Grant dollars;
- Designed, competitively procured, and awarded contracts for **two new 20-bed Co-Occurring Enhanced Intensive Residential Programs** in Bridgeport and Waterbury, primarily for individuals diverted from the state's emergency departments. The Bridgeport site was fully implemented as of July 2008; the Waterbury site was partially implemented as of December 2008, with full implementation anticipated by January 2009;
- Expanded the two **Co-Occurring Practice Improvement Collaboratives** for a total of 25 mental health and addiction treatment agencies actively working to increase their capacity to serve individuals with co-occurring disorders; experts provide onsite training and consultation and progress is measured by program assessment measures developed by Dartmouth Medical School;
- Implemented **workforce development** activities, including: 1) enhancements to DMHAS' training curricula, such as specific trainings and follow-up consultations to improve education

and support for families of individuals with co-occurring disorders, prescribing practices for this population, and outreach and engagement to this group of individuals (using the evidence-based practice contingency management); and 2) collaboration with Southern Connecticut State University's School of Social Work to implement in August 2008 an Intensive Weekend Program focusing on co-occurring disorders for individuals pursuing their MSW degree;

- Continued to use the resources from the 5-year, $4 million federal **Co-Occurring State Incentive Grant (COSIG)** awarded in 2005 to CT by the Substance Abuse and Mental Health Services Administration (SAMHSA) to assist in infrastructure building efforts. In addition to the above activities, CT's COSIG is funding management information system (MIS) improvements to support data-based decision making in a quality improvement framework, and two co-occurring enhanced pilot programs in Waterbury and New Haven. These pilot sites have implemented integrated services and increased their capacity by an average of 200 outpatient slots each during the pilot period. In addition, the New Haven pilot is serving monolingual Spanish-speaking Latinos with co-occurring disorders and now has a service model for statewide replication for this underserved population.

The DMHAS public behavioral health system is striving to be co-occurring capable across all agencies, and co-occurring enhanced in a significant number of agencies/programs.

III. CHALLENGES

The single overarching goal of DMHAS as a healthcare service agency is promoting and achieving a value-driven, culturally responsive, and recovery-oriented system of care. The full attainment of this goal is not possible if service system design, delivery, and evaluation are not enhanced to accommodate co-occurring disorders. Some of our challenges include:

- **Adequate service capacity for all subpopulations of individuals with co-occurring disorders**. There is a dearth of inpatient and residential treatment slots for individuals with the most severe mental illnesses and severe substance use disorders (Quadrant IV subpopulation of people with co-occurring disorders).
- **Full implementation and sustainability of evidence-based practices for co-occurring disorders across the behavioral health system**, which includes several challenges related to workforce development:
  - More basic and advanced **trainings** on co-occurring disorders and integrated treatment for clinicians and clinical supervisors are critically needed. The current courses offered through DMHAS' Co-Occurring Academy are full within days of the catalogue being released and there are long waiting lists.
  - **Clinical supervision** is a critical component to ensure that training is implemented, practices are improved, and enhancements are sustained; over the years, many provider agencies have decreased the amount of clinical supervision provided.
  - **Recruitment and retention** of the behavioral health workforce is very difficult, contributing to the difficulties in implementing and sustaining improvements for serving individuals with co-occurring disorders.

There have been advances in research and practice related to co-occurring disorders and it is important that our system continue to work toward closing the science to service gap. Through these and other related improvements, the citizens of the state can expect better processes of care and better outcomes for people with co-occurring disorders.

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INFO Brief

Healthy People, Healthy Communities. Let's Make It Happen!

September 4, 2008

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

Increasing Co-Occurring Capability: Progress Being Made

Individuals with co-occurring mental health and substance use disorders present difficult challenges, but can and do achieve positive outcomes as a result of integrated, recovery-oriented services. Over the past 18 months, the DMHAS-operated facilities and nine DMHAS-funded private non-profit agencies, have been working intensively to increase their capability to better serve individuals with co-occurring disorders (COD).

DMHAS-Operated Agencies

Connecticut Valley Hospital
Cedarcrest Hospital
Capitol Region Mental Health Center
Connecticut Mental Health Center
River Valley Services
Southeastern Mental Health Authority
Southwest Connecticut Mental Health System
Western Connecticut Mental Health Network

Private, Nonprofit Agencies

Birmingham Group Health Services
Community Prevention & Addiction Services
Harbor Health Services
InterCommunity Mental Health Group
Midwestern Connecticut Council on Alcoholism
Morris Foundation
Rushford Behavioral Health Services
United Community and Family Services
Wheeler Clinic

New to the Collaborative in 2008

Alcohol & Drug Recovery Centers
APT Foundation
Center for Human Development
Connecticut Renaissance
Perception Programs, Inc.

Feedback from Programs Participating in the Co-Occurring Practice Improvement Collaborative

- "We tripled our COD groups and strengthened our COD intensive outpatient program."
- The Collaborative process is "like building a fellowship."
- "It's a work in progress. We are moving in a positive direction."
- "Extend the length of the Collaborative…Allow for ongoing consultation for sustainability."

Observations and Lessons Learned

- **LEADERSHIP -** CEO and other administrators are essential to the process.
- **CHANGE IS NOT A LINEAR PROCESS -** sometimes there is a step backwards before moving forward.
- **SUSTAINED FOCUS -** is required at all levels over a long period of time.

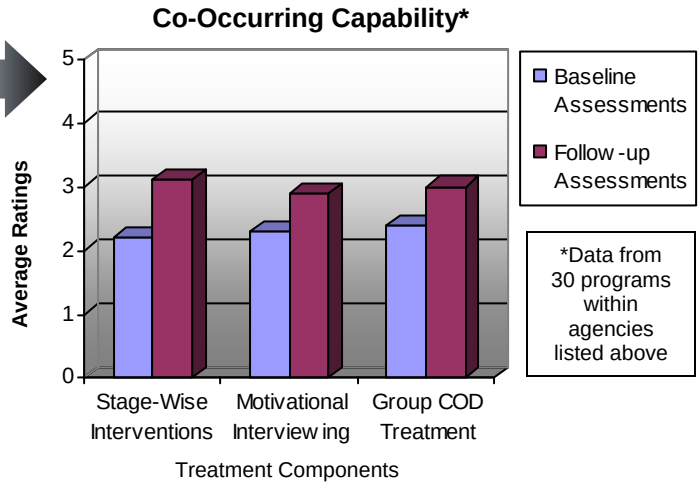
Progress!

Programs made great progress and, on average, reached the co-occurring capability level (i.e., rating of 3) on the following three key program components:

***1)* Stage-wise Interventions -** Matching service interventions with an individual's readiness to reduce their substance use and better manage mental health symptoms

2) Motivational Interviewing - Using this evidence-based skill to successfully engage individuals who are in the early "stages" of wanting or being able to reduce substance use and better manage mental health symptoms

3) Group COD Treatment - Groups educate about both mental health and substance use disorders, and include interventions for both disorders



For more information, please contact Julienne.Giard@po.state.ct.us or 860-418-6946.

To view previous issues, visit www.ct.gov/dmhas/infobriefs

CRISIS INTERVENTION TRAINING

I. BACKGROUND

Traditionally, law enforcement officers are the first to respond to crisis situations involving individuals with mental health or co-occurring substance use and mental health disorders. Law enforcement personnel encounter individuals with behavioral health disorders of all ages in five general situations: 1) as a victim of a crime; 2) as a witness to a crime; 3) as the subject of a nuisance call; 4) as a possible offender; and 5) as a danger to themselves or others.

Several approaches have been developed to enable law enforcement personnel, in partnership with behavioral health personnel, to effectively assess situations involving individuals with behavioral health disorders that reduce their contacts with the criminal justice system, arrests, and ensure on-scene safety. The Crisis Intervention Team (CIT), a well-documented approach, employs specially trained law enforcement officers, in partnership with behavioral health specialists, to act as primary or secondary responders to every call in which behavioral health disorders are a factor.

Nationwide, CIT programs have resulted in significant reduction in arrests, reduced injuries to police and individuals with psychiatric disorders, reduced workers' compensation claims for police, reduced incidents of "suicide by cop," improved engagement for consumers, and enhanced skill sets for law enforcement officers in de-escalation and problem solving.

II. HIGHLIGHTS/ACCOMPLISHMENTS

- Starting in 2004, DMHAS received a three-year $1.5 million grant from the U.S. Dept. of Justice to develop a CIT program. Beginning in SFY 08, the project is fully state funded.
- CIT provides seven DMHAS-employed CIT clinicians to assist the following police departments with serving persons with psychiatric needs – **Waterbury, Hartford, New Haven, West Haven, Stamford, Bridgeport, New London, Norwich, and Groton** as of December 2008. **CIT clinicians assisted police with over 2,500 persons in SFY 08** – more often as follow-up than on-site with police.
- CIT provides a **five-day, 40-hour training (based on the Memphis model) and one-day refresher course for police officers** on dealing with persons with psychiatric disorders. **In SFY 09, DMHAS will fund 5 trainings for over 175 individuals.**
- As of December 2008, **643 individuals, including 517 police officers, 32 police department civilians, and 94 Correctional Officers, Parole Officers, Probation Officers, and mental health staff attended the 40-hour training.**
- As of December 2008, **27 police departments** (state, municipal, college, hospital) have a CIT policy and a sufficient number of CIT-trained officers to provide a CIT response to their jurisdiction. **Another 20 police departments** have at least one officer who has attended CIT training and many of these intend to have more officers trained.
- In SFY 08, over **95 police officers, other responders** and mental health staff attended the **one-day refresher courses.**
- CIT-trained officers report that they use their CIT knowledge and skills on all calls, whether or not the call involves a person with a psychiatric disorder.
- Assistance by the CIT clinicians has improved engagement in services and interagency collaboration for persons with psychiatric disorders.
- DMHAS funds CIT training by the Connecticut Alliance to Benefit Law Enforcement, Inc. (CABLE) and outreach and support to police departments and providers by NAMI-CT.

III. CHALLENGES

- **Service Gaps/Capacity Limitations:** CIT programs are not available in all areas of the state. Additional police departments in CT have requested CIT training and the services of a DMHAS-employed CIT clinician.
- **Plans:** In collaboration with DMHAS' Health Care Systems Division, the Division of Forensic Services would like to build capacity of Mobile Crisis programs to respond by telephone or in person to requests from police departments at times when the CIT clinician is not available. Mobile Crisis clinicians are included in the 5-day, 40-hour CIT training, as possible.
- **Community resistance:** Several municipal police departments have rejected offers of CIT training for their agencies. DMHAS, in collaboration with the Connecticut Alliance to Benefit Law Enforcement, NAMI and the Regional Mental Health Boards are conducting outreach efforts to engage community leaders, local service providers and law enforcement agencies to the benefits of CIT.

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INFO Brief

Healthy People, Healthy Communities. Let's Make It Happen!

October 23, 2008 State of Connecticut Department of Mental Health and Addiction Services
Thomas A. Kirk, Jr., Ph.D., Commissioner

MENTAL ILLNESS IS NOT A CRIME

While it is true that individuals with serious mental illness are no more likely to commit a crime than the general population, the nature of the illness makes people vulnerable to police contacts during times of crisis. There clearly is a need for meaningful collaboration between the police and DMHAS agencies. In Hartford, this collaboration began in January of 2005 with the implementation of the ***Hartford Crisis Intervention Team (CIT)***. ***CIT*** supports the DMHAS goal of meeting the service needs for persons who are challenging and whose needs have traditionally not been well met in either the mental health or substance abuse programs.

Unfortunate Facts

- 20% of 331 people hospitalized with severe mental disorders reported being arrested or picked up by police in the 4 months prior to hospitalization, most commonly for alcohol, drug or public disorder crimes (Swanson et al, 1999).
- 7% of all police contacts in U.S. cities of 100,000 or more involve people believed to have mental illness (Deane et al, 1999).

How the Hartford CIT Works

- **59 Hartford police officers** who were trained by the Connecticut Alliance to Benefit Law Enforcement (CABLE) act as CIT officers and respond to calls which are believed to involve a person with mental illness.
- A Licensed Clinical Social Worker at the DMHAS Capitol Region Mental Health Center (CRMHC) is a **full time CIT clinician and rides along with police, responds to calls, and functions as a liaison** to the police department. He is in constant radio contact with HPD and also responds to the calls involving a person with mental illness.
- CRMHC **Mobile Crisis Team covers** when the CIT clinician is unavailable.
- The CIT clinician also functions as a **faculty member of the Hartford Police Academy**, teaching or coordinating the teaching of mental health issues to new recruits and in the ongoing officer recertification program.
- There are also **CABLE-sponsored trainings** at least annually in Connecticut and nationally for CIT programs.

CIT Clients more likely to be linked to treatment than arrested.

- Hartford CIT responded to **578 calls in the past three years**.
- **No Hartford Police Negotiation Team** calls for persons with mental illness since CIT inception.
- Most seen by the CIT officers/staff **sent to hospital ER for evaluation.**
- CIT clinician assists in **linking people with services** if they are not connected with a service provider.

- **60% of officers found CIT training helpful;**
- **29% found it moderately helpful;**
- **Only 11% found it slightly helpful.**

For more information, please contact Michael.Levinson@po.state.ct.us .
To view previous issues, visit http://www.ct.gov/dmhas/infobriefs.

EFFECTIVE SERVICES

I. BACKGROUND

Effective services are those which are accessible, attractive to the individual in need of services and produce optimal outcomes. DMHAS is committed to investing in services that meet these criteria as a means of conserving public funds and maximizing the health benefits of the services it delivers.

DMHAS learned from research that effective services must be tailored to the individual's history, background, gender and culture and has undertaken a number of initiatives to individualized care. Three such areas of investment in meeting individual needs are the **Women's Practice Improvement Collaborative, the Trauma Initiative, and activities stemming from the Office of Multi-cultural Affairs (OMA)** that addresses cultural issues. Services that also address individual needs, including those of young adults, persons involved in the criminal justice system, uniformed personnel and for persons with co-occurring mental health and substance use issues are addressed in separate sections of this briefing book.

II. HIGHLIGHTS/ACCOMPLISHMENTS

- **Women's Practice Improvement Collaborative:** DMHAS, in partnership with researchers, service providers, and individuals in recovery formed a collaborative to identify and implement best practices for women. Services were designed to enhance Connecticut's behavioral health system for women in ways that are trauma-informed, gender-specific, and that promote self-determination.
  - Gender Responsive Treatment Guidelines, that acknowledge women's specific behavioral health and an Outcomes Study were developed and implemented. Subsequently, DMHAS became a nationally recognized leader in gender-responsive programming.
  - DMHAS instituted a utilization management process for its women's residential programs and funded Women's Recovery Specialists, who are now providing recovery oriented case management, to women transitioning from residential care back into the community.
  - Technical Assistance (TA) and training in the area of supervision relative to gender-responsive programming have been implemented in DMHAS' Women and Children's programs.
  - An evaluation of gender-responsive practices is currently underway and the goal in 2009 is to develop a Gender-Responsive Assessment Tool.

- **DMHAS Trauma Initiative:**
  - The Trauma Initiative provides training for substance abuse and mental health clinicians in the treatment of co-occurring post-traumatic stress disorder and other long-term effects of trauma in order to achieve better health outcomes for women and men within the DMHAS system of care. The guiding principle is that persons who have survived psychological trauma, in particular interpersonal trauma, can and do recover when provided services that are sensitive to their special needs. Safety, trustworthiness, choice, collaboration, and empowerment are key characteristics for successful treatment.
  - DMHAS is committed to developing and promoting a recovery oriented system of behavioral health care that is gender-responsive, culturally competent and trauma informed to adults. Over the past several years, DMHAS has sponsored a comprehensive

statewide initiative to assist mental health and addiction services in becoming trauma informed and to introduce a complete clinical system revision.

- Between 2007 and the present, a total of 1,050 staff have received training in *Understanding Trauma* as it relates to *System's Chang*e and 39 have become active trainers.
- To date, 42 DMHAS funded agencies and 1,500 clinical staff have received trauma-specific clinical training in one of the following evidence-based models: Trauma, Recovery & Empowerment Model (TREM), Seeking Safety and TARGET.
- Connecticut is one of three states, along with Maine and New York, to develop awareness, policy, and training in trauma-sensitive services.
- Research is currently being conducted as it relates to the Trauma System's Change effort to determine the effectiveness of the approach as well as assessing fidelity to the model.

- **Multi-Cultural Affairs:**
  - Policies and procedures for evaluating cultural competence were developed.
  - Health Disparities Initiative (with Yale University), DMHAS initiatives and culture specific programming, with a focus on improving cultural competence, have addressed some disparities in accessing care.
  - After 10 years of promoting cultural competence, multicultural plan was revised to recognize priorities, objectives and activities to serve as a guide for continued policy development, resource allocation, data collection and workforce development.
  - Multicultural behavioral healthcare guidelines developed and disseminated to DMHAS facilities and funded agencies. All DMHAS funded providers and state-operated facilities are required to have cultural competence plans that detail the strategies for incorporating cultural competence into its delivery system and program development.
  - Annual 21-day multicultural training program continues (35-40 students) over a 10 month period. On request, OMA will also provide five-day multicultural institutes on cultural competency for specific agencies, levels of care or regional groups.
  - OMA developed and implemented the Project for Addictions Cultural Competence Training (PACCT). PACCT is designed to recruit and train African Americans and Latino candidates as well as other underserved populations. PACCT offers 18 weeks of tuition-free training, a 100 hour practicum placement in counseling related or prevention related services and a mentoring program to connect PACCT graduates with mentors to achieve the goals of counselor certification.

III. CHALLENGES

- The shortage of safe, affordable housing remains a primary obstacle to recovery for women with psychiatric and substance use disorders. Progress has been made in helping women secure appropriate housing, but the challenge remains.
- Staff training in gender and trauma specific services is needed.
- Individuals receiving DMHAS services often have contact with multiple state agencies and, as a result, service delivery is sometimes fragmented. Of particular concern is the need to use standardized, best practices for women and trauma survivors across the network of state agencies.
- Connecticut state statutes do not contain language that is culturally appropriate and respectful of the diversity of the state's citizens.
- Services are not currently available to ensure that all individuals who speak a language other than English can receive services in their preferred language.

- The annual multicultural training curriculum needs to be brought to a higher level of clinical skills development so that service providers will have culturally competent supervisors to compliment agency cultural competence plan implementation.
- Health disparities in our behavioral health system of care need to be recognized and eliminated.
- DMHAS needs to continue its efforts to promote a diverse staff skilled in delivering culturally appropriate services.

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

INFORMATION ...foundation for good policy

The Department of Mental Health & Addiction Services

A Healthcare Service Agency

M. Jodi Rell
Governor

April 3, 2008

Thomas A. Kirk Jr., Ph.D.
Commissioner

HEALTH DISPARITIES: WE'RE PAYING ATTENTION

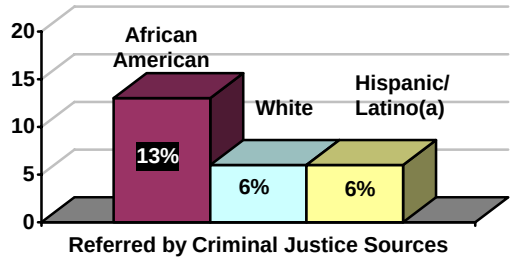
"Striking disparities in care are found for racial and ethnic minorities…The system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages or value systems of culturally diverse groups."

President's New Freedom Commission Report on Mental Health, 2003

Behavioral health disparities are **systematic differences** in healthcare practices, service utilization patterns, quality and outcomes related to race, ethnicity or gender and not due to a health condition. DMHAS' Office of Multi-Cultural Affairs (OMA) partnered with the Yale University Program for Recovery Health to create the **Health Disparities Initiative** to identify disparities in the public behavioral health system of care and introduce strategies to systematically eliminate those disparities.

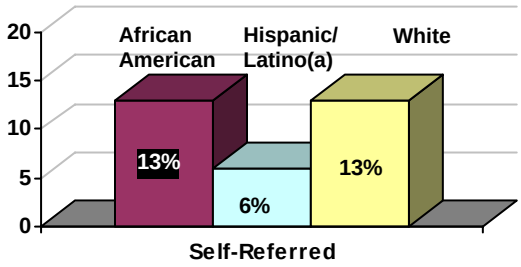
Disparities in Inpatient Substance Abuse Settings

African Americans were significantly *more* likely than White and Hispanic/Latino(a) Americans to be referred by criminal justice sources



Disparities in Inpatient Mental Health Settings

Hispanic/Latino(a)s were significantly *less* likely than African and White Americans to be self-referred.



Other Disparities Identified in Inpatient Mental Health Settings

- 63% of Hispanic/Latino(a)s were referred by a crisis/emergency source vs. 48% of White and 47% of African Americans.
- 28% of African Americans have a primary admission diagnosis of Schizophrenia vs. 11% of Hispanic/Latino(a)s and 16% of White Americans (non-Hispanic).
- 20% of African Americans have a primary admission diagnosis of Mood Disorders vs. 41% Hispanic/Latino(a)s and 40% of White Americans.
- 6% of African Americans were likely to be discharged from care Against Facility Advice vs. 3% of Hispanic/Latino(a)s and 2% of White Americans.

Products of the DMHAS Health Disparities Initiative

- Data-driven policies and targeted cultural competence interventions
- Cultural Competence Resource Kit for conducting cultural competence self-assessments and developing cultural competence action plans
- DMHAS Multicultural Best Practice Standards updated and disseminated
- DMHAS Multicultural Training Initiative teaching cultural competence to direct care staff and managers
- 2008 Evaluation of Racial and Ethnic Health Disparities in State Inpatient Services Report by DMHAS' OMA

For more information, please contact Jose.Ortiz@po.state.ct.us .
To view previous issues, visit http://www.ct.gov/dmhas/infobriefs.

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

INFORMATION . . . *foundation for good policy*

The Department of Mental Health and Addiction Services
A Healthcare Service Agency

M. Jodi Rell
Governor

June 21, 2007

Thomas A. Kirk, Jr., Ph.D.
Commissioner

A New Life and New Chance for Latinos and Latinas

Proyecto Nueva Vida - PNV ("Project New Life") is a highly innovative, effective service strategy which enhances the treatment system for Latinos and Latinas. It assists them to eliminate risky behaviors and regain their lives through culturally appropriate and recovery-focused approaches. **PNV** was originally supported (2001) through a five-year federal grant to the DMHAS from the Center for Substance Abuse Treatment (CSAT). It continues to operate today in Bridgeport through funding from the DMHAS. The primary goal of PNV is to reduce the spread of substance abuse-related HIV/AIDS and infectious diseases in Latinos and Latinas released from prison.

Proyecto Nueva Vida Partners

- Bridgeport Community Health Center
- Chemical Abuse Services Agency (CASA)
- CO-OP Center—Council of Churches of Greater Bridgeport
- The Dept. of Mental Health and Addiction Services

"Before [this program], I used to be in the middle of the ocean without an oar.

Proyecto Nueva Vida was the oar I needed to get to the other side."

PNV provides culturally appropriate recovery services and supports:

- Outpatient Substance Abuse Treatment
- Peer Mentoring
- Case Management
- Family Supports
- Primary Health Care
- Vocational/Employment
- Mental Health
- Prevention, Education, and Health Promotion

Evaluation of PNV, based on data collected from over 500 Latinos/as, reveals that:

- More than **72%** of Latinos and Latinas served through PNV *stayed with the program* for a minimum of six to twelve months.
- Latinos and Latinas in PNV were successful in *abstaining from alcohol and other drugs*, improving their abstinence by over **77%** from intake to 6 months and 12 months in the program.
- **Nearly 100%** of Latinos and Latinas who stayed in PNV for 6 months or longer *reduced or eliminated their involvement with the criminal justice system.*
- Forty percent (**40%**) Latinos and Latinas reported *improved health*.

What factors have contributed to the success of PNV?

- Emphasis on the **importance of family and community** in supporting long-term recovery.
- **Multifaceted approach to care** in which the three partnering agencies worked together to assist Latinos and Latinas in sustaining their recovery.
- **Awareness, understanding, and acknowledgement of individual's culture** greatly effects treatment and recovery outcomes.

PNV has made important contributions to improving culturally appropriate substance abuse treatment, HIV/AIDS, family interventions, mental health, vocational, and other supportive services for Latinos and Latinas in Bridgeport. It has also had a lasting effect on the integration of services across multiple community-based agencies by facilitating coordination of seamless care.

For more information, contact Jose Ortiz or email at Jose.Ortiz@po.state.ct.us
To view previous issues visit *http://www.ct.gov/dmhas/infobriefs*

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

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The Department of Mental Health & Addiction Services

A Healthcare Service Agency

M. Jodi Rell
Governor

May 24, 2007

Thomas A. Kirk Jr.,
Commissioner

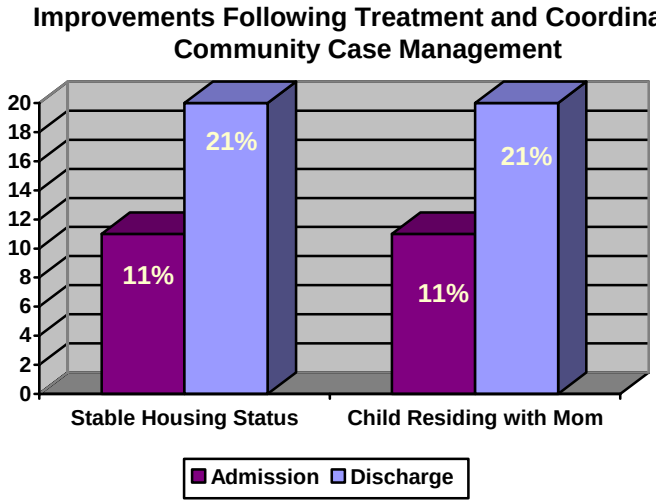
Women's Services Practice Improvement Collaborative

In October 2004, DMHAS launched a three-year initiative, the Women's Services Practice Improvement Collaborative (WSPIC), to enhance the behavioral health service system for women in a way that is trauma-informed, gender-specific, and that promotes self-determination.

A 2004 study from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) showed that ***women with histories of psychiatric disorders, substance use disorders, and violence (trauma) have improved results when treatment addresses all three issues. Findings also revealed that women who actively participate in their own treatment report better "recovery" outcomes than those who do not.***

The goal of WSPIC is to improve treatment outcomes and the quality of services for women receiving substance abuse treatment in Connecticut through participation in a recovery-oriented treatment system of care that incorporates best practices in gender-responsive and trauma-informed programming.

DMHAS and other key stakeholders developed strategies to improve programs for women and to measure whether these changes were successful. Retreats involving national experts were held with 17 women's specialty program providers and resulted in the development of Gender-Responsive Treatment Guidelines; Gender-Responsive Guidelines Self-Assessment Tool; and Outcomes Tool and Research Methodology.



After receiving residential treatment with coordinated discharge planning and community-based case management, nearly twice as many women had stable housing. Significantly more women had their child residing with them.

WSPIC Highlights

- ***535 women admitted*** to women's specialty residential programs October 2004 through December 2006.
- ***78%*** of women eligible for case management services were ***served by Women's Recovery Specialists.***
- ***Best practice guidelines*** distributed to all Women's Specialized Residential Programs.
- Women's specialized residential ***programs across CT collaborated*** to improve the quality of services.
- ***Ongoing data collection*** helps to understand the needs of women and the effectiveness of clinical and case management interventions.

For more information, contact Terry.Nowakowski@po.state.ct.us. To view previous issues, visit http://www.ct.gov/dmhas/infobriefs.

EMPLOYMENT

I. BACKGROUND

Employment is a stabilizing factor that supports recovery from mental health and substance use disorders, improves health and quality of life, often moving the person from "dependence" to "independence." Persons with mental illness have the highest rate of unemployment of all disability groups. An estimated 9-15% of people receiving DMHAS mental health services are working. Yet, research documents little relationship between an individual's psychiatric symptoms and capacity to work. Employment rates for persons actively abusing alcohol or other drugs range from 15-30%.

Work increases retention rates in substance use treatment programs saving taxpayers the high cost of repeated acute treatment episodes. Innovative programs place over 50% of people with serious mental illness in competitive employment and a newly implemented employment program for individuals with substance use disorders successfully places an average of 50% of its participants in jobs.

Job seekers with mental illness and/or addictions face a stigma ingrained in the culture of potential employers and co-workers. However, employers that have hired individuals with mental illness report higher than average attendance and punctuality and good or better motivation, quality of work and job tenure than with other employees. Over 70% of employers who have hired people with serious mental illness express a willingness to continue working with their local vocational rehabilitation programs.

II. ACCOMPLISHMENTS/HIGHLIGHTS

- DMHAS created **three staff positions** to coordinate employment initiatives, one with mental health stakeholders, another with the addiction system and a third coordinating state training. The mental health coordinator is a **shared position** with DSS's Bureau of Rehabilitation Services (BRS) to maximize the collaborative array of employment resources and cost-effective practices of the agencies while decreasing service duplication.
- All Local Mental Health Authorities (LMHAs) submit annual **plans for recovery-oriented employment**. The plans, which are now in the fourth year, feature strategies for insuring on-going quality improvement based on employment outcome data, building staff and consumer capacity, fully integrating employment within the treatment system, adopting evidence-based and preferred practices, facilitating collaborative relationships with local employment resources, and increasing the visibility of employment and educational services.
- The **Mental Health Employment RFP** requires bidders to demonstrate these same strategies including evidence-based integrated practices, interagency collaboration and on-going quality improvement.
- **A steering committee of multiple stakeholders** continues to develop recovery-oriented employment principles and practices, and a toolkit for implementing those practices for the addictions system.
- DMHAS is working with Dartmouth Psychiatric Research Center to **pilot evidence-based supported employment strategies** at six key LMHAs.
- DMHAS is collaborating with the Office of Workforce Competitiveness, DOL, the Corporation for Supportive Housing and two Workforce Investment Boards to **promote employment service linkages** between the One Stop Centers and DMHAS supportive housing residents. A Medicaid Infrastructure Grant through DSS will further expand these

partnerships to create an integrated employment service system for residents of supportive housing.

- A new employment program model operating in DMHAS regions three and four as of July, 2008 is bridging the gap between addiction treatment and the recovery advocacy community. This model includes connecting people receiving addiction treatment with a recovery-based employment curriculum, appropriate resources, volunteer activities, and ultimately employment opportunities.
- DMHAS providers **distribute informational packets on employment resources** at the point of admission and address **employment goals on all treatment/recovery plans**.
- DMHAS is linked with a **strong pool of peer advocates**, both in the mental health and addiction systems, to improve employment outcomes. Three LMHAs are piloting a project with Dartmouth University and CT NAMI to engage families in employment planning and supports.
- DMHAS providers link persons in recovery with the **BRS benefits counselors** to minimize risk and promote choice based on individualized career planning.
- Through collaboration with CT DOL, a pilot is scheduled to begin at the end of January, 2009 where employers will be offered the opportunity to post their open positions with a "recovery-friendly" designation on DOL's Job Central. Job seekers will be able to search for "recovery-friendly" employers.

III. CHALLENGES

- Lack of transportation, prison records, lack of birth certificates or Social Security information, and inaccessibility of educational programming and supports are **barriers to employment that can only be addressed by a multi-agency approach**.
- **Benefits serve as a disincentive to work for persons in recovery**. Under current General Assistance eligibility criteria, individuals with earned income lose their medical benefits. While those on SSI or SSDI can keep their medical benefits and are generally better off financially when they work, the fear of losing benefits continues to be pervasive. Much more advocacy and community education will be required to encourage and enable persons to choose work.
- **Employment models** such as self-employment and peer-run businesses, while highly desired by persons in recovery, are resource-intensive and have been slow to be developed by the provider system.

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INFO Brief

Healthy People, Healthy Communities. Let's Make It Happen!

November 7, 2008

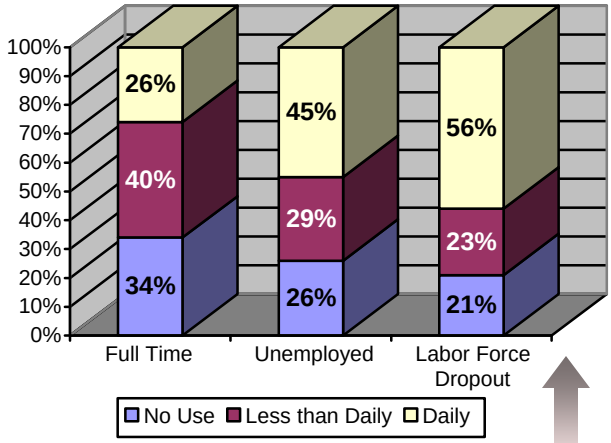
State of Connecticut Department of Mental Health and Addiction Services
Thomas A. Kirk, Jr., Ph.D., Commissioner

RECOVERY IS WORKING

Research shows that employment is one of the best predictors of success for people in recovery from substance use disorders. Yet, barriers to employment for individuals in recovery from substance use disorders can be formidable. DMHAS launched a unique new employment initiative aimed at assisting individuals with substance use disorders to find and sustain employment.

ROES*, Recovery-Oriented Employment Services,** had its kick off on July 1, 2008 in the north central and eastern regions of Connecticut. DMHAS contracts for ***ROES services with Alcohol and Drug Recovery Centers, Inc. (ADRC), a treatment provider, and the Connecticut Community for Addiction Recovery (CCAR), a recovery advocacy group that operates recovery Community Centers throughout the state. ***ROES*** connects with employers, chambers of commerce and business consortiums to educate them about recovery, reduce stigma, and make employment connections.

Frequency of Alcohol/Drug Use by Employment Status
(National data. Source: SAMHSA)



Working people do better in their recovery.

50% of the 102 persons served by *ROES* have been placed in jobs!

What's Different about ROES?

- Connects treatment providers and recovery advocacy community with clients
- Full-time employment specialists located in Community Recovery Centers connect clients to employment/education and recovery resources
- Coordinates vocational services with treatment and person centered recovery plans
- Provides recovery-oriented vocational skills development curriculum
- Connects with state and local employment services and education resources
- Works with other treatment providers who want to participate
- Provides orientation and training
- Collects and evaluates data

HOW *ROES* WORKS

- Participants must be in treatment
- Persons in need of employment services are identified
- Vocational screen used to determine best employment or education options
- Employment/educational plan developed
- Immediate activation of CCAR Telephone Recovery Support service for employment/recovery related support
- Referrals to community employment/educational resources and employers
- Phone and in-person assistance to monitor progress
- Participation in at least 20 hours of CCAR peer support recovery activities for volunteer job experience reference
- Mutual support groups focused on employment and job skills
- Service Satisfaction measured

For more information, please contact Linda.Guillorn@po.state.ct.us or 860-418-6732.
To view previous issues, visit www.ct.gov/dmhas/infobriefs

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

INFORMATION . . . *foundation for good policy*

The Department of Mental Health and Addiction Services
A Healthcare Service Agency

M. Jodi Rell
Governor

March 16, 2006

Thomas A. Kirk, Jr., Ph.D.
Commissioner

The Earn Program: Employment and Recovery Network

The **Employment and Recovery Network (EARN)** is a collaborative project between the Chrysalis Center, Inc., a private not for profit agency, and DMHAS' Capitol Region Mental Health Center, a state-operated local mental health authority serving the Hartford area. In April 2004, **EARN** began using Individual Placement and Support (IPS) model for employment, an evidence-based model for employment created at Dartmouth University. Its goal is to assist people in recovery to obtain competitive employment in the community with the support they need from the program. This model involves delivering services in the context of a multidisciplinary team that integrates clinical and vocational services. Its emphasis is on finding work that fits the job preferences and needs of the person, offering time-unlimited support, promoting rapid job search and on the job training. This collaboration relates in a meaningful way to the DMHAS goal of promoting evidence-based practices and recovery-oriented services.

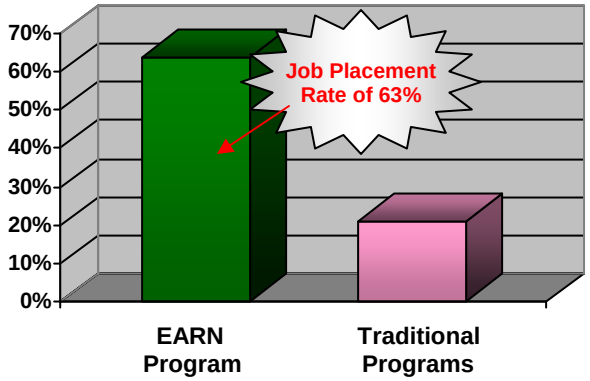
The Collaboration - How it works

- Six Employment Specialists from the Chrysalis Center are integrated within clinical teams of various units at Capitol Region Mental Health Center.
- Anyone may request and receive services in this zero-exclusion approach.
- Engagement services are provided for people wishing to obtain employment.
- Individualized goal planning and a rapid job searches are based on people's job preferences and needs.
- Time-unlimited follow-along supports assist in maintaining employment.
- Education and support for employers, job accommodations and follow-along employer contacts are provided with people's' consent.
- Ongoing, work-based employment assessments are conducted.

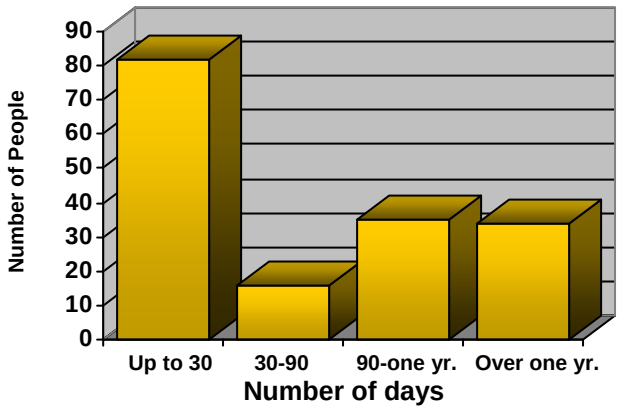
OUTCOMES

In its first 18 months of operation, the **EARN** program has received 259 referrals, and has placed 165 persons in competitive jobs, a 63.7% placement rate. This compares favorably with placement rates in traditional employment programs of 18-28% (see Bond at al, *Psychiatric Services*, March 2001). Impressive results in sustaining employment are evident in this relatively young program. Of those 165 people who have been placed, slightly over 40% have been on the job at least 90 days and in many cases over a year, as noted in the graph below.

Comparison of Job Placement Rates Between Programs



Longevity of Employment ***(past 18 months)***



For more information on the EARN program, contact Gayle.Gagliardo@po.state.ct.us or 860-297-0824.
To view previous issues visit http://www.dmhas.state.ct.us/infobriefs/index.htm

HEALTH PROMOTION

I. BACKGROUND

Prevention is the sum of our efforts to ensure that all CT citizens live healthy, safe, and productive lives. When applied to alcohol, tobacco, and other drugs (ATOD), and mental health, prevention mitigates associated problems from occurring. All prevention efforts are an investment in public health and safety, and strengthen communities, schools, families and individuals.

The goal of prevention services is to foster a climate where illegal substances are not used at all and legal substances are only used by those of legal age and are not misused and abused. Prevention interventions also prevent co-morbidity, relapse and the consequences of stress and mental illness for individuals and families. DMHAS is therefore focused on promoting healthy people and healthy communities and achieving a quality-driven, culturally responsive system of care. Under it's prevention services, DMHAS has concentrated its efforts on the planning and development of evidence-based strategies, expanding system capacity through training, technical assistance and consultation, promoting the involvement of community coalitions and improving its capacity for data-driven decision making.

During SFY 08, approximately 324,396 persons were served by individual and population-based DMHAS-funded prevention programs and strategies. Of those served, approximately 150,906 were male and 173,490 were female; 60,987 were between 0-11 years; 97,769 were between 12-17 years; 36,970 were between 18-24 years; 58,377 were between 25-44 years and 70,293 were 45 years and older.

II. HIGHLIGHTS/ACCOMPLISHMENTS

The 2006 National Survey on Drug use and Health (NSDUH) reflected modest declines in CT among 12-25 year-olds in tobacco, marijuana and other drug use compared to the national average. Although 30-day alcohol use in CT was 22% higher than the national average, it still represented a decline over the previous year's figures. The 2007 Youth Risk Behavior Survey (YRBS) of high school students in Connecticut reported them to be at greater risk for suicide attempts compared to the US and other New England states. These data are indicative of prevention efforts having an impact in the state but underscore the need for more resources and greater coordination in order to make solid gains. Below are significant prevention accomplishments over the last year.

- Facilitated town hall meetings in 33 Connecticut communities that joined two thousand others across the United States to discuss and raise public awareness about the critical issue of underage drinking.
- Developed and administered the Connecticut Community Readiness Assessment for Substance Abuse Prevention to assess, plan for and evaluate substance use problems at the community level.
- Provided 24 trainings to 413 participants who pursued professional development through the DMHAS Prevention Training Collaborative.
- Convened a breakfast for college presidents as part of the Statewide Healthy Campus Initiative to call attention to the problem of alcohol and other substance abuse on college campuses and to recommit presidents to addressing the problems.

- Served 593 youth and families and 432 adults and professionals through the CT Youth Suicide Prevention Initiative in 2008.
- Sponsored a statewide prevention conference entitled "Preventing Underage Drinking in Connecticut—Moving Toward Solutions" which featured local and national speakers that focused on current strides, future direction and ideas for enhancing efforts.
- Conducted sub-regional needs and response capacity assessments of the use and consequences of six priority substances identified in the DMHAS Strategic Prevention Plan. The results of these assessments will be used to inform prevention programs and policies.
- Chosen by the federal Substance Abuse & Mental Health Services Administration (SAMHSA) to develop a short video showcasing underage drinking prevention efforts within the state. The video will be used as a promotional/informational tool to inform CT residents and policymakers, update current coalition members, and recruit new members to participate in important underage drinking prevention efforts.

III. CHALLENGES

- Increasing resources to fill unmet needs and support prevention service and management goals.
- Integrating prevention into the DMHAS recovery-oriented framework.
- Refocusing the existing training and technical assistance resources to align with the current and future prevention direction.
- Increasing coordination with state and local agencies; expanding partnerships with state and local agencies; and implementing several memoranda of agreements with state agencies.
- Developing a comprehensive strategic plan that integrates the goals and objectives of other multi-agency plans and facilitates the tracking of prevention outcomes across initiatives and programs.
- Communicating the capabilities, accomplishments and outcomes of DMHAS prevention initiatives and programs.
- Maintaining gains made by prevention through reinforcement of prevention messages across all sectors of society.

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

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The Department of Mental Health & Addiction Services

A Healthcare Service Agency

M. Jodi Rell
Governor

March 13, 2008

Thomas A. Kirk Jr.,
Commissioner

TEEN DRUG USE CONTINUES DECLINE

"Overall, illicit drug use by American teens continues gradual decline in 2007,"is the headline for the release of the 33rd national survey in the Monitoring the Future (MTF) series conducted by scientists at the University of Michigan's Institute for Social Research. It goes on to offer even more good news: Among the youngest students surveyed - 8th graders - **cumulative declines since peak levels of drug involvement in the mid-1990s are *substantial*.**

According to the latest MTF survey, ***long-term trends of decreasing youth drug*** use have continued from 2001 to 2007:

- *Use of any illicit drug dropped 24%*
- *Marijuana use decreased 25%*
- *Steroid use dropped by 1/3rd*
- *Ecstasy use is less than 1/2 of what it was in 2001 (54% decline)*
- *Methamphetamine use plummeted a staggering 64%*
- *Alcohol use, including binge drinking, decreased by 15%*
- *Cigarette smoking decreased by 33%*

The **drugs most responsible for this year's decline are *marijuana*** and various **stimulant drugs,** including ***Ritalin, amphetamines***, ***methamphetamine***, and ***crystal methamphetamine***. The only drug showing signs of an increase in use is MDMA (ecstasy).

In 2007, 860,000 fewer youth were using illicit drugs than in 2001

Percent Reporting Past Month Use

	2001	2007	Change as a % of 2001
Any Illicit Drug	**19.4%**	**14.8%**	**-24***
Marijuana	16.6%	12.4%	-25*
MDMA (Ecstasy)	2.4%	1.1%	-54*
LSD	1.5%	0.6%	-60*
Amphetamines	4.7%	3.2%	-32*
Inhalants	2.8%	2.6%	-7
Methamphetamine	1.4%	0.5%	-64*
Steroids	0.9%	0.6%	-33*
Cocaine	1.5%	1.4%	-7
Heroin	0.4%	0.4%	0
Alcohol	35.5%	30.1%	-15*
Cigarettes	20.2%	13.6%	-33*

* Denotes statistically significant change from 2001.

Note: Past month use, 8th, 10th, and 12th grades combined; percent change calculated from figures having more precision than shown.

Source: 2007 Monitoring the Future (MTF) study special tabulations for combined 8th, 10th, and 12th graders, December 2007.

CHALLENGES!

In the context of the continuing long-term progress, these data show that there are still challenges that remain:

- Overall, youth prescription drug abuse is second largest category of abuse, only behind marijuana
- Past-year use of Oxycontin increased 30 percent between 2002–2007
- Attitudes toward perceived risk of Ecstasy use have softened.

Challenges remain…but Connecticut is ready for them.

To draw meaning from these national data, **Connecticut's Strategic Prevention Framework** (see August 23, 2007 *Information…*) is focusing resources to collect, analyze, and report data on drug use among Connecticut's youth, including alcohol, tobacco, marijuana, heroin, prescription drugs, and cocaine. This information will not only allow us to understand drug use and consequences in our state, but by looking behind the numbers, we will also be able to identify specific factors that contribute to youth drug use and find the right kinds of strategies and programs to prevent it.

For more information, please contact Dianne Harnad at 860-418-6827 or e-mail at Dianne.harnad@po.state.ct.us.
To view previous issues, visit http://www.ct.gov/dmhas/infobriefs.

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

INFORMATION ...*foundation for good policy*

The Department of Mental Health and Addiction Services

A Healthcare Service Agency

M. Jodi Rell
Governor

August 23, 2007

Thomas A. Kirk Jr., Ph.D.
Commissioner

A Framework to Reduce Underage Drinking

Connecticut's prevention system has made substantial progress in decreasing substance use and abuse and promoting health. Aided by the federal Substance Abuse and Mental Health Services Administration's Strategic Prevention Framework (SPF), a 5-year, $11.8 million initiative funded by SAMHSA, 52 towns receive funding aimed at reducing underage drinking. The CT SPF is a collaborative effort of several State agencies, community, and academic partners that have a long history of working together to successfully implement evidence-based health promotion strategies.

Alcohol and Underage Drinking in CT: According to the 2002 National Household Survey of Drug Use and Health, 59% of people ages 12 or older in Connecticut are current users of alcohol. Underage drinking cost Connecticut taxpayers an estimated $600 million. Data on alcohol-related crashes resulting in fatalities places Connecticut in the "fatal 15" with 45.2% of all fatal motor vehicle crashes involving alcohol. The Connecticut SPF provides funding to 28 communities to address this problem.

Connecticut's Toolkit for Promoting Healthy Communities

- Coordinated approach to reducing alcohol, tobacco and other drug use, at the state, regional and local levels
- Statewide prevention services for individuals, families and schools
- State, community, and academic partnerships and resource sharing
- State and local data-driven planning and decision making processes
- Statewide Resources/Training Centers
- Underage drinking coalitions in communities and on college campuses
- Over 130 town-based Local Prevention Councils covering the state
- Evaluating and sustaining what works

Gains in Promoting Health

- CT youth and young adults engaged in promoting healthy behaviors among their peers
- Over 40 CT colleges and universities united to combat underage drinking on campuses
- Social Host Law enforced to deter providing alcohol to teens at house parties
- Retail compliance checks focused on reducing teen access to alcohol increased
- Education provided to alcohol sellers and servers
- Members of 28 new coalitions that are developing plans and strategies to reduce underage drinking and enforce policy and laws supported
- Use and consequence data tracked to measure progress towards a healthier Connecticut

Connecticut's Prevention Efforts Work!

- ✓ A 2002 survey found **decreased** alcohol, tobacco, marijuana, and inhalant use among middle and high school students.
- ✓ Data show a six-year **decline** in the rate of cigarette use with 7th-8th and 9th-10th grade student's rate falling to12% and 22% respectively.
- ✓ Tobacco merchants willing to sell tobacco products to minors **decreased** from 69% in 1996 to 10.7% in 2005.

For more information, please contact Dianne Harnad at 860-418-6827 or Dianne.harnad@po.state.ct.us .
Visit "www.ct.gov/dmhas/infobriefs" on the Web to see previous issues of "Information."

INFORMATION SYSTEMS DIVISION (ISD) AND EVALUATION, QUALITY MANAGEMENT, AND INFORMATION (EQMI)

I. BACKGROUND

The mission of EQMI is to continuously evaluate and improve the quality of the DMHAS service system. This is accomplished by ensuring data integrity, timely reporting and feedback to providers, and comprehensive analysis and evaluation regarding the effectiveness and quality of our services. EQMI's mission is supported by the Information Systems Division which has responsibility for information technology services.

The mission of the Information Systems Division is to provide quality Information Technology services and solutions to DMHAS, effectively aligning business and technology objectives through collaboration, in order to provide stable, secure, and cost-effective solutions.

II. HIGHLIGHTS/ACCOMPLISHMENTS

- DMHAS collects **service level data** for all persons it serves. This data is processed monthly.
- **Data Quality reports** are sent out to all providers monthly, identifying areas of improvement.
- **Quality site-visits** are an ongoing part of how DMHAS interacts and works with its provider community. The first phase of quality visits were completed in June 2008. Targeted data quality visits are continuing in order to address those providers with unresolved data quality issues.
- **Performance measures (PM)** with identified benchmarks are part of the human services contracts. Connecticut is one of the few states that reports on all required National Outcome Measures (NOMS) that are a condition of our federal block grant funding. The outcome measures cover the domains of employment, living situation, involvement with the criminal justice system, abstinence and reduction in substance use, stability in housing, access, capacity, retention, social connectedness, perception of care, to name a few. Monthly Performance Measures reports are sent out monthly at the provider and program level.
- **Annual Consumer Survey** is conducted to hear the opinions from people that receive care in our system and what they have to say about access, appropriateness, general satisfaction, outcomes, recovery, participation in treatment, and their interaction with our network of care. Over 24,000 consumers participated in this year's survey.
- **The World Health Organization Quality of Life (WHOQOL)** was incorporated into the Consumer Satisfaction Survey in FY 08 in order to better measure improvements in an individual's quality of life. Over 14,000 consumers participated in this survey. DMHAS may be the first publicly funded behavioral health system to utilize the WHOQOL.
- DMHAS continues to evolve its **data warehouse** that has made it possible to count people in services across various funding streams.
- **Recovery Management System (RMS):** RMS is an enterprise electronic treatment planning system being developed at CT Valley Hospital (CVH) that will provide all facilities with a person-centered, recovery-oriented conceptual framework, in which treatment planning is clearly driven by the person's goals. The electronic treatment plan, risk and suicide assessments, interface to the Behavioral Health Information System (BHIS). Service delivery and progress notes were all implemented at CVH in 2008. The addition of outpatient functionality and multi-facility features is scheduled to be complete by April, 2009. This will be followed by implementation at other DMHAS facilities.
- **DMHAS Provider Access System (DPAS):** DPAS is used for the core data capture, storage and retrieval required for its agency reporting and provider management. DMHAS is in the

process of re-writing its DPAS system, which is currently over ten years old. The replacement system, DMHAS Data Performance System (DDaP), will be a web-based data entry and on-line file processing application. The new application will provide enhanced functionality and efficiency, business rule enforcement at the database level and one central reporting repository. This system is scheduled to be implemented in spring 2010.

- **Behavioral Health Information System (BHIS).** BHIS is the admission, discharge and transfer system used at all DMHAS operated facilities since 1999. DMHAS is in the process of upgrading BHIS to its vendor's upward migration system, Avatar. The upgrade is scheduled to be complete by spring 2010.
- **Microsoft Exchange and Active Directory:** DMHAS plans to begin the migration to DOIT's Microsoft Exchange e-mail system in the second half of 2009. To accomplish this, DMHAS first needs to migrate from Novell to Microsoft's Active Directory structure which also resides within DOIT. This process has already begun and is scheduled to be complete in April, 2009. Once the migration to Active Directory is complete, DMHAS will be included when DOIT deploys system updates, patches, etc. resulting in reductions in administration, support and operational costs and ensuring adherence to state policies.
- **HIPAA Security Remediation**: The DMHAS infrastructure has been identified in the HIPAA Risk Analysis as a high risk area that requires immediate consideration. The current switches do not provide adequate security and are not configured for optimal performance. The agency will be replacing/upgrading the switches at all DMHAS facilities and is starting with the Connecticut Valley Hospital (CVH). DMHAS will work with Cisco design consultants (ePlus) and DOIT to review and re-design the infrastructure to utilize optimal security configuration options.
- **Learning Management System (LMS)**: LMS is a computer based learning management system which will allow for better management of training at clinical facilities. The chosen solution is an off the shelf software (SABA) acquired via an RFP along with DOIT and eleven other agencies. The new system will be centralized and capture all training for DMHAS and will encompass a large variety of support, e.g., certificates, class rosters, sign-in sheets, central transcripts for JCAHO, on-line registration and class space availability. It supports instructor led training as well as on-line/web-based training. Implementation is scheduled for early 2009.
- **Disaster Recovery**. DMHAS is continually working toward improving its security posture. This includes the establishment of a backup site in Sterling Forest, NY which houses full computer systems and application backups. Following a disaster or other disruptive event, DMHAS computer systems will be operational again within two days, the timeframe required by the business.
- **Training.** The Information Systems Division provides training for DMHAS employees to enhance their on-the-job computer skills. Classroom training sessions are held for BHIS, DPAS, Clinical Workstation, and Microsoft Office products monthly or quarterly depending on need. Each class is one-half day and they are available to all DMHAS facilities and Private Non-Profit providers.
- **Governance.** DMHAS has begun the process of implementing a Governance Model for all IT related projects. The primary goals for IT governance are to assure that new systems and projects have business value, meet or exceed customer expectations, and are delivered on time and within budget. This is being done in part by implementing an organizational structure with well-defined roles and responsibilities. The Governance Committee meets periodically to review project status and determine future direction.

III. CHALLENGES

- **Application Upgrades/Replacements:** Two of DMHAS' major applications, DPAS and BHIS, will need to be upgraded or replaced over the next two years. There are also several smaller applications, which will need to be replaced. Older systems are at an increased risk of failure and are generally more expensive to support or in some cases are unsupported by the vendor. Data collection enhancements are needed in order to have the desired information technology infrastructure and support to improve quality.
- **Data Quality Tracking:** An enhanced data quality tracking system needs to be in place to more systematically monitor provider data submissions and the quality of these submissions. EQMI is in the process of finalizing a new, automated tracking system that will simplify the data monitoring process.
- **Enhanced quality training program:** The quality training program must be enhanced. Providing on-going training and ensuring that persons in recovery are part of each and every effort that is initiated to improve quality of care for the people that we are tasked to serve.
- **Resource Availability:** Issues with resources may impact agency projects due to multiple and overlapping IT projects, and limitations imposed by the Governor's legislation regarding spending (e.g. use of consultants, durational employees). The agency plans to manage the situation by using the governance process to evaluate commitments and set priorities.

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

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The Department of Mental Health and Addiction Services

A Healthcare Service Agency

M. Jodi Rell
Governor

December 7, 2007

Thomas A. Kirk, Jr., Ph.D.
Commissioner

LISTEN AND LEARN
DMHAS 2007 CONSUMER SURVEY

One of the important ways to evaluate the quality of a healthcare system is seek the opinions of the people who receive services. 2007 is the 5th year that DMHAS has used the **Consumer Survey** to gauge the perspective of its customers and as a framework for a report card on its service providers. Twenty eight questions were asked on the survey to measure 7 domains, and for the first time, **consumers' direct quotes** were included.

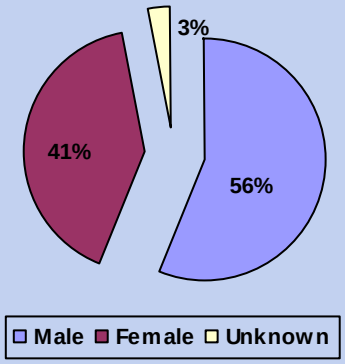
Satisfaction Measured in 7 Domains

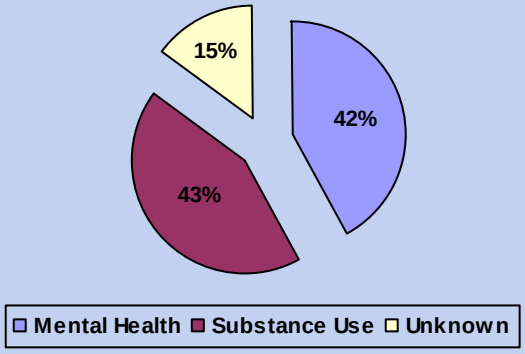
Access: Did I get services I need at times that were good for me?
Appropriateness/Quality: Did staff tell me about side effects?
Outcome: Did I get better?
General Satisfaction: Would I recommend this agency to others?
Participation in Treatment: Did I feel comfortable asking questions about my treatment?
Respect: Did staff respect my wishes?
Recovery: Can I have the life I want despite my disorder?

24,147 surveys completed statewide

Over 120 agencies participated

Who Completed the Survey?





QUOTES ON THE BRIGHT SIDE

As of today, my life has taken a complete turn around. I am able to walk with my head up.

I have a sense of independence I haven't had in a long time. I am not getting help from welfare and I am hopeful that I will not be a recipient in the future.

May I please have a letter of recovery typed up? I feel that I have recovered.

QUOTES SHOW IMPROVEMENT NEEDED

I never received the services I really needed.

Counselors are indifferent. No real interest in me. Use time poorly.

20 minutes is not long enough for a psych appointment.

"Constant evaluation of the service system is essential; it ensures that we keep in touch with the reality of our services and listen to the people that we aim to serve…Listening to their feedback is so important - about their strengths, what works best for them, how they feel they are treated, and the value of services. This must be meshed with the input of skilled, dedicated staff and be at the center of all quality care and system improvement efforts."
Commissioner Thomas A Kirk, Jr., Ph.D.

See the full 2007 Consumer Survey on line at www.ct.gov/dmhas/lib/dmhas/consumersurvey/07csreport.pdf .

JAIL DIVERSION/OFFENDER REENTRY/TRANSITIONAL SERVICES

I. BACKGROUND

Approximately 21% of the CT jail and prison population are in need of mental health treatment. Approximately 80% of offenders meet criteria for substance use disorders. Substance use leading to violation of probation or parole is a common cause of re-incarceration and is commonly related to criminal recidivism. By engaging offenders in services prior to release, they are less likely to be re-incarcerated or rearrested for new offenses and more likely to remain engaged in treatment in the community.

Many individuals in the criminal justice system with psychiatric needs were arrested for behaviors related to their psychiatric disorders and/or use of alcohol and other drugs. They are often people who have had difficulty engaging in community services and have been served with expensive crisis services in hospital emergency rooms and commitment to hospital psychiatric units. In some cases, arrest is the only option available to police officers for dealing with problem behaviors.

Connecticut has made a significant investment in a broad array of services and programming for individuals with mental health and substance use disorders who are involved in criminal justice system. Extraordinary results indicate this has been a good investment that saves money, makes our communities safer and improves the health of individuals. Connecticut has been recognized as one of the leaders in the nation in developing creative solutions to divert many persons with psychiatric needs from incarceration following arrest.

II. HIGHLIGHTS/ACCOMPLISHMENTS

- **Jail Diversion Program (JD)** provides a community treatment option for people with serious psychiatric disorders involved in the criminal justice system. JD programs are in all 20 Geographic Area (GA) criminal courts. JD provides consultation for over 10,000 cases annually, clinically screens approximately 4,500 individuals with serious psychiatric disorders, and diverts approximately 2,000 (44%) individuals. Some programs have one or more transitional beds.
- **Women's Jail Diversion Programs (JDW)** is an innovative, gender specific program that serves women with substance use disorders who experience serious psychiatric consequences from emotional, physical, and/or sexual abuse. Integrated mental health and substance use and trauma treatment, intensive outreach, engagement and comprehensive community support, and life skills training are provided in New Britain/Bristol and New Haven courts and Probation. Twenty individuals are served in each location (up to 50 annually), with the length of stay of 6 months. Over half of the participants successfully complete the program and are not incarcerated. Annual program costs to serve 50 women equals 6 months incarceration for 20 women. Arrest rates were cut by approximately 50% in the year following program admission for all participants. The New Britain/Bristol program funds 1 shelter bed and 1 DMHAS certified sober house bed permitting diversion for women who need housing/support.
- **Specialized Trauma-Informed Jail Diversion Program (JDT)** - DMHAS received a three-year, $1.2 million federal grant in 2006 to expand the Women's JD program in Hartford to also serve men. After 2½ years of operation it was concluded that this model is not effective for serving pretrial men with trauma so the program is now serving only women. JDT has provided valuable insights that will be used to guide future program development.

- **Alternative Drug Intervention (ADI) Program** is a diversion program implemented in 2005 to replace the New Haven Drug Court. Intensive outpatient substance abuse treatment is provided to New Haven area residents. Case management, basic needs, education, linkage to 12 step groups, individual and group treatment are also provided. Non traditional groups, such as acupuncture, relaxation group and yoga, augment treatment. In SFY 08, ADI admitted 157 clients and discharged 83 clients. Of the 83 discharged clients, 70 (84%) avoided incarceration. Duration in the program was 3-6 months. DMHAS partners with Yale to administer the program.
- **Advanced Supervision and Intervention Support Team (ASIST)** is jointly managed and funded by DMHAS, the Department of Correction (DOC) and the Court Support Services Division (CSSD) of the Judicial Branch for pretrial defendants, probationers, and parolees with moderate to serious mental illness. It places DMHAS clinical staff in 7 existing Alternative to Incarceration Centers (AIC) where supervision increases numbers who can be diverted or released from incarceration. ASIST uses an innovative skills training model to reduce recidivism. It is located in Bridgeport, Hartford, Middletown, New Britain, New Haven, New London, and Waterbury. Transitional beds are provided in New Haven (1) and New London (2). ASIST is still in implementation phase with the capacity expected to be 350 or more per year.
- **Community Recovery Engagement Support and Treatment Center (CREST)** is a day reporting center with access to long-term vocational, educational, social and psychiatric rehabilitation services. It provides intensive case management, skill development and supervision for pretrial defendants, probationers, and parolees who might otherwise be incarcerated. Implemented in 2007, its capacity is 30 individuals served by the New Haven area court. Length of stay is 3-6 months. Program outcome evaluation preliminary data indicates that more than 75% of participants successfully complete the program and avoid incarceration saving $65,000 each in incarceration costs annually.
- **DMHAS-DOC Interagency Program** facilitates referrals of sentenced inmates with serious psychiatric disorders to appropriate community services after release. Staff from the DMHAS Local Mental Health Authority (LMHA) visits the inmate in prison 3-6 months prior to release to begin development of discharge plans. Monthly inter-agency meetings are held to discuss quality improvement, policy development and discharge planning for difficult cases. Through continued collaboration with DOC, systems issues continue to be addressed resulting in improvements in the referral process. In SFY 08, DMHAS processed 308 referrals of inmates from DOC to community services and an additional 50 who were referred to the CT Offender Reentry Program.
- **Connecticut Offender Reentry Program (CORP)** assists with community reentry of sentenced male and female inmates with severe psychiatric disabilities and/or co-occurring mental health and substance use disorders who are returning to Bridgeport, Hartford, New Haven, Waterbury, Norwich/New London and Stamford. Staff begin working with inmates 6-12 months prior to release. The program operates in Garner, York and Osborn correctional facilities. DMHAS-led groups are held twice a week in the three DOC facilities. CORP provides comprehensive pre-release assessment and skills building program including the development of a community support network. In FY 08, CORP accepted 50 individuals; 24 were discharged to the community. Only 10% of clients served in SFY 07 were re-arrested and 10% were re-incarcerated. The program capacity is 120 per year for the three sites. Limited transitional beds are available in Hartford (3), New Haven (2), and Bridgeport (2).
- **Transitional Case Management Program (TCM)** assists with reentry of sentenced male inmates with substance use disorders who are returning to Hartford, Waterbury, Bristol/New Britain and Norwich/New London. Staff begin working with inmates in the DOC facilities 3-4 months prior to release by providing discharge planning, assistance with housing, and

application for entitlements. After release, staff provides continued community support, housing assistance, outpatient substance abuse counseling, and assistance with employment for 4-5 months. In SFY 08, TCM served 110 individuals and transitioned 90 to the community. During their time in the program, only 10% of participants were re-arrested and 2% re-incarcerated. Hartford's capacity is 80 per year. Capacity at other sites is 60 per year. TCM also provides payments to DMHAS certified sober houses for up to 3 months.

- **Collaborations with DOC and CSSD** - DMHAS has extensive collaborations with DOC and CSSD that have increased interagency understanding of different roles, improved continuity of care for mutual clients, developed formal referral systems, created integrated programming, facilitated acquisition of federal grants, and allowed quick resolution of difficult cases.
- **Housing** - DMHAS is making Housing Assistance Funds (HAF) available to its criminal justice programs serving individuals with serious mental illness. HAF provides temporary rent subsidy and loans for security deposits for permanent housing. DMHAS is also developing an RFP for additional transitional housing beds for this population with implementation in late SFY 09.

III. CHALLENGES

- **Data Management** - Insufficient data system to track program activity, effectiveness, service utilization, engagement in services, recidivism, and inter-program activity. New data screens implemented in 2008 will improve tracking of Judicial Department clients.
- **Service Gaps/Capacity Limitations** - While DMHAS has programs that cover the full range of involvement in the criminal justice system for persons with psychiatric disabilities, these programs are not available in all areas of the state. Programs are short term and regular LMHA/affiliate programs often do not have sufficient capacity to fully serve criminal justice clients so offender programs continue services beyond the planned length of stay.
- **Housing** - Insufficient housing that is safe, affordable, and appropriate impairs engagement in community services, increases the risk of arrest, prevents diversion from incarceration, and prevents early release from incarceration. DMHAS staff has been meeting with CSSD and DOC to identify resources to address this issue.
- **Stigma** - DMHAS, DOC, and CSSD have encountered local opposition to establishing much-needed residential programs for offenders with psychiatric disabilities. DMHAS has used these situations to educate communities about the need for such services, misconceptions about individuals with behavioral health disorders, and the effectiveness of programs.

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

INFORMATION . . . foundation for good policy

The Department of Mental Health and Addiction Services
A Healthcare Service Agency

M. Jodi Rell, Governor

July 15, 2005

Thomas A. Kirk, Jr., Ph.D., Commissioner (860-418-6700)

Melissa's Project

***Melissa** is seriously impaired by prolonged mental illness. She requires extensive treatment and recovery support services in order to live in the community. Melissa has a court-appointed conservator to act on her behalf in making important decisions that she is unable to make for herself. Melissa was plagued by repeated hospital admissions, homelessness and arrests for nuisance behavior stemming from her illness. Other individuals in the community have similar profiles—seriously impaired, conservator, repeated hospitalizations, arrests, and homeless. Melissa and some persons with similar conditions are doing better now, thanks to a new service that is named for her.*

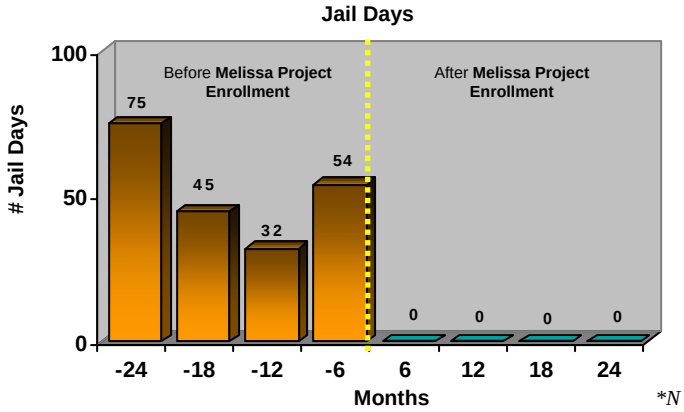
The Melissa's Project was created to break this unfortunate cycle. Funded by the Probate Court Administration and DMHAS, its mission is to monitor and coordinate services for people with complex mental-health needs to help ensure access to quality healthcare and services by facilitating linkages among community service providers.

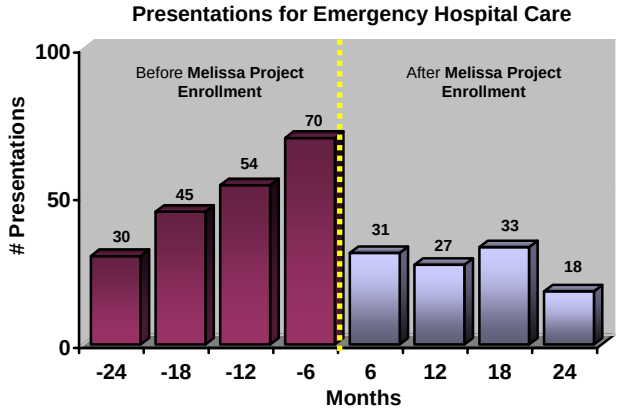
Administered by Guardian Ad Litem Services, Inc., a private, non-profit agency in northwestern CT, Melissa's Project:

- *Serves people with serious, prolonged mental illness who have court-appointed conservators.*
- *Provides better-informed treatment options and outcomes for individuals and their conservators.*
- *Cuts through red tape to access services.*
- *Identifies community resources and specialty services, and solves problems around accessing these.*
- *Diminishes hospitalization, homelessness, and criminal recidivism.*
- *Provides practical approaches to safe-and-affordable housing and other basic human needs.*

Judge James J. Lawlor, Probate Court Administrator

"Melissa's Project has been a wonderful resource for our Probate Courts. The Project started as a small pilot aimed to assist persons with mental illness who were repeatedly coming before the court. Our own internal review indicates what we all believe to be true, that the Melissa's Project is successful. . . . Melissa's Project is also an example of interagency collaboration at its best."





**N = 44 for study graphs*

The Melissa's Project, while still quite young, is demonstrating significant reductions in recidivism rates, homelessness and behavioral symptoms that can result in actual or perceived criminal behavior. This proactive response to needs has translated into demonstrable gains for our people, as evidenced by a dramatic reduction in both emergency room visits, days spent in jail and a 65% reduction in days of inpatient hospitalization comparing patients two years before and two years after Melissa's Project.

For further information, please contact Sara Valentino, Angela Caron at 203-723-4332 or Karen.Evertson@po.state.ct.us .
To view previous issues visit http://www.dmhas.state.ct.us/infobriefs/index.htm

MENTAL HEALTH TRANSFORMATION

I. BACKGROUND

Mental health transformation (MHT) is an "opportunity to fundamentally alter the form and function of the mental health service delivery system to better meet the needs of the individuals and families it is designed to serve" (*Transforming Mental Health Care in America: The Federal Action Agenda: First Steps,* July 2006). This means that mental health services and treatments must be geared to provide consumers/individuals in recovery real and meaningful choices about treatment options and providers; and must focus on increasing each individual's ability to achieve their maximum potential in all aspects and stages of their lives.

Findings from the President's New Freedom Commission Report on Mental Health provided the rationale for mental health transformation:

- Mental health services are fragmented.
- The focus of mental health care is on managing disabilities rather than strengths, promoting independence and recovery.
- Access to care may be limited by stigma or other barriers.
- Mental illness is often detected too late.
- Research on effective mental health treatment and Evidence-based practices are slow to be adopted.

In October 2005, CT was 1 of 7 states awarded a Mental Health Transformation State Incentive Grant (MHT-SIG) by the Substance Abuse and Mental Health Services Administration (SAMHSA). Connecticut's MHT SIG, totaling $13.7 million over 5 years, is being led by the Governor and a group of state agency partners, non-profit and private program providers, and consumers, youth and family members. MHT SIG dollars support infrastructure change allowing CT to continue moving towards a recovery-oriented system.

II. HIGHLIGHTS/ACCOMPLISHMENTS

Connecticut's Mental Health Transformation efforts have been organized into four domains: **Consumer/Youth and Family Driven System**; **Community Education**; **Data-Driven Decisions**; **and Workforce Development**.

- **Consumer/Youth and Family Driven System**
  - A Consumer/Youth and Family **Advisory Council** informs the transformation process, participates in decision making and shapes implementation to ensure inclusion of the consumer, youth and family voice. Recently the Advisory Council formally outlined their roles, functions and membership.
  - **Connecticut implemented a stipend process to increase and expand Consumer, Youth and Family** involvement to **all levels** of the Transformation process including:
    - Planning councils and collaboratives, ad hoc committees, grant review committees and evaluation activities.
    - Over 50% of reviewers for a recent MHT RFP were consumers or family members.
    - Other state agencies are involving consumers and family members in planning and procurement processes as a result of MHT.
  - **15 individuals** in recovery, youth, or family members **have been employed** as a direct result of the MHT Grant.

- **Consumer Recovery Employment Consultation Service (C-RECS)**, implemented by Focus on Recovery United (FOR-U), is preparing and supporting persons in recovery for employment in the behavioral health workforce. This includes:
  - Training;
  - Post-hire support, retention and career development efforts;
  - Consultation and technical assistance to agencies to promote culture change supporting the success of persons in recovery as workforce participants.

  Sixty applications for services were received within the first 10 days of operation, exceeding the target goal by 100%. Thirty six persons have received at least one coaching session. Four individuals secured employment and over 50 remain interested in C-RECS services.
- **Quality Improvement Collaborative (QuIC)**: Consumers/youth/family will identify and implement recovery-resilience oriented performance measurements for quality improvement. They will design an assessment system to evaluate the service delivery models and programs. This consumer, youth and family run initiative recognizes consumers/youth/families as experts in their own recovery. QuIC Partners include: Regional Mental Health Boards, Advocacy Unlimited, NAMI and FAVOR. A kick-off event held in September 2008 drew more than 150 persons and over 200 attended a follow up event in October, the majority of participants were individuals in recovery and family members.
- **Consumer Research and Evaluation Network (C-REN)** trains consumers and family members to undertake evaluation work. C-REN will also provide consultation and/or technical assistance on research and evaluation activities to consumer-run projects.

- **Community Education**
  - A Town Hall Meeting, ***"Opening Doors, Opening Minds"*** was broadcast live on CPTV on June 26, 2008. Over 200 viewers called in or e-mailed questions. The Town Meeting can be viewed online at www.cpbn.org/program/opening-doors-opening-minds.
  - Since launching in October 2007, the ***Ct.NetworkofCare.org*** website has received over 3,500,000 hits. MHT staff has provided demonstrations of the site to over 300 persons across the state. Training sessions have been added to the DMHAS Training and Education Catalog for fall 2008 and spring 2009.
  - In October 2008, **CPTV** broadcast the first of three half hour **documentaries on mental health**. The second was broadcast on January 29, 2009. Plans are in place to secure foundation funding to expand this to a ten part series.
  - With the assistance of a professional media consultant, MHT developed and implemented a statewide Communications Campaign to address stigma and mental health awareness. Ads were published in regional editions of Time, US News and World Report, Newsweek and Sports Illustrated magazines. Radio ads were broadcast on several local radio stations throughout the day, including during peak drive times. Public responses to these ads have been positive and have resulted in requests from individuals and communities for additional information and education.

- **Data-Driven Decisions**
  - A **Memorandum of Agreement** was signed by the Department of Mental Health and Addiction Services, the Bureau of Rehabilitation Services and the Department of Developmental Services to pilot a data sharing project. The analysis of the data and results of the pilot were shared with State Agency Commissioners in October 2008. Further analysis to establish service overlap and cost is underway.

- **Workforce Development**
  - The Yale Center for Workforce Development has implemented multiple initiatives to address Behavioral Health Workforce issues. Key to the sustainability of these efforts is the **CT Workforce Collaborative for Behavioral Health**. A memorandum of agreement is currently being reviewed by more than 12 state agency partners to coordinate workforce activities and ensure sustainability of the Collaborative.
  - The Yale Center for Workforce Development issued a Request for Qualifications (RFQ) in January 2008 for the Supervisor Competency Development Initiative (SCDI). The initiative was designed to strengthen the knowledge and skills of supervisors in selected Connecticut mental health clinical and/or rehabilitation agencies. Training and technical assistance was provided at no cost to participating agencies. To date, the initiative has trained 16 senior leadership, 105 supervisors and 154 direct care staff. All supervisors who attended trainings will receive 24 continuing education credits through DMHAS and the National Association of Social Workers.
  - A large number of health and human service personnel who are not part of the specialty behavioral health workforce routinely respond to the needs of persons with mental health or addiction problems. This workforce development initiative was designed to strengthen the ability of these personnel to support persons with behavioral health needs by providing training about the nature of behavioral health problems and treatment. Staff from the CT Department of Labor (DOL) were selected to be the focus of this initiative, given the frequency with which they encounter individuals with behavioral health needs. A training curriculum was designed specifically through an inter-agency collaboration with The Yale Center for Workforce Development, NAMI-CT and the Department of Labor (DOL). A total of 67 DOL staff were trained as part of this initiative.
  - Four CT Universities will teach graduate students in the Schools of Social Work, Psychology and Marriage and Family Therapy about Intensive In-home treatment, an evidenced based practice using a curriculum developed by the Wheeler Clinic for MHT Workforce Development.
  - A proposal submitted by the CT Chapter of the National Alliance on Mental Illness was selected in response to an RFP to provide Parent Leadership Training across the state using the Agents of Transformation curriculum. Parent Leadership Training was conducted with 71 parents in the first month. Twenty one parents went on to receive Advanced Leadership Training and seven participants have been accepted to become trainers for the program.
  - A **Request for Qualifications** was released in June 2008 to identify two communities that will receive infrastructure support for implementing Wraparound services to divert youth with behavioral health issues from the juvenile justice system.
  - The Coordinating Center for Wraparound Initiative and the Court Support Services Division will expand the impact of the **Wraparound initiative** by linking it with a school-based juvenile justice diversion funded by the MacArthur Foundation.

- **Mini Grants**
  - A **request for proposals** was issued in the spring 2008 releasing **$1.3 million dollars** to consumer/youth/family organizations, state agencies and private non-profit organizations to promote infrastructure changes consistent with the goals of the Mental Health Transformation Grant. Seven review committees, consisting of 52% consumers and family members, reviewed 74 applications and 35 received funding.

III. CHALLENGES

MHT SIG are widespread in nature and attempt to create fundamental changes in the way mental health services are delivered by each participating agency. Strategies of such a transformative magnitude present their own unique challenges:

- The extent and scope of programs to be included in a consumer/youth/family-driven continuous quality improvement process which utilizes recovery-oriented performance data to inform service delivery.
- Preparing persons in recovery of various ages and multiple agencies for successful placement and retention of certified peer specialists.
- Exploring and facilitating data interoperability across state agencies to identify needed system change.
- Establishing the Connecticut Workforce Collaborative on Behavioral Health as a permanent body charged with planning, coordinating, and implementing interventions to strengthen the workforce.
- Expanding the workforce skilled in providing evidence-based intensive in-home family treatment.
- Strengthening the role of parents in the workforce by providing leadership training.
- Developing the capacity of supervisors to train, manage, and mentor direct care staff with the support of Web-based learning resources.

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PEOPLE WITH SERIOUS MENTAL ILLNESS IN NURSING HOMES

I. BACKGROUND

Medicaid Waiver – In March, 2006, a study group established by the General Assembly recommended that Connecticut apply to the federal government for a Medicaid Home and Community-Based Services (HCBS) waiver to divert and discharge adults with serious mental illness from nursing homes. Following development and submission of the waiver application, the federal Centers for Medicare and Medicaid Services (CMS) approved Connecticut's waiver program to begin operation on April 1, 2009. The Mental Health Waiver program (to be operated by DMHAS with oversight from the Department of Social Services) will serve 216 individuals (72 new participants, in each of three years) using a unique, individualized blend of Medicaid and state funded community based services.

Each person who enrolls in the Mental Health Waiver is slated to participate in a Person-Centered Planning process leading to the development of an individualized Recovery Plan. The plan, developed collaboratively with the participant, a DMHAS Support Coordinator, and a Transitional Case Manager from the Local Mental Health Authority would include one or more of the following services:

- **Rehabilitative Services:**
  - **Assertive Community Treatment (ACT)** – intensive clinical and rehabilitative care provided by an interdisciplinary team; nationally recognized as an "Evidence-Based Practice."
  - **Community Support Program (CSP)** – a flexible, team-based approach to community rehabilitation.
  - **Peer Support** – a "step-down" and follow-up to ACT or CSP provided by a trained and certified peer specialist (i.e., a person who understands mental illness and recovery from his/her own personal experience).
  - **Supported Employment** – an effective array of mental health supports designed to help participants find and sustain competitive employment.

- **Support Services:**
  - **Recovery Assistant** – homemaker, companion, personal care, and in-home respite services designed to help a participant maintain his/her own home.
  - **Transitional Case Management** – services provided during the weeks prior to, and immediately following, discharge from a nursing home, to help locate and set up a suitable apartment or other living arrangement.
  - **Short Term Supervision and Support** – services designed to stabilize a participant in an emerging crisis situation.

- **Other Ancillary Services:**
  - **Specialized Medical Equipment**
  - **Home Accessibility Adaptations**
  - **Non-medical transportation**

Money Follows the Person – In a closely related development, the Department of Social Services recently obtained CMS approval to establish a *Money Follows the Person* (MFP) program in Connecticut. MFP is designed to serve at least 700 people, 100 of whom would transition to the Mental Health Waiver within the waiver's first three years of operation. In combination, the waiver and MFP offer great potential to use Medicaid funding in support of

community-based alternatives to long-term institutional care, a strategy our federal partners have dubbed "rebalancing."

II. HIGHLIGHTS/ACCOMPLISHMENTS

- In order to support new services for the elderly and for people being diverted or discharged from nursing homes, DMHAS has established an Office of Older Adult Services (OAS), and has hired an OAS program director. The waiver program will operate within OAS. A Mental Health Waiver Program Director and waiver staff have also been hired and trained.
- In preparing the Mental Health Waiver, DMHAS had extensive involvement in: 1) developing reimbursement rates; 2) writing waiver service definitions; and 3) conducting clinical assessments of nursing home residents in support of the cost-neutrality analysis required by the federal government.
- In addition, DMHAS has conducted assessments on more than 400 nursing home residents with serious mental illness as part of the start-up of the waiver and MFP, and to plan for community placements and supports.
- DMHAS is negotiating a contract with an Administrative Services Organization (ASO) that will provide assistance to service providers as part of waiver operations (e.g., credentialing, claims processing).
- DMHAS has conducted several training programs for waiver service providers.
- In addition to the Mental Health Waiver, DMHAS has increased efforts to divert people with serious mental illness from entering nursing homes by providing funding for the establishment of registered nurse (RN) positions in several LMHAs.

III. CHALLENGES

- Federal rules for the operation of waiver programs are extremely complex. This is the first Medicaid waiver to be operated by DMHAS. In order to prepare the waiver application and operate the waiver program, the Department has had to develop expertise in many new technical areas. Much remains to be learned when the waiver program is fully operational.
- The lack of safe, affordable housing is one of the foremost challenges in developing community placements for people with serious mental illness being diverted or discharged from nursing homes. The Connecticut legislature has helped to address this problem by providing funds and Rental Assistance Program (RAP) Certificates to participants in MFP and the Mental Health Waiver.

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PRIMARY HEALTH CARE AND WELLNESS

I. BACKGROUND

Primary or physical healthcare and substance use/mental health (SU/MH) care are generally treated as separate fields with patients seeking physical healthcare from primary care physicians and mental health or substance use care from behavioral health providers. Little or no dialog takes place between the two. However, physical health and substance use/mental health care are closely linked, with each impacting the other. Overall health wellness is essential to mental health and recovery. Therefore, we strive for an integrated healthcare and mental health and substance use system for people with serious mental health and substance use conditions.

- Individuals with serious mental illnesses living in the community have a **shorter lifespan than the general population by 20-25 years** with suicide playing only a small part of this. Rather, it is generally caused by unhealthy living, poverty and inadequate physical healthcare.
- **50 to 80% of patients with diagnosable mental illness are smokers** compared to approximately 21% of the US population over age 18.
- People with serious mental illness are two times more likely to have **diabetes, hypertension, or obesity,** yet are significantly less likely to receive cardiovascular disease risk-lowering drugs, including aspirin, beta blockers and ACE inhibitors.
- Some **antipsychotic medications contribute to obesity**, raising cholesterol (triglyceride) levels and exacerbate the likelihood of developing diabetes, hypertension, heart disease and stroke.
- People with serious mental illness often have **trouble accessing basic health services** and often **use emergency departments** for obtaining routine medical care resulting in inappropriate care and a significant number of **preventable medical admissions** to acute care and inpatient settings.
- **75,000 deaths are attributable to excessive alcohol use** in the U.S. each year making it the third leading lifestyle-related cause of death. In 2003, **over 2 million hospitalizations** and over **4 million emergency room visits** were alcohol-related.
- **Heavy drinking** over a long period of time **increases the risk for heart disease, high blood pressure, and some kinds of stroke.** Long-term heavy drinking increases the risk of certain forms of **cancer**, especially cancer of the esophagus, mouth, throat, and larynx (voice box).
- Injection drug use is responsible for more than **1/3 of all adult and adolescent AIDS cases** and more than **1/2 of all AIDS cases in infants and children.**
- More than 2 million Americans suffer from alcohol-related liver disease. About 4 million people in the U.S. have Hepatitis C (HCV), a virus that leads to cirrhosis and liver cancer, causing between 10,000 and 12,000 deaths each year. Drug users are 2 to 6 times more likely to contract tuberculosis.
- Potential **life lost before 65 in heroin users is 18.3 years**. The leading cause of death is heroin overdose, followed by chronic liver disease and accidents. Cancer, cardiovascular diseases and homicide also ranked highly as causes of death.
- The healthcare systems that serve physical and SU/MH needs are fragmented and isolated from one another, negatively impacting the quality of care. Persons with SU/MH disorders **often don't have their medical needs met**. Physical health problems among persons with SU/MH disorders often go undiagnosed and are inappropriately treated by primary care practitioners. **Patients with mental health problems** receive poorer quality and less intense medical health care **compared to those without mental illnesses. There are many**

possible explanations, including barriers to accessing services, patient help-seeking barriers, patient-physician communication difficulties, stigma and bias against SU/MH patients, and other barriers.

II. HIGHLIGHTS/ACCOMPLISHMENTS

- A range of **primary health/wellness initiatives** has been implemented by individual hospitals and clinics within the DMHAS system. These include programming on **diabetes management**, **vaccinations, cancer screening, good nutrition, exercise** and other preventive/wellness concepts.
- An initiative has begun, with leadership by the DMHAS Medical Director, to identify strategies for **assessing the primary healthcare needs** of persons in the DMHAS health care system and **delivering integrated primary and substance use and mental health care**. A steering committee of primary and SU/MH care professionals has been established. DSS and DMHAS have begun to collaborate to identify high utilizers of primary and SU/MH care services. A demonstration project will be developed to provide education and consultation from expert SU/MH professionals to primary health practitioners and community clinics.
- **Smoking cessation programs and supports** have been implemented across the state at many DMHAS operated and funded programs. Through coordination between DMHAS and DPH, access to Quitline supports is available to individuals receiving substance abuse and/or mental health services in the community.
- DMHAS' Capitol Region Mental Health Center participates in the **Hartford Advisory Council**, a collaborative of healthcare providers that includes St. Francis and Hartford Hospitals, Burgdorf/Fleet Health Center and the Hartford Health Department to address health concerns for Hartford residents. Recent focus has been on diabetes, depression and hypertension.
- Community Health Services, Inc. and DMHAS have created a **collaborative care model**, incorporating treatment modalities from medical and behavioral health disciplines that include: medical screenings for persons receiving behavioral healthcare and mental health and substance use screenings for people receiving primary health care; a standardized and seamless referral process, and care coordination strategies.
- DMHAS' Southeast Mental Health Authority, in conjunction with the DMHAS Office of Multicultural Affairs, developed a **pilot project to offer telemedicine/telehealth to Latinos** in the southeast region using electronic information, imaging and communication technologies where long distances and language barriers impede access to healthcare.

III. CHALLENGES

- Providing medical health, mental health, and substance abuse services within the same location leads to improved outcomes. However, such **integration of services is not commonly available or may be difficult to establish.**
- **Placing behavioral health consultants at primary care clinics to identify persons** with behavioral health problems through screening, brief intervention and referral to treatment (SBIRT)**.**
- Providing consultation on specific cases, and/or collaborative and educational strategies **aimed at increasing primary care physicians' effective detection and treatment of mental health and/or substance use disorders.**
- Providing **specialty mental health training for primary care physicians, or including mental health practitioners on primary care teams.**

- Embedding primary care professionals within SU/MH care clinics, incorporating primary healthcare in all behavioral health treatment/recovery plans **and including primary care professionals on the SU/MH care treatment teams.**
- **Improving coordination of care between substance abuse treatment providers and pain management physicians** to reduce incidents of polypharmacy, "doctor shopping" and other practices that increasingly result in opioid analgesic-related overdose events including deaths.

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INFO Brief

Healthy People, Healthy Communities. Let's Make it Happen!

May 29, 2008

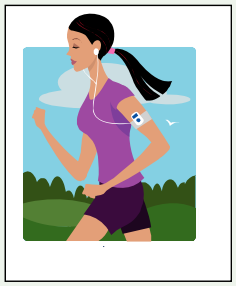
Connecticut Department of Mental Health &Addiction Services
Thomas A. Kirk, Jr., Ph.D., Commissioner

Taking Action Against Obesity

Obesity is a serious medical problem that disproportionately affects people with severe mental illness. Obesity is a condition of excess body fat with negative consequences that can include diabetes, hypertension, heart disease, strokes, increased risk of certain cancers, osteoarthritis, and possibly shortened life expectancy.

Patients with severe mental illness have an increased rate of obesity due to:

- Sedentary lifestyle and lack of exercise
- Inadequate knowledge of health maintenance issues
- Lack of availability of healthy food options because of low income
- Adverse effects of antipsychotic medications (weight gain, insulin resistance, elevated triglycerides—a chemical form of fat in the blood)



Results of the CMHC study

There was a significant weight loss of 6.4 lbs. at the end of the 16 week intervention and a mean weight loss of 10.41 lbs. at 6 months without booster sessions. There was also a significant reduction in blood sugar levels and a trend toward significant reduction of triglycerides in patients who completed the intervention.

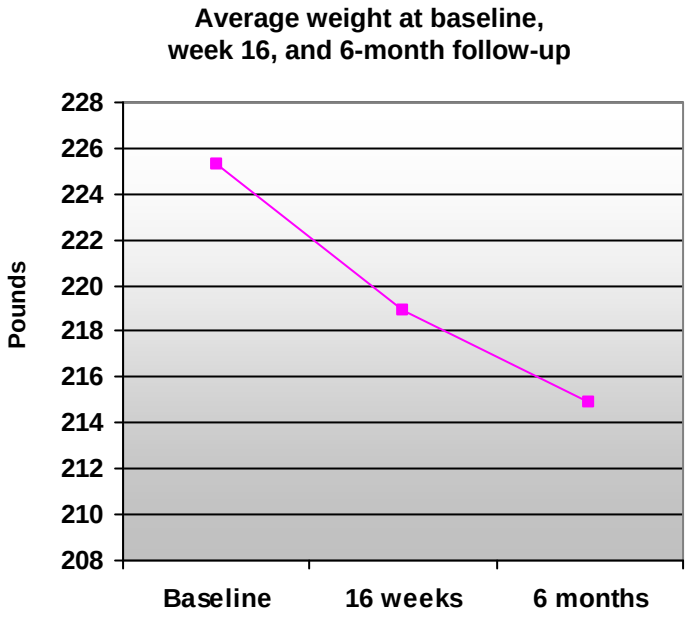
What are the implications for our DMHAS population?

Simple, well designed behavioral programs can produce lasting weight loss for people with serious mental illness and obesity, and can decrease medical risk factors and improve quality of life.

What can be done about the problem?

Researchers at the DMHAS Connecticut Mental Health Center (CMHC) conducted a weight management program for 18 obese outpatients with serious mental illness. The interventions were as follows:

- 16 weekly meetings with a nutritionist from Yale-New Haven Hospital
- Nutrition education on food choices, portion control, healthy cooking, reading food labels, healthy snacks
- Behavioral modification strategies for permanent lifestyle changes: goal setting, daily food diary, weekly review of diary with dietician
- A novel incentive program: patients reimbursed up to $25 each week for items purchased from a list of allowed healthy foods
- Grocery store tours led by the dietician
- Exercise encouragement: step counters were provided to track level of activity and outdoor group walks were conducted.



For more information, please contact Michel.Jean-Baptiste@yale.edu . To view previous issues, visit http://www.ct.gov/dmhas/infobriefs.

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

INFORMATION . . . *foundation for good policy*

The Department of Mental Health and Addiction Services

A Healthcare Service Agency

February 16, 2005

M. Jodi Rell
Governor

Thomas A. Kirk, Jr., Ph.D.
Commissioner
860-418-6700

Improving Medical Care for People with Severe Psychiatric Illness

Diabetes is a growing health concern in the United States. The Centers for Disease Control and Prevention has reported that:

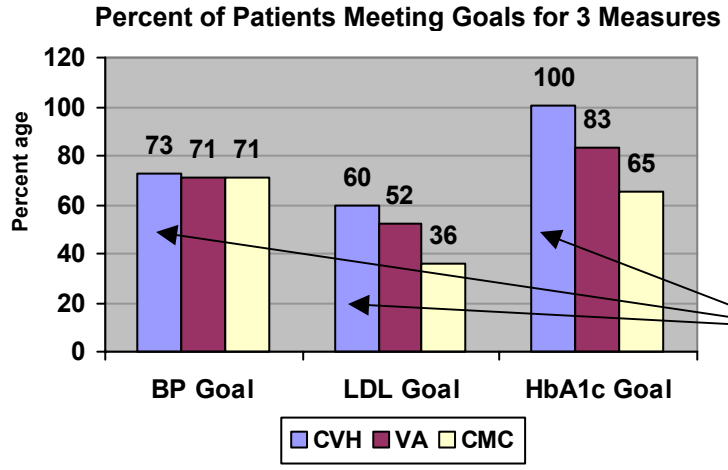
- The prevalence of diabetes rose dramatically during the 1990s.
- Approximately 4% of Americans had diagnosed diabetes in 1990, whereas an estimated 7.3% had diabetes in 2000.
- Nearly 800,000 new cases are diagnosed each year; 90 to 95% of them are type 2 (non-insulin dependent) diabetes.

Large clinical trials have shown that better control of risk factors such as blood pressure, and lipid levels (good and bad cholesterol in the blood) can reduce the frequency of developing complications in individuals with diabetes. Thus, the effective early recognition and the treatment of diabetes are important "treatment outcome measures" for any health care delivery system.

Of further concern for mental health providers are the data showing an ***increased prevalence of type 2 diabetes*** in patients with Schizophrenia and Bipolar Disorder and the association of new-onset diabetes with the use of the newer type of antipsychotic medications (atypicals).

"Best Practice" Produces Results

The DMHAS Connecticut Valley Hospital Medical Services Unit undertook a "best practice" initiative in July 2003 for the assessment and treatment of patients with diabetes. Outcome data were collected on patients meeting the clinical guidelines established by the American Diabetes Association for patients with Diabetes and then we compared our "best practice" results with those from the recent national initiative, **Translating Research into Action for Diabetes** (TRIAD) study in which quality measures of 8205 diabetic patients were compared between the Veterans Administration (VA) and commercial managed care (CMC) systems.



The three outcome measures examined were blood pressure (BP), LDL ("bad cholesterol"), and HbA1c (a measure of diabetes control over the prior 3-6 months). CVH's diabetes management results compare favorably with those in the TRIAD study.

Our data suggest that the diabetes care provided at Connecticut Valley Hospital equals or exceeds national standards in head-to-head comparisons.

The CVH Medical Staff, and Ambulatory Care Services clinicians in particular, are proud to be at the vanguard of DMHAS's efforts to provide superior preventative health care to the patients we serve.

[1] Performance Improvement Audit developed by Kenneth Freedman, MD and managed by Edward Drew, APRN. References upon request – contact Cynthia Conrad, MD, PhD at Cynthia.D.Conrad@po.state.ct.us.

PROBLEM GAMBLING SERVICES

I. BACKGROUND

Based on past surveys, about one percent of Connecticut adults suffer from the most severe form of problem gambling called "pathological gambling" by the psychiatric community. An additional two percent of adults experience less severe but still significant problems. A Study of the Impact of Gambling in Connecticut is in progress and will hopefully provide a more current estimate on the prevalence of problem gambling in the state.

Even though no recent study has assessed the prevalence of problem and pathological gambling among specific racial/ethnic groups in Connecticut, data from several national prevalence surveys indicate **gambling problems to be 3 – 4 times higher among African Americans, Latinos, Native Americans and Asian Americans.** Research has also identified **incarcerated individuals as an underserved population** with high rates of gambling problems (9-30%). A 2007 Connecticut **Youth Survey reported high rates of gambling participation and about a 10% rate of gambling related problems among Connecticut students.**

The consequences of problem gambling include significant disruption to financial, vocational, familial and social responsibilities. Family members may be profoundly affected by the problem gambler's erratic behavior, legal and financial consequences, and failures to meet normal responsibilities.

The variety and availability of forms of commercial gambling has increased dramatically in recent years. Once an illegal and often viewed as disreputable behavior, gambling is now seen as a mainstream, glamorized activity that in fact provides significant revenues to the state. More Connecticut residents participate in commercial gambling than ever before and many are seeking help for gambling-related problems. Poker and on-line gambling recently have gained popularity and appear to be responsible for increases in the number of young people seeking counseling services for gambling problems. Results from the 2007 Connecticut Youth Survey also indicate that parents, teachers and school administrators have limited recognition of the potential risk that gambling poses for youth.

Since casino gambling came to Connecticut in 1992, the number of state residents in treatment at State funded programs has risen from about 60 clients in 1992 to more than 800 in 2008. Nearly 40 percent of those seeking gambling treatment are women, up from less than 5 percent prior to the availability of slot machines. Over 75% of female helpline callers report that their primary gambling problem is with slot machines. For both male and female gamblers casino slot machines remain the primary form of problem gambling (54%), followed by lottery scratch offs (34%).

II. HIGHLIGHTS/ACCOMPLISHMENTS

- **DMHAS Problem Gambling Services (PGS)** is the primary source of specialized treatment and prevention **services for problem gambling in Connecticut**. Through the efforts of PGS, state-funded treatment is available at 17 outpatient sites and one site for brief residential treatment. All services are offered based on ability to pay. Many individuals, saddled with large gambling debts, pay little or nothing for treatment services.
- DMHAS-PGS also funds prevention services through Regional Action Councils and other organizations. These projects include high school and college prevention and awareness

programs as well as a Congregational Assistance Program to increase problem gambling awareness in faith based organizations.

- In addition, PGS funds the statewide, toll free Problem Gambling Helpline through the Connecticut Council on Problem Gambling (CCPG).
- Through the Bettor Choice Programs, PGS has established groups for incarcerated problem gamblers at York and Osborn Correctional facilities
- For **FY 08,** about **$2 million** is provided for problem gambling prevention and treatment through DMHAS. Most of these funds ($1.9 million) are derived from lottery proceeds; about $100,000 comes from the pari-mutuel industry.
- PGS has facilitated many activities of the Connecticut **Impact of Gambling** study funded through DSR that is currently being conducted. We have provided data for the study on funding, service utilization and treatment outcome. We have participated in focus groups and assisted in organizing focus groups of recovering individuals.

III. CHALLENGES

- Oregon is one of just a few states that has sought to determine "need" for services. Based on empirically derived information, the state of Oregon estimates it should be providing care to 3,250 adult gamblers per year. Given the comparable population of the two states (Oregon's population is 3.5 million; Connecticut's population is 3.4 million), **Connecticut's treatment system could be serving more than four times as many problem gamblers and family members as it currently serves.** Oregon's greater service utilization may be driven by the widespread availability of video poker machines, but the state's annual commitment of $700,000 for public awareness and education programs is probably a more important factor.
- In the current economic environment, one of the main challenges has been to utilize the most cost-neutral or cost-saving strategies to maintain or expand problem gambling services. In collaboration with CCPG, we have added questions to the helpline interview to assess the impact of current economic stressors on helpline callers.
- DMHAS-PGS recognizes the **importance of preventing and treating problem gambling** among vulnerable populations, **especially youth, elderly and specific racial-cultural groups**. However, it has been limited in its ability to develop services for these groups in part because public awareness of problem gambling and its consequences has remained low.
- Despite little change in the availability of legal forms of **gambling in Connecticut** in recent years, the gambling landscape continues to evolve. **While casino revenues have decreased in the past year as a result of broad economic problems, lottery profits have reached record levels.**
- In order to address these concerns, DMHAS-PGS is working to expand the interest of stakeholders and service providers in addressing problem gambling among vulnerable populations. To accomplish this goal, **PGS continues to educate professionals who work with vulnerable groups**, to create and distribute educational and public awareness materials, advocate for additional services, and engage a variety of agencies and organizations in collaborative prevention and awareness projects.

DMHAS CONTACT: Lori Rugle, Ph.D., Director of Gambling Services,
Lori.Rugle@po.state.ct.us or 860-344-2244

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

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The Department of Mental Health and Addiction Services

A Healthcare Service Agency

M. Jodi Rell
Governor

March 23, 2007

Thomas A. Kirk, Jr., Ph.D.
Commissioner

Problem Gambling Services: A Lifesaver

I woke up and I was in the intensive care unit. I heard voices and realized they were my daughters. They were crying. What was going on? Why was I here? As I began to regain my thoughts, it started coming came back to me. I had taken an overdose of pills. I wanted to die. I couldn't face my family or myself for that matter, because of the shame, embarrassment and guilt, all due to my compulsive gambling. I had promised I'd never do it again. But I did. They had bailed me out so many times. How could I tell them that I was in debt again, all of my utilities were going to be turned off, the IRS was looking for me, and I risked the repossession of my car? The only answer was to kill myself. So that's what I tried to do. That was over a year ago. And now, listening to my family, I wonder, what was I thinking? I have been through countless hours of therapy at Problem Gambling Services. I attend Gamblers Anonymous, participate in a weekly Women's Recovery Group, meet with a therapist weekly, and my daughters meet with a therapist also. Most importantly, I haven't gambled and I am repairing my financial, spiritual and family life with lots of help from the folks at Problem Gambling Services.

Anonymous Problem Gambler

DMHAS Problem Gambling Services (PGS) is the statewide organization responsible for problem gambling treatment, prevention and intervention services at multiple locations throughout Connecticut. As the nation's oldest continuously operating outpatient treatment service for problem gamblers, it is a well-recognized leader in the development and delivery of services for problem gamblers and their families. With annualized funding of about $1.7 million, PGS funds and operates treatment services at 16 outpatient sites and one site for brief residential treatment. Each year about 750 gamblers and family members receive help through these services. In addition, PGS funds and provides a variety of other services, including prevention, counselor training, a gambling-specific helpline, advocacy and outreach, and research. More than $1.1 million is allocated to fund services at non-profit treatment agencies, such as the Wheeler Clinic, and Regional Action Councils, such as the Regional Youth/Adult Substance Abuse Project in Bridgeport.

PGS Clients' Preferred Forms of Gambling:

- Slots- 29%
- Other Casino games- 31%
- Sports Gambling- 8%
- Scratch tickets- 10%
- Animal Races/OTB- 6%
- Lottery Draw Tickets-3%
- Miscellaneous- 13%

How we spend our funds:

- Treatment: 59.9 percent
- Prevention: 16.4 percent
- Administration: 11.6 percent
- Helpline: 8 percent
- Training and Education: 2.3 percent
- Outreach: 1.6 percent
- Research: 0.2 percent

For help with problem gambling, call
800-346-6238

Currently the DMHAS PGS, in collaboration with the Department of Education, is developing a comprehensive approach to school-based youth problem gambling prevention. This project, funded by a one-time appropriation of $200,000., includes a Yale University survey of more than 4,000 high school students. The Yale study, the largest and most detailed study of youth gambling behavior yet conducted in this region, complements a concurrent analysis of school readiness to address youth gambling. In addition, we have funded four replicable pilot prevention programs that can be readily adopted by motivated schools.

For more information, contact Chris Armentano at 860-344-2244 or christopher.armentano@po.state.ct.us
To view previous issues visit *http://www.dmhas.state.ct.us/infobriefs/index.htm*.

RECOVERY FROM PSYCHIATRIC AND SUBSTANCE USE DISORDERS

I. BACKGROUND

Over the long-term, serious mental illness typically involves cyclical periods of acute symptoms (e.g., hallucinations, delusions, and very confused thinking) that may be followed by periods of relative quiescence. These cycles usually occur over a span of years or decades. Sometimes acute symptoms build for weeks or months. In a traditional mental health system, treatment is provided when symptoms are most severe – the goal of treatment is symptom reduction – as soon as acute symptoms are under control, treatment is discontinued (see Figure 1). However, for people with the most serious forms of mental illness, like schizophrenia, the challenge is to address not only the acute symptoms but also behavioral deficits that are seen during the quiescent phase of the illness (e.g., social isolation, poor hygiene, lack of motivation). Historically, mental health experts thought that people with serious mental illness got worse over time, not better.

Similarly, serious substance abuse or dependence is often cyclical and recurrent. People from the addiction recovery community have long noted the "cunning and baffling" nature of alcohol and other drug dependence. They also have recognized the importance of peer and spiritual supports in the recovery process.

Today, researchers, clinicians, and people in recovery know that with the right combination of treatments and supports, those among us with serious mental illness or substance use problems can show significant improvement over time. Instead of focusing on deficits, 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 one's condition while regaining a meaningful, constructive, sense of membership in the broader community.** This is accomplished by engaging the individual so that he/she becomes an active participant in illness self-management and rehabilitation (Figure 2). In other words, the person is supported in becoming fully involved in the recovery process.

In related development, there has been growing recognition in Connecticut and nationally regarding the importance of peer support as a means to facilitate recovery. Peer support services are provided by people in stable recovery from psychiatric and addiction disorders who assist others based on first hand experiences with these conditions. Peer services currently available include:

- **Telephonic Support – Recovery Check Ups:** Follow-up calls to people who have completed treatment for an addiction disorder to offer support, identify early relapse indicators, and provide outreach to those in need of additional treatment.
- **Transportation/Peer Mentoring:** Transportation to and from outpatient treatment or to a residential treatment program, and supportive suggestions about how to deal with day to day problems.
- **Emergency Room Collaboration:** Trained peers working in hospital emergency rooms offer support for people seeking care for acute psychiatric symptoms.
- **Warm Lines/Mentoring:** Telephonic support provided by trained peers workers to people who need to talk to someone who has had a similar experience with a psychiatric and/or addiction disorder.

II. HIGHLIGHTS/ACCOMPLISHMENTS

- During 2004, Connecticut became one of 13 states and one tribal nation to receive the competitively awarded "**Access to Recovery**" (ATR) grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The grant provided $22.3 million for innovative recovery supports.
- Again, in 2007, DMHAS received an additional $14.5 million in ATR II funding to continue using creative strategies as a means to promote recovery among people with serious substance use disorders.
- During 2005, in recognition of Connecticut's efforts toward building a recovery-oriented system of care, SAMHSA awarded DMHAS a $13.4 million **Mental Health System Transformation – State Incentive Grant**. DMHAS has worked collaboratively with 13 other state agencies and the judicial branch to develop and implement a wide range of transformation strategies.
- In 2006, **Connecticut and Ohio received Report Card ratings of "B"** for their public-sector mental health systems from the National Alliance on Mental Illness **(NAMI)**. These were the **highest ratings in the U.S. The nation as a whole received a "D" rating.** NAMI is the largest and most influential family and consumer advocacy organization for people with mental illness in the United States.
- In 2008, DMHAS began developing a process to train and certify peers in positions called **Recovery Support Specialists**.
- Implementation of the rehabilitation-oriented services, presently underway, will help consolidate gains that promote recovery among people with serious behavioral health conditions in Connecticut's public sector system.

III. CHALLENGES

- System change requires the engagement and participation of many stakeholders including educators, scientists, service providers, people in recovery, and many others, to help raise awareness about multiple effective treatments.
- As awareness about the importance of behavioral health issues becomes **part of everyone's agenda**, we can improve the quality of life for all Connecticut citizens.
- Difficult economic conditions create pressure on government to cut services. While recovery support services are among the most useful in producing favorable treatment outcomes, paradoxically, they also may be vulnerable to cuts.

Figure 1
Traditional Mental Health/Substance Abuse
Service Delivery and Funding System

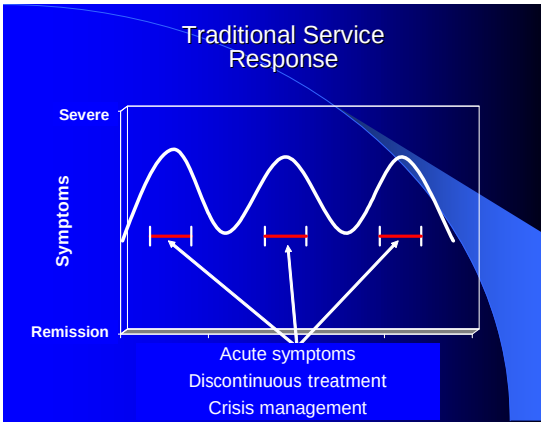
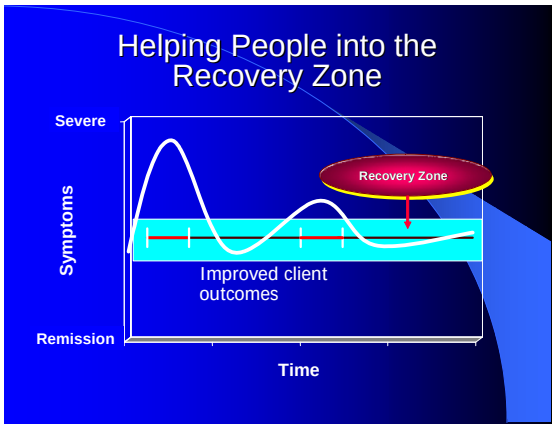


Figure 2
Recovery-Oriented
Service System



DMHAS CONTACT: Wayne F. Dailey, Ph.D., Senior Policy Advisor, Wayne.Dailey@po.state.ct.us or 860-418-6899

INFO Brief

Healthy People, Healthy Communities. Let's Make It Happen!

October 2, 2008

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

The General Assistance Recovery Supports Program

Food, clothing & shelter are basic necessities that serve as the building blocks for maintaining a stable life. Consider for a moment a person in recovery from a serious health condition who isn't able meet these basic needs. Imagine how difficult it would be to attain and sustain recovery from a mental health or substance use disorder with the additional stress caused by not having a safe place to live, food to eat, or the clothing needed to return to work.

The DMHAS **General Assistance Recovery Supports Program (GA RSP)** is committed to helping State-Administered General Assistance (SAGA) recipients meet their basic needs. GA RSP provides crucial recovery support services to individuals engaged in behavioral health treatment with the goal of assisting them to remain in treatment while promoting recovery, independence, employment, self-sufficiency, and stability.

GA RSP offers recovery support services such as:

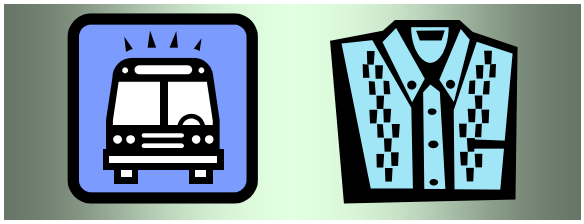
- Recovery housing
- Independent housing
- Bus passes
- Food
- Clothing
- Personal care items

GA RSP has a contracted network of 33 congregate recovery housing providers with over ***80 sites*** throughout the state. Each site has been certified by DMHAS. The network includes:

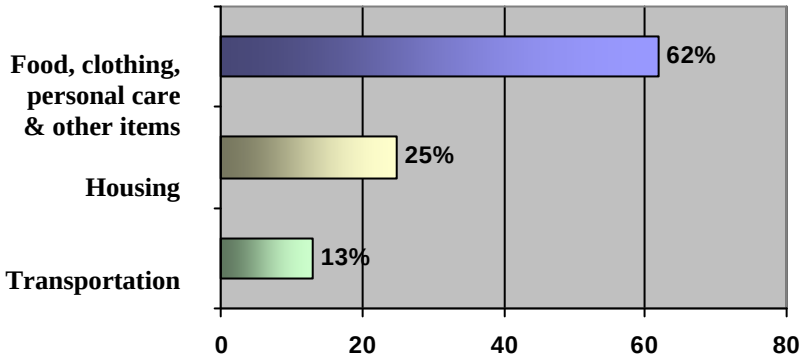
- Non-smoking houses
- Gender specific houses
- Houses offering faith-based and/or peer/based services

- GA RSP receives over **14,545 applications** from **7,135 individuals** annually
- Applications can contain multiple requests for a variety of supports
- Applicants are **notified within one (1) day** of the outcome of their applications, on average

25% of all GA RSP payments are for recovery housing.



Percentage of Requests



More individuals have been received an increased quantity of GA RSP services over the last three years, and the outcomes continue to be positive. **In FY '08, 70% of GA RSP service recipients connected to the next level of care following an inpatient admission in comparison to 49% of individuals who did not receive recovery supports. Moreover, 25% of individuals who did not receive recovery supports dropped out of treatment following an inpatient admission in contrast to 11% of GA RSP service recipients.** Thus, the General Assistance Recovery Supports Program continues to increase connections to care and promote treatment retention in an effort to strengthen treatment outcomes and encourage recovery.

To view previous issues visit http://www.ct.gov/dmhas/infobriefs
For information, contact Jennifer Hutchinson at Jennifer.Hutchinson@po.state.ct.us.

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

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The Department of Mental Health and Addiction Services
A Healthcare Service Agency

M. Jodi Rell
Governor

October 4, 2007

Thomas A. Kirk, Jr., Ph.D.
Commissioner

Reach Out and Touch Someone: Sustaining Recovery One Call at a Time

"When asked if I find the Telephone Recovery Support calls helpful, I can't say yes enough. There's something so supportive about knowing that, no matter what happens in my life, there's someone who genuinely cares about how my recovery is going. My volunteer has shared in every victory I have had in my recovery since the calls began. I hope to continue receiving these calls for a long time to come."

~Constance C., enrolled in the Connecticut Community for Addiction Recovery's (CCAR) TRS program for 70 weeks.

"Out of all of the commitments I've had – TRS is my favorite way of giving back. Honestly – it's a toss up as to who gets more out of it…me or them."

~Caroline M.
CCAR TRS Volunteer

What is Telephone Recovery Support?

Sometimes the simplest measures can have **amazing results**. That is the case with the **DMHAS funded** Telephone Recovery Support (TRS) initiative. A person new in their recovery from a substance use disorder receives a call once a week for a minimum of twelve weeks from trained one of **more than 50 CCAR trained volunteers,** to check in on their recovery. This has proven over time to be **a low cost (thanks to volunteers), win/win program.** It helps both the new "recoveree" and the volunteer making the call.

Connecticut has been a national leader and innovator in telephone peer support dating back to 2004 when DMHAS began working with Community Prevention and Addiction Services (CPAS) and CCAR in a DMHAS Center of Excellence project to provide telephone recovery support. A 90-day pilot was launched in the spring of 2005 when CCAR volunteers from the Windham Recovery Community Center called recoverees referred by CPAS treatment programs. The results showed that this type of recovery support service effective.

TRS volunteers called more recoverees in the first quarter of 2007 than they did in all of 2006.

IT WORKS!

93% of the 4,036 people contacted reported they were **still in recovery**—many of whom have been in recovery over a year! Of the 70 people who relapsed, volunteers were able to help 32% back into recovery.

Steady and Dramatic Growth

Year	Unduplicated Recoverees	Contacts Attempted	Contacts Made	In Recovery	In Relapse	Assisted w/Relapse
2005	27	227	55	21	1	0
2006	339	4,688	1,828	1,697	38	13
2007 (Jan-June)	513	7,607	2,153	2,049	31	10
Total	879	12,522	4,036	3,767	70	23

Call Now: To receive a call from a TRS volunteer call 860-244-2227. Bi-lingual volunteers are available.

Visit www.ct.gov/dmhas/infobriefs on the Web to see previous issues of "Information"

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

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The Department of Mental Health and Addiction Services
A Healthcare Service Agency

M. Jodi Rell
Governor

March 8, 2007

Thomas A. Kirk, Jr., Ph.D.
Commissioner

Getting Down to Basics

Housing, food, clothing, transportation—these are things that most people take for granted. Consider, for a moment, a person in recovery from a serious health condition—mental health or substance use disorders—people who, because of their illness, may not have these basic needs met. Imagine how difficult it would be to do the hard work of recovery when the stressors of lacking basic needs comes into play.

That is precisely why DMHAS began the **Basic Needs Program (BNP)**. It provides **critical recovery supports** for General Assistance (GA) recipients who are engaged in behavioral health treatment. Treatment providers work with individuals to request BNP supports that enhance the applicant's recovery plan. The BNP is an easily accessible, person-centered approach to helping GA recipients stay in treatment and promoting recovery, independence and stability.

- BNP receives over **12,134 applications** from **6,513 unduplicated individuals** annually.
- Recovery Specialists distribute vouchers to applicants at **13 centers around the state.**
- Applications can contain **multiple requests for support**.
- Applicants are **notified within 1.5 days** of the outcome of their requests, on average.

Of the requests received annually:

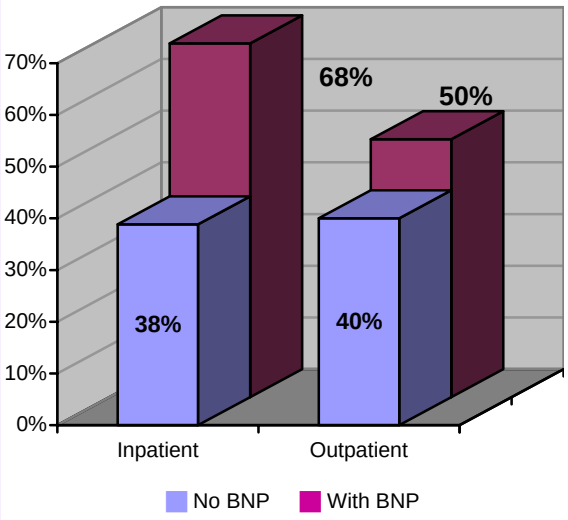
- 34% are for housing
- 15% are for transportation
- 12% are for personal care
- 2% are for food & other basic items

"I was at the end of my rope and the Basic Needs Program, and all the people who administer it, were nothing short of saving my life."

Dennis M.

BNP gives a hand up to people in recovery. It provides integral recovery supports throughout every stage of the treatment and recovery process.

People Who Successfully Connect to Lower Level of Care With BNP and without BNP FY06



BNP provides for:

- Independent housing
- Security deposit escrow
- Shelter payments
- Utilities
- Transportation from one treatment setting to another
- Bus transportation for job search
- Food
- Clothing
- Personal Care
- Phone cards, haircuts and other supports needed to return to work

Research has repeatedly demonstrated that overall treatment outcomes are better the longer a person stays in treatment. One goal of the BNP is to transition individuals from acute care (e.g. detoxification or inpatient care) to less restrictive, yet clinically appropriate levels of care (e.g. partial hospital, outpatient, etc.). Increasing connections to care contributes to longer overall lengths of stay in treatment with fewer readmissions back to more intensive levels of care. As seen above, the BNP ensures improved connections to lower levels of care.

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

INFORMATION . . . *foundation for good policy*

The Department of Mental Health and Addiction Services
A Healthcare Service Agency

M. Jodi Rell
Governor

November 29, 2006

Thomas A. Kirk, Jr., Ph.D.
Commissioner

Mini-Grants Open New Doors to Recovery

Some of the most successful interventions to assist people in recovery from serious mental illness and/or substance use disorders come from people who are in recovery. The philosophy, ***"helping others helps yourself"*** is clearly evident in a highly successful Mini-grant Project begun in 1999. With a pilot grant from DMHAS, the Regional Consumer Advisory Council (RCAC) engaged a consultant to instruct their members in aspects and processes for grant funding. With that information in hand, the RCAC developed a proposal to provide mini-grants to adults in recovery. These mini-grants would fund recovery-enhancing projects that would help to develop skills and self-confidence. The North Central Regional Mental Health Board's consumer planning council has continued to issue these highly popular grants for seven years.

Grants Awarded

- ✓ 75 mini-grants totaling $119,000 funded to date
- ✓ $17,000 in mini-grant funds released annually
- ✓ 56 mini-grants awarded to adults in recovery from psychiatric and/or substance use disorders
- ✓ 19 mini-grants awarded to adults in recovery from substance use disorders

What do the Mini-Grants Fund?

- 18 related to ***creative expression***: writing, painting, dancing, acting
- 14 were ***wellness-related***: peer support groups, relapse intervention committees, educative prevention forums, and research projects
- 12 were ***technology***-related
- 11 were for ***training and skill building***
- 8 were ***work-related***: training or education to provide specific work skills
- 5 enhanced adults' ***social skills***: outings to cultural events, summer camp
- 4 provided ***substance abuse prevention*** forums
- 3 were ***advocacy***-related

"This project helped us get our lives back on track." Michelle P.

"Being accepted by the National Association of State Mental Health Program Directors to exhibit nationally was a validation of our work." Dawn L.

"Becoming a certified facilitator and establishing a local chapter of a nationally affiliated support group is a dream come true and a healing experience." Selina N.

"These grants opened up possibilities where there were no possibilities." Julie H.

"One of my peers shared with me that taking part in my project was one of the best weeks he had had in recovery all year long." Rob P.

"Going to the Mark Twain Museum inspired me to read some of his books." Kathy M.

"Some of us would never have had the chance to go to camp and learn boating and archery." Mike D.

For further information, please contact Phoebe Hamilton at the North Central Regional Mental Health Board at phamilton@ncrmhb.org or 860-667-6388.
To view previous issues visit http://www.dmhas.state.ct.us/infobriefs/index.htm .

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

INFORMATION . . . foundation for good policy

The Department of Mental Health and Addiction Services
A Healthcare Service Agency

M. Jodi Rell, Governor

May 5, 2005

Thomas A. Kirk, Jr., Ph.D., Commissioner (860-418-6700)

Urban Initiatives…Successful Engagement & Recovery Interventions

Substance abuse is one of the primary contributors to preventable deaths, a major factor in the incarceration of 80% of individuals in the prison system, and costs American businesses between $50 and $100 billion each year. A Department of Mental Health and Addiction Services report in 2000 revealed that 40% of all patients in general hospitals required treatment due to complications related to alcohol abuse, and that nearly one-half of the 19,467 cases of family violence resulting in arrests were due to alcohol and other drugs.

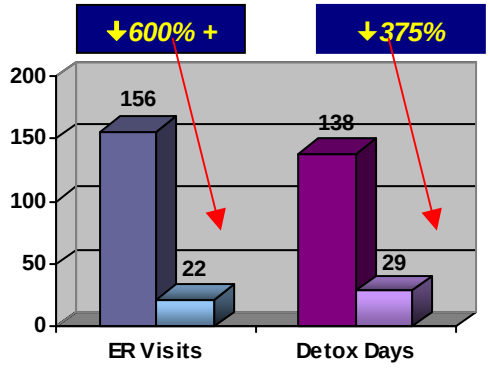
The Urban Initiative Projects (UIPs) in New Haven and Bridgeport were implemented as one of the direct responses to the above alarming findings. The mission of both UIPs is the same— help people with substance use and psychiatric disorders, for whom traditional treatment services have not been effective, to engage in recovery. Both programs share a belief in recovery as an on-going journey where pitfalls and setbacks are inevitable. Both UIPs began in 2001 and include outreach, engagement, and case management services and are ***collaborative partnerships among multiple agencies***.

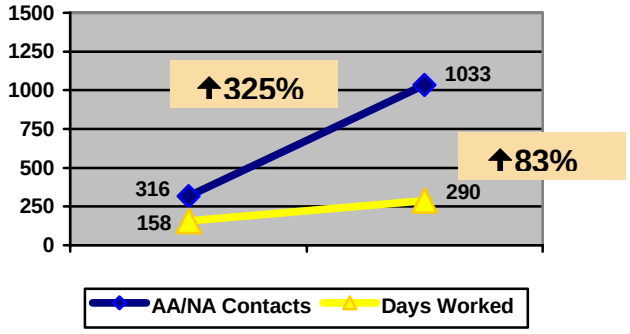
The programs differ. Bridgeport's focus is on **stable housing**; New Haven's is on **employment.** Both are consistent with a recovery focus…improved management of one's illness and better quality of life in the community in spite of the illness.

BRIDGEPORT URBAN INITIATIVE

As individuals are more effectively engaged in treatment, they may be admitted to temporary beds at Prospect House. They may also enter longer-term supportive housing located on Poplar Street. Service partners include DMHAS' Southwest CT Mental Health System, Regional Network of Programs, Inc. and Chemical Abuse Services Agency, Inc. For people transitioning to Poplar Street, the following occurred: (Compares the month preceding admission & the month preceding discharge).

- ***ER visits decreased from 156 to 22 = ↓600% +***
- ***Detox days used decreased from 138 to 29 = ↓375%***
- ***AA/NA contacts increased from 316 to 1033 = ↑325%***
- ***Days worked increased from 158 to 290 = ↑83%***

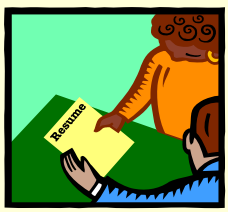




NEW HAVEN URBAN INITIATIVE

Individuals participate in specialized engagement activities at the **Taking Initiatives Center (TIC)** which offers an array of groups including assistance with employment. Service Partners included Columbus House, Inc., Easter Seals Goodwill, Inc., Marrakech, Inc., Apt Foundation, Inc., South Central Behavioral Health Network, Empower New Haven, and DMHAS' Connecticut Mental Health Center. As a result of involvement in the New Haven UI Program:

- **540** people have participated in activities at the TIC
- **100** people have engaged in employment-related activities
- **45** people have found jobs using employment providers
- **700** people have been transported from city shelters to the TIC



For further information, please contact Sue Tharnish at 860-418-7000 or email at sue.tharnish@po.state.ct.us
To view previous issues visit http://www.dmhas.state.ct.us/infobriefs/index.htm

RESIDENTIAL OPTIONS

I. BACKGROUND

Today, there are multiple effective treatments for most psychiatric and substance use disorders, but treatment has limited positive benefits for people who lack stable housing. Simply stated, sustained recovery requires stable housing. DMHAS has created a wide array of housing options to meet the needs of individuals and provide a safe and stable home environment that fosters recovery.

II. HIGHLIGHTS/ACCOMPLISHMENTS

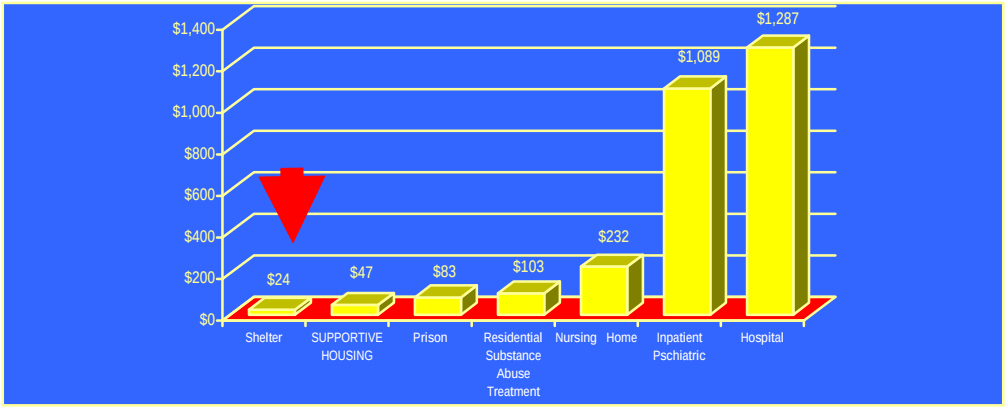
- **Supportive Housing:** Supportive Housing is affordable housing linked to flexible, accessible supportive services that help people address everyday problems and lead more productive lives. In Supportive Housing, a tenant pays no more than 30%-40% (ideally 30%), of household income toward rent and holds an individual lease or similar agreement. Supportive Housing requires ongoing communication between supportive services providers and property owners or managers, and/or housing subsidy programs. Connecticut is the only state in the U.S. developing supportive housing on a statewide basis and its housing efforts are among the most productive and innovative in the country. DMHAS and the Corporation for Supportive Housing (CSH) have partnered with nonprofit providers for over 14 years to expand housing options. DMHAS presently serves/will serve (once all scattered site units are leased up and all projects under development are completed) in excess of 2,250 people in Supportive Housing in over 70 communities in Connecticut.

  Supportive Housing initiatives involve collaboration between state agencies (DMHAS, OPM, DSS, DECD, and DCF), the Connecticut Housing Finance Authority (CHFA), the CSH, philanthropic organizations and corporations, consumers, family members and community-based nonprofit housing and service providers. This unique blending, in combination with the State Rental Assistance Program, and the Federal Shelter Plus Care and Supportive Housing Programs, has allowed us to provide rental subsidies and implement creative housing options.

  An independent evaluation found that Supportive Housing resulted in positive outcomes for tenants while **decreasing** use of acute care and other expensive health services. In addition, property values in adjacent neighborhoods **increased or remained steady** following the development of Supportive Housing units. Supportive Housing builds healthy homes and communities for previously homeless and at-risk persons and families. **Permanent housing is a foundation to recovery**. Research has found that people improve in supportive housing whether this housing involves single-site or scattered-site housing units.

  - Harvard University's Ash Institute of Government named the State of Connecticut's Supportive Housing Pilots Initiative as winner of the 2006 Fannie Mae Foundation Innovations Award in Affordable Housing; one of only seven award winners nationwide.
  - Monitoring and Training – DMHAS in collaboration with DSS, has subcontracted with the Corporation for Supportive Housing and Center for Urban Community Services to provide training for all supportive housing providers, including courses on Motivational Interviewing, Working with the Chronically Homeless, and Housing Individuals with substance abuse disorders. This initiative will also monitor DMHAS providers to standardize tenant selection and services provided statewide. This Monitoring and Training Initiative is the first of its kind in the country.

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



- **Sober Housing**: A Sober House is not a treatment program. Sober Houses are privately owned dwellings where people in recovery from substance use disorders live while they consolidate the gains they have made in treatment. Many people in Sober Houses are recent graduates of residential substance abuse treatment programs; they may be currently receiving outpatient care, or involved with peer supports, such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). House rules prohibit the use of alcohol and other drugs. Some Sober Houses receive no state funds; they are supported exclusively by tenant rent. Approximately 80 Sober Houses in CT meet enhanced certification requirements to be eligible to receive rental payment from DMHAS on behalf of tenants deemed eligible by DMHAS. Rent payments go directly to landlords and are usually limited in duration to 2 or 3 months while the individual seeks permanent housing and steady employment. (More detail on Sober Housing below.)
- **Mental Health Group Homes:** The most intense level of care; congregate houses staffed 24/7 with highly intensive teaching and training activities with 6 to 17 residents per site. DMHAS funds 185 beds.
- **Mental Health Intensive Residential:** An intense level of care, congregate houses staffed 24/7 with intensity teaching and training activities and capacity for 15 to 17 people per site who generally are referred upon discharge form state psychiatric hospitals. DMHAS funds 46 beds.
- **Mental Health Supervised Apartments:** Congregate houses and apartments, where teaching and training occur, are staffed 24/7 to enable people to live on their own. Capacity varies. DMHAS funds 412 beds.
- **Mental Health Supported Apartments:** People live in their own apartments (with and without roommates) scattered throughout the community. Staff facilitate community living and integration with in vivo interventions and activities. Staff interact daily to weekly, based on need. Capacity varies. DMHAS funds 1,400 beds.
- **Mental Health Transitional Housing:** Considered short-term housing to facilitate integration into the community from a more restricted setting. Provides interim housing and respite until permanent housing can be secured. DMHAS funds 43 beds.
- **Addiction Services Intensive Residential:** Provides very intensive treatment with 24/7 staffing and medical staff available as needed. Provides stabilization and counseling with length of stays generally 2 weeks to 30 days. DMHAS funds more than 300 beds.

- **Addiction Services Intermediate/Long Term Treatment:** Intensive treatment with 24/7 staffing that provides counseling and focuses on self management, community re-integration and relapse prevention. Length of stay is generally 2 weeks to 6 months. DMHAS funds 784 beds.
- **Addiction Services Halfway Houses:** Provides moderate, tapered counseling, relapse prevention, community re-integration and 24/7 staffing. Length of stay is generally 4 to 9 months. DMHAS funds 93 beds.
- **Addiction Services Long Term Care:** Program for people with more chronic addiction issues. Staffing is 24/7 and counseling focuses on relapse prevention, community living and reintegration. Length of stay is generally 6 to 12 months. DMHAS funds 50 beds.
- **Addiction Services Therapeutic Shelter:** Provides 24/7 staffing with counseling focused on relapse prevention, community living and re-integration. Length of stay is generally 6 to 12 months. DMHAS funds 21 beds.
- **Addiction Services Recovery Houses:** Provides structured, supportive, sober environments for people in recovery. Focus is on relapse prevention, access to needed treatment and community supports. It is used by people in transition to the community or between levels of care. DMHAS funds 88 beds.
- **As part of the State-Administered General Assistance Behavioral Health Program (SAGA) Recovery Support Program**:
  - **Independent Housing** is provided where private landlords are reimbursed for 1 or 2 months in non-congregate settings. Residents must be able to provide evidence that they can afford the apartment when DMHAS Support ends.
  - **Sober Housing** is provided in a congregate setting. Residents must abide by house rules, including sobriety and clean from drugs; must be employed or looking for work; and must be financially able to maintain living in the Sober House after the subsidy ends. DMHAS has certified 27 Sober Housing vendors with 80 sites.

III. CHALLENGES

- **Not-in-My-Back-Yard (NIMBY)** – Community opposition to the development of housing for people with disabilities is a problem everywhere in Connecticut.
- **Housing Stock** – Safe, affordable housing is in short supply, especially in the southwestern part of the state. The cost of housing drives people with disabilities into urban centers and unsafe neighborhoods. The limited availability of affordable housing and housing subsidies means that people in recovery are often unable to secure their own housing even when they no longer have need for the services supplied by DMHAS.
- **Expanding rental subsidies** – With the federal government reducing Shelter Plus Care and Section 8 rental assistance funding there is the need for more state subsidies beyond those used for Supportive Housing.
- **Uniform Standards** – DMHAS is working with all housing programs to develop statewide standards, regional/sub-regional housing offices and a statewide monitoring tool.
- **Current Economic Situation** - The current downturn in the national economy has had significant effect on housing in the state. The increased rate of foreclosures and layoffs may put more individuals at risk for homelessness. The homeless shelters have already seen increases in individuals and families seeking their services. Any increase in homelessness or individuals being at risk for homelessness puts added strain on the limited supportive housing resources.
- **Opposition to Sober Housing.** There continues to be opposition to Sober Housing in some towns. Coupled with an inadequate supply of safe, affordable housing, this leaves few housing options.

- **Fair Housing vs. Local Zoning.** Some tension about Sober Housing has occurred between municipalities with restrictive zoning ordinances and landlords operating Sober Houses who allege towns are not making "reasonable accommodation" for protected populations under the federal Fair Housing law.

DMHAS CONTACTS:

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

INFORMATION . . . *foundation for good policy*

The Department of Mental Health and Addiction Services
A Healthcare Service Agency

M. Jodi Rell
Governor

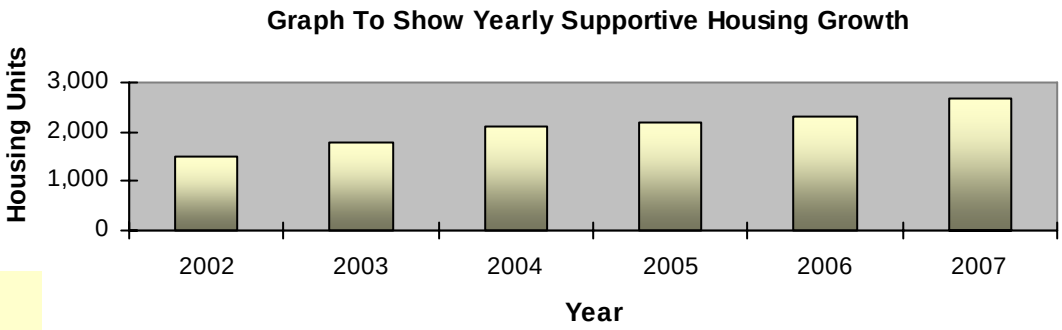
Thomas A. Kirk, Jr., Ph.D.
Commissioner

April 12, 2007

Supportive Housing: Better Care, Better Value

Research shows that one of the most important factors for achieving recovery from mental illness and substance use disorders is safe, permanent, affordable housing. ***Supportive Housing*** is such a housing option for previously homeless and at-risk persons and families. It is linked to flexible, accessible, supportive services that help people address everyday problems and lead more productive lives. In Supportive Housing, a tenant pays no more than 30% of household income toward rent and holds an individual lease or similar agreement. Permanent Supportive Housing requires ongoing communication between supportive services providers and property owners or managers, and/or housing subsidy programs.

Connecticut is the only state in the U.S. that has supportive housing on a statewide basis—its supportive housing efforts are among the most productive and innovative in the country. DMHAS and the Corporation for Supportive Housing have partnered with nonprofit providers and other state agencies for over 14 years to expand housing options. In 2007, housing will be provided for over 2,600 people. Supportive Housing is a cost-effective use of Connecticut's resources, building healthy homes and communities.



Supportive Housing Partners

- State agencies (DMHAS, OPM, DSS, DECD, and DCF)
- Connecticut Housing Finance Authority
- Corporation for Supportive Housing
- Philanthropic organizations and corporations
- Consumers and family members
- Community-based nonprofit housing and service providers
- Federal Shelter Plus Care and Supportive Housing Programs

An independent evaluation found:

- Positive outcomes for tenants while decreasing their use of acute care and other expensive health services
- Property values in adjacent neighborhoods increased or remained steady following the development of Supportive Housing units
- People improve in supportive housing whether this involves single-site or scattered-site housing units.

Supportive Housing – It Works!

Rebuilding lives, restoring neighborhoods, and providing a cost-effective and prudent investment of public funds.

Upcoming Initiatives

- ***Expanding rental subsidies*** with DSS Rental Assistance Program certificates.
- ***Uniform Standards***—DMHAS is working with the Corporation for Supportive Housing and the housing providers in developing and implementing the first set of statewide standards for supportive housing in the nation.
- ***Monitoring/Training***—DMHAS, in collaboration with DSS and CSH, will develop a mechanism for compliance with these statewide standards.

For more information, contact Barbara Geller at Barbara.Geller@po.state.ct.us .
To view previous issues visit http://www.dmhas.state.ct.us/infobriefs/index.htm

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

INFORMATION

...foundation for good policy

August 29, 2002

The Department of Mental Health and Addiction Services

A Healthcare Service Agency

John G. Rowland
Governor

Thomas A. Kirk Jr., Ph.D.
Commissioner

Building on What Works

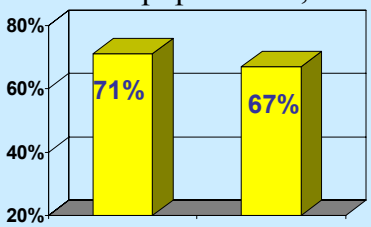
What is a basic desire that each of us has? *To have a safe and decent place to live.* For someone with a serious mental illness or substance use disorder, living in decent housing helps them to manage their illness, to feel part of a community, and to improve the quality of their daily life. These outcomes are all parts of their **journey towards recovery**. Thus, the Department of Mental Health and Addiction Services (DMHAS) pursues many strategies to promote safe, decent and affordable housing for persons receiving behavioral health care. ***Supportive housing*** is one such strategy.

Mary Seymour Place
Hartford

Supportive housing provides community-based, affordable housing options and supportive services for persons who have special needs but who are able to live independently if they have some assistance. Residents typically hold their own lease and onsite case management or other supportive services are available as a voluntary option for tenants. Housing developed under the program also serves individuals and families without special needs in order to create integrated housing settings.

What has our experience taught us about supportive housing? During the 1990's DMHAS participated in a partnership known as the Connecticut Supportive Housing Demonstration Program that developed 281 units of affordable, service-enriched rental housing for homeless and at-risk populations, many with mental illness, histories of substance abuse, or HIV/AIDS.

An independent evaluation* of this demonstration program found that tenants **decreased** their use of restrictive and expensive health services and **increased** their use of less expensive ongoing and preventive health care. Neighborhood property values increased for eight of the nine projects and remained stable for the ninth. Overall, development of the project yielded $72 million in direct and indirect economic and fiscal benefits to Connecticut communities.



Decrease in inpatient costs | % of tenants employed or in training

Building on Success

The Governor and the Legislature authorized a **new Pilots Supportive Housing Initiative**. DMHAS is currently working with many other organizations to develop housing units for 570 persons whose head of household has serious mental illness and/or substance use disorder, is homeless or at risk of homelessness, and has an income at or below 50% of the area median income. **Extraordinary collaboration** among many public and private organizations is essential for the success of these projects. Credit must be given to these key partners.

Partnerships Work

Connecticut Departments of Mental Health and Addiction Services, Social Services, and Economic and Community Development, Office of Policy and Management, CT Housing Finance Authority, private entities including the Corporation for Supportive Housing, local housing developers and behavioral health service providers, private foundations such as the Melville Charitable Trust, and the federal Department of Housing and Urban Development.

Housing being created is **affordable, good quality, accessible to transportation, and safe and secure**. Units are being developed both through leasing of existing scattered-site apartments, and through acquisition, new construction or rehabilitation.

** Thank you to the Corporation for Supportive Housing for information used in this issue. Copies of the evaluation report may be requested from them at (203) 789-0826 or ct@csh.org.*

SERVICES FOR UNIFORMED PERSONNEL

I. BACKGROUND

DMHAS was one of six states from across the U.S. to be recently awarded a federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant to establish Jail Diversion and Trauma Recovery services for veterans.

In addition, DMHAS established two distinct programs within DMHAS Veterans Services Division for uniformed personnel: The **CT Military Support Program** which began in March, 2007 and the **State Troopers Offering Peer Support (STOPS) Program** serving state troopers within the Department of Public Safety (DPS) which started in October, 2007.

DMHAS is charged with providing behavioral health services to National Guard and Reserves members and their families throughout the deployment cycle (pre-, during, and post-deployment) (Sec. 17a-453d). A total of $1.4 million was set aside for OEF/OIF (Operation Enduring Freedom-Afghanistan/Operation Iraqi Freedom) activities, of which $530,000 was directed to researchers at Yale University to study the needs of OEF/OIF Soldiers, and $891,000 to the Military Support Program. The allocations are non-lapsing.

DMHAS also implemented a pilot program of peer counseling within the Department of Public Safety's Division of State Police in recognition of the occupational hazards, prevalence of stress, and unique needs of the State Police within the DPS (Sec. 17a-485g). One hundred thousand dollars ($100,000) was provided to support implementation of the STOPS program.

II. HIGHLIGHTS/ACCOMPLISHMENTS

The Military Support Program (MSP)

- The program provides free, transitional, confidential, locally available outpatient counseling services to Citizen Soldiers and their family members (spouse, children, parents, siblings, significant others).
- The central feature of the MSP program is a statewide panel of over 225 licensed clinicians who provide a full range of counseling services to soldiers, veterans and their family members. The clinical panel is managed through a contract with an Administrative Service Organization (ASO) -- Advanced Behavioral Health, Inc.
- MSP is accessed through a 24/7 toll-free call center.
- In addition to locally available outpatient counseling services, MSP Community Clinicians provide outreach, information, referral, advocacy and in vivo case management services.
- From March 2007 to February 2009:
  - 797 individuals contacted the MSP 24/7 Call Center.
  - 456 received intensive community case management services.
  - 315 participated in outpatient counseling (61% were military personnel/vets and 39% were family members).
  - 143 received intensive assistance in entering VA healthcare.
  - 82 received transportation services.
- MSP staff, in partnership with OEF/OIF Coordinating Committee members, routinely provides psycho-education in deployment health matters to veterans, families and community members.
- MSP services are timely, flexible and locally available. MSP has initiated a transportation program, consisting of livery service and gas cards.

- MSP has initiated a 2-day Veterans' Resource Representative training program for DMHAS (and DMHAS-funded) clinicians. The curriculum covers OEF/OIF homecoming, VA healthcare, and state and federal veterans' benefits including when and how to apply. Key VA clinicians are among the faculty.
- The Military Support Program recognizes and honors fellow Connecticut State Troopers who are Citizen Soldiers by assuring that when called to active duty in the military, they, and their families, receive the support they need throughout the deployment cycle.

State Troopers Offering Peer Support (STOPS) Program

- In a 12 month period, 70 STOPS Peer Support Volunteers were screened, trained and credentialed.
- In the past year:
  - The majority of peer support contacts related to either personal stress (23%) or job stress (30%). 21% percent of all contacts involved issues relating to family life or personal relationships.
  - 83 individuals, or 11%, were directly referred to the Employee Assistance Program.
  - DMHAS developed a formal approach to recognize, honor and support Citizen Soldiers within DPS – through an agency *Military Support Program.*
- The ***Family Support Program*** was created to support Troopers and their families through periods of personal crisis.
- Regional ***Critical Incident Stress Management (CISM)*** Teams were established.
- The DPS ***Chaplaincy Program*** was renewed and strengthened.
- STOPS Peer Support Volunteers are a bridge to recovery support services for colleagues in need of assistance.
- Trained Peer Support Volunteers are available to respond to Troopers, provide leadership in referring colleagues to professional help when necessary, and provide follow-up support as needed.
- The DPS Family Support Program strives to foster a sense of community among Troopers and their families by assuring that in times of crisis, each receives the support they need to fully recover.
- The agency's regional Critical Incident Stress Management Teams provide an effective and valuable crisis intervention system designed to mitigate the impact of traumatic incidents on Troopers.

III. CHALLENGES

- Many veterans experiencing trauma-related symptoms lack insight into their problems, yet less than 40% of veterans with service in the Afghanistan and Iraqi Wars enroll in VA healthcare.
- Many veterans are at risk of dropping out of treatment with VA due to accessibility challenges.
- Congress has not authorized the VA to serve veterans' family members. VA and Vet Centers routinely refer family members needing outpatient counseling services to MSP.
- Often non-VA clinicians lack knowledge about the unique treatment needs of veterans, particularly our newest generation of veterans. Many fail to inquire about a veteran's status, their character of service, whether they are service-connected disabled, or if they are enrolled with VA.
- Noted in the literature is the pervasive influence of stigma, not only within the ranks of military organizations but also among police organizations, which can be a formidable barrier to accessing needed services.

- There is a preponderance of evidence that law enforcement personnel in crisis typically choose to exercise an Employee Assistance Program (EAP) as an option only when commanded to do so or as a "last resort."
- Often, behavioral health needs within the broader State Police community may go unaddressed.

DMHAS CONTACT: Jim Tackett, Director of Veterans Services, Jim.Tackett@po.state.ct.us or 860-418-6979

INFO Brief

Healthy People, Healthy Communities. Let's Make It Happen!

September 22, 2008

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

CONNECTICUT MILITARY SUPPORT PROGRAM

"After my husband deployed, my oldest child began to act out. She was having such a hard time. And the truth is so was I. We'd never been apart. We'd always been a team. I just couldn't stop thinking about him being in danger every minute he was there. I became depressed. I am so grateful for the support I received from my MSP clinician. She really helped me get through it." ~28 year old wife of a deployed CT Army National Guard soldier

The Military Support Program (MSP) addresses the mental health and substance use needs of National Guard and Reserve personnel affected by deployment in Operation Enduring Freedom (Afghanistan) and Operation Iraqi Freedom (Iraq). Administered by the Department of Mental Health and Addiction Services (DMHAS), MSP began in March 2007. Connecticut is the first state in the U.S. to offer mental health counseling services to its approximately 5,000 National Guard and Reserve personnel, sometimes called "Citizen Soldiers," and their families.

Free, confidential outpatient counseling provided to National Guard and Reserve personnel and their families.

Over 225 licensed clinicians specially trained by DMHAS to provide marriage and family counseling and counseling for stress related to deployment, service in a war zone, and homecoming.

Outreach; 24/7 call center; information, referral and advocacy; and community case management services provided by MSP staff.

MSP Features

MSP provides ***up to 15 outpatient counseling sessions,*** but may expand to 30 visits in certain circumstances.

Transportation assistance: Livery service and gas cards offset transportation costs.

Total Number of Counseling Sessions: 1,302
FY '08

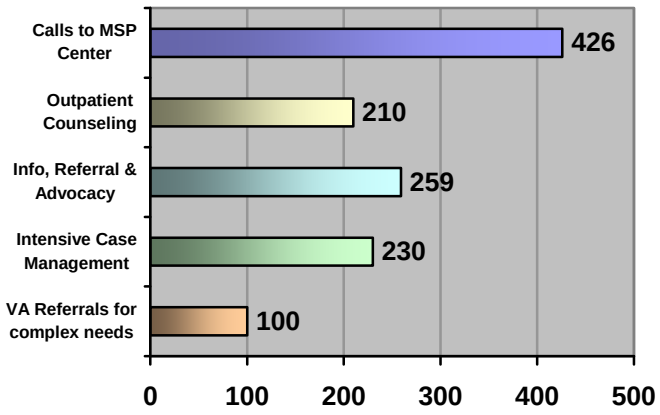
Additional MSP Highlights:

Educating clinicians: DMHAS recruits, trains, credentials and manages MSP clinicians using a new training program on veterans' unique health needs, benefits, eligibility criteria, and how to apply.

Children and deployment: School-based clinicians to be trained by DMHAS expert in family systems and school based services on the adjustment issues of children of deployed parents. In partnership with the National Guard/Reserves Family Support Programs, children of deployed parents will be identified and services will be offered to the child, parents and school personnel.

Collaboration: MSP works closely with VA and Vet Centers in facilitating workshops on deployment health at family conferences and all unit demobilizations and 30, 60, and 90-day drills.

Number of Individuals Served 7/1/07 – 6/30/08



"The MSP has rapidly become an invaluable resource available to our Connecticut Guardsmen and their families. The service is prompt, the staff caring, as they routinely seek to provide flexible support options designed to meet the diverse needs of our military community. Speaking as a Commander, I am fortunate to have access to the resources the MSP can provide to our soldiers, airmen and their families."

~Maj. Gen. Thad Martin, Adjutant General

Just Call

National Guard/Reserve personnel and their family members seeking referral to counseling services are encouraged to call the 24/7 toll-free call center at **1-866-251-2913** to get names and contact numbers of at least three clinicians in their area.

For more information, please contact jim.tackett@po.state.ct.us. To view previous issues, visit: http://www.ct.gov/dmhas/infobriefs.

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The Department of Mental Health and Addiction Services

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M. Jodi Rell
Governor

October 25, 2007

Thomas A. Kirk, Jr., Ph.D.
Commissioner

State Troopers Helping State Troopers

By any measure, the first ever Coordinator of the Department of Public Safety **State Troopers Offering Peer Support Program (STOPS),** which commenced on October 1, 2007, is a formidable presence. Physically imposing, he has a garrulous personality somewhat on the scale of Mt. Rushmore. Larger still is his passion to do "the right thing" by his fellow troopers through his new position. Meet Sgt. Troy Anderson:

"You know, our troopers are well trained to serve and protect the public. I don't know how many people appreciate though, what it's like to respond to multiple roadside fatalities, homicides, horrific crimes against women and children and bad guys with guns on an almost routine basis. We learn to compartmentalize and then go home and kiss our loved ones. Sometimes it's hard though. We're professionals but sometimes you don't have an option— it's hard."

Exposure to Trauma is Inherent in Police Work

- **One third of police officers exposed to work related traumatic incidents develop significant PTSD symptoms**
- **Research finds that 20% of front-line officers meet criteria for alcohol abuse**
- **Police suicide rate is 1.5 times that of the general population**
- **Police families experience significantly higher rates of domestic violence than civilian families**

SOURCE: Am J Psychiatry 163:1, January 2006

Legislation Establishes STOPS

In recognition of the occupational hazards and attendant needs of State Police officers, the Connecticut General Assembly enacted legislation directing the Department of Mental Health and Addiction Services to establish a pilot program of peer counseling (officer helping fellow-officer) in the Dept of Public Safety Division of State Police.

For the past year, DMHAS has collaborated with representatives from the Department of Public Safety executive, union administrators, and rank and file troopers to design the **STOPS** peer initiative. **STOPS** currently features a cadre of 40 State Trooper volunteers who are trained to provide their colleagues with emotional and tangible support through periods of personal or professional anguish. The number of trained volunteers will increase to as many as 75 with additional training classes to be held in the future. **STOPS** services are an augmentation to the Department of Public Safety Employment Assistance Program, not a replacement.

Program Coordinator Sgt. Anderson is charged with managing peer operations and cultivating an environment where voluntarily seeking help is seen by Department of Public Safety personnel as a sign of strength rather than as a weakness. *"Look, our road troopers, as soldiers of the law, are heroic but not invincible. We are expected to function, no matter what, and there is the pervasive aversion to what may be perceived as weakness or failure to take care of business. There is real fear of stigmatization and negative job consequences such as a modified assignment to desk duty."*

In order to promote a personal sense of security among troopers in need, the **STOPS** training regimen inculcates peer volunteers with the imperative that interactions with colleagues are strictly confidential. The only exceptions are for mandated reporting and disclosure to manage imminent risk required under law.

DMHAS is proud to have worked with the most venerable State Police force in the nation to implement **STOPS**. It is the Department's hope that the experience gained from this program will be used to replicate future programs within our municipal police departments throughout the state.

WORKFORCE DEVELOPMENT

I. BACKGROUND

In gathering information about the state of mental health care in America, the President's New Freedom Commission found evidence of diverse and substantial concerns about the behavioral health workforce. The New Freedom Commission recognized that the education, training, recruitment and retention of mental health leaders, professionals and personnel were essential elements of sustainable reform and critical vehicles for transforming current systems of mental health care.

In applying for the Mental Health Transformation State Incentive Grant (MHT SIG), Connecticut identified workforce planning as an issue to pursue in the initiative's Comprehensive Mental Health Plan. Specifically, Connecticut sought to assess the knowledge and training of its workforce, its capacity and its needs for transformation to a recovery-oriented system of care. *See Mental Health Transformation Section for specific workforce related initiatives funded through this grant.*

Commissioner Kirk identified workforce development as one of six priority areas in the Department of Mental Health and Addiction Services Strategic Plan 2008. As a result, a workforce development workgroup, accountable to the Commissioner's Strategic Analysis and Implementation Group has been developed. A sustained effort to recruit, retain, train, supervise and support Connecticut's behavioral health workforce must be foremost among the state's priorities as it strives to improve access to a recovery-oriented system of care.

II. HIGHLIGHTS/ACCOMPLISHMENTS

- Established a Workforce Development Workgroup within DMHAS to establish, **r**ecruit, retain, and train a highly competent workforce.
- In collaboration with several state agency partners, a learning management system (LMS) is in the process of being implemented to manage both instructor-led training and to provide a platform for web-based training. This system will be used at all state-operated facilities as well as managing training provided to the entire DMHAS system-of-care. The LMS will create efficiencies in tracking and monitoring training as well as providing web-based that will be widely available and will reduce costs associated with staff travel, replacement staff, and paying instructors.
- In FY 08, the DMHAS Education and Training Division provided training to over 6,000 participants in a variety of topic areas including training in its Recovery Institute and Co-occurring Disorders Academy.
- Supportive Housing Training: Developed two course catalogs specifically for supportive housing staff in collaboration with DMHAS Statewide Services.
- Dialectical Behavioral Therapy (DBT) Training and Consultation: Established eleven teams throughout the state to deliver DBT for people with severe problems with emotional regulation and suicidal behaviors.
- Family Psychoeducational Intervention Initiative: Training and consultation to three agencies delivering Integrated Dual Diagnosis Treatment (IDDT) programming to implement family services: Cedarcrest (Cedar Ridge and Blue Hills), Western (Torrington, Danbury, Waterbury), Rushford. All agencies have begun meetings with families.
- Trauma Practice Enhancement Initiative: Training and consultation to increase trauma sensitive services in addiction treatment at the following agencies: Community Prevention & Addiction Services (CPAS), APT Foundation and Birmingham Group.

- Functional Behavioral Assessment and Positive Behavioral Support: Provided support training and consultation for Young Adult Services and DMHAS state-operated clinical staff in positive behavioral support of people with severe and dangerous behaviors.
- Connecticut Recovery Purchasing Project Clinical Supervision Project: Provided training and consultation for multi-state agency project (CSSD, DOC, DCF, DMHAS).
- New England Institute of Addiction Studies Summer Programs: Provided participants scholarships and collaborated in the planning and implementation of two week long summer training programs to support substance abuse counselor certification and the training of behavioral health staff in substance abuse and co-occurring disorders services.
- Leadership Institute: Provide scholarships and project management for Connecticut's participation in collaboration with New England Addiction Technology Transfer Center, New England Institute of Addiction Studies and Antioch Business School in training emerging leaders in the Connecticut's behavioral health workforce.
- Direct care staff and supervisors at Connecticut Valley Hospital (CVH) continued to receive skills-based training in person-centered planning and psychosocial rehabilitation. Thus far, over 600 supervisors and 1,700 direct care staff have been trained.
- In October, 2007, the Department of Mental Health and Addiction Services was awarded a three year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) totaling $642,000 to develop and implement a comprehensive strategy to reduce, and ultimately eliminate, use of restraint and seclusion among young adults, ages 18-25, with serious mental illnesses. Staff at Connecticut Valley Hospital and Cedarcrest Hospital are being trained in trauma informed approaches to care and the prevention of violence to reduce and ultimately eliminate the use of seclusion and restraint in those settings.

III. CHALLENGES

- Provider agencies report **major difficulties in recruiting and retaining qualified employees**, particularly in the private non-profit sector.
- Today's mental health practitioners are far **less diverse in their cultures and languages** than the people they serve, raising concerns about the ability of the existing workforce to provide culturally relevant services.
- **Individuals most often seek help for mental health problems outside of the formal behavioral health systems of care**, from persons such as teachers, primary care providers, and emergency room personnel. Yet, substantive training on mental health disorders and treatment is seldom offered to these caregivers.

There is broad consensus in Connecticut that strengthening the workforce is essential if efforts to transform the state's system of mental health care are to succeed. The workforce is the principal vehicle through which access to care is provided and effectiveness of care is assured. The vast majority of the state's behavioral health expenditures are, in fact, expenditures on human resources. A concerted and coordinated effort is required to more effectively recruit, retain, and train those who care for persons with behavioral health issues.

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YOUNG ADULT SERVICES

I. BACKGROUND

In 1998, the Connecticut Department of Mental Health and Addiction Services (DMHAS) received funding from the legislature to develop and administer a comprehensive program of services for young adults who were aging out of the Department of Children and Families (DCF), who were exhibiting high risk behaviors and who may or may not meet DMHAS criteria. In collaboration with the Department of Children and Families (DCF), Office of Policy and Management (OPM), and the Department of Mental Retardation (DMR) now recognized as the Department of Developmental Disabilities (DDS), DMHAS developed processes to enable the early identification, referral, transition and admission of these youth to a comprehensive range of age and developmentally appropriate clinical and support services.

The statewide Young Adult Services (YAS) program currently provides inpatient services at Cedarcrest Hospital and a range of outpatient/community support services at 12 local mental health agencies (LMHAs). Contracts that provide funding to three additional Private Non Profit (PNP) community service providers augment the primary service delivery system. In addition to these programs, YAS contracts with both instate and out of state specialty services in order to meet the unique and complex needs of referred youth. Clinical and support services provided include community residential support, assistance with accessing educational and employment services, social and independent living skills training, support in developing recreational and leisure activities, and ongoing clinical treatment.

The creation of a separate division within the adult mental health system to provide developmentally appropriate and age specific service is unique to Connecticut. When the program began admitting clients in 1998, there were 41 referrals. In SFY 08, there were 433 referrals for the year. It is anticipated that DCF will continue to refer at a rate of 30-35 per month; the average referral rate over the past four years from DCF has been 32 referrals per month. Over the ten years that YAS has been operating, over 2,300 referrals have been made to YAS. The majority of the referrals (84.3%) came from DCF. Of these, 66.3% have been found eligible for services with 19.9% having been found ineligible. The remainder of the referrals are either pending review, pending additional information or have been withdrawn. Currently, YAS serves over 800 clients in its existing programs.

II. HIGHLIGHTS/ACCOMPLISHMENTS

- Nationally recognized program that provides age and developmentally appropriate services to high risk youth.
- Development of four new YAS programs in FY 08.
- Collaborative effort between state agencies that continues to identify, refer and treat high risk youth with serious behavioral health issues who may not ordinarily continue in services once they age out of DCF.
- Development of trauma informed programs.
- Utilization of best practice standards in the treatment of high risk, psychiatrically compromised youth.
- Creation of interagency groups (including private not for profit, state operated, educational institutions and others) to develop standards and best practices for employment and education, competency assessment and skills training, residential programming and housing/fiscal support.

- Implementation and training of staff in many areas related to high risk youth: trauma based treatment practices, state wide training in Positive Behavioral Support Planning, Risk Assessment, Assessment and Treatment of Youth with Sexual Behavior Issues, Behavioral Management and Young Adults, Adolescent Development, etc.
- Development and implementation of a new Utilization Management process.
- Reorganization of the inpatient unit.
- Development of new programs to meet the needs of youth with neuropsychiatric conditions and/or Pervasive Developmental Disorder who were "stuck" in existing services.
- Creation of interagency groups to develop standards and best practices for employment and education, competency assessment and skills training, residential programming and housing/financial support.
- Development of an employment/education assessment tool that is age and developmentally appropriate.
- Identification and development of assessment and skills training tools that can be administered to youth in various agencies that will allow for the monitoring of skill acquisition over time.
- Piloted a work and learn program in three agencies that has demonstrated positive outcomes in improving the quality of life for youth who are participating.
- Development of housing guidelines for all agencies.

III. CHALLENGES

- Timely assessment, review and eligibility determination for the increasing number of referrals.
- Locating and providing funding for housing/living subsidies for youth.
- Expansion of the work/learn model of employment strategies for youth.
- Collection and analysis of data to inform model development.
- Lack of capacity in existing Young Adult programs to meet the increased influx of referrals.
- Lack of ability to develop programs and to train staff in the unique services that are needed by the various cohorts of youth referred to our services.
- Need for funding to provide structured residential services for identified populations.
- Need for additional staff and training to provide comprehensive behavioral assessments for psychiatrically compromised young adults.
- Need to expand age and developmentally appropriate services for young adults in all regions of the state.
- Need to continue to identify funding and programs that will afford us the opportunity to provide appropriate treatment for youth with sexual behavior issues.
- Need to develop and identify funding to provide a range of services for young parents.
- Need to develop policies and outcomes addressing the inclusion of families throughout treatment.
- Need to explore the utilization of peers as mentors and recovery facilitators.
- Need to develop a comprehensive, holistic system wide process for identifying, assessing, monitoring and intervening in identified risk.

All of the above challenges are being addressed through a variety of strategies such as developing collaborative relationships with other agencies in order to access services for our population; reorganizing services; training of staff in best practices; and in seeking funding to support these initiatives.

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INFO Brief
Healthy People, Healthy Communities. Let's Make It Happen!
June 26 , 2008
State of Connecticut Department of Mental Health and Addiction Services
Thomas A. Kirk, Jr., Ph.D., Commissioner

CRUNCH TIME PROJECT

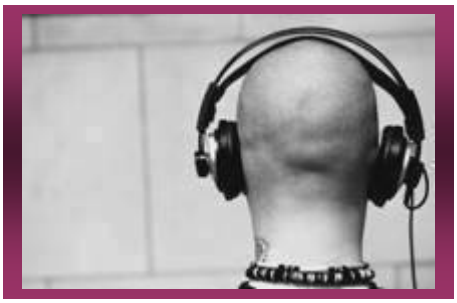
Young adults at DMHAS' Capitol Region Mental Health Center (CRMHC) expressed an interest in learning marketable skills in the multimedia industry. Desire became a reality through partnership with Street Smart Ventures, LLC, Crunch Time Youth, LLC, My Sister's Place, and the continued interest and commitment of Young Adults Services staff. Using the "Work and Learn Model" promoted through Street Smart Ventures, it has been found that work experience improves young adults' ability to learn new skills, cooperate with others, and feel more confident in dealing with daily challenges. Sixteen young adults participated in four 10-week cycles—four individuals in each of the first two cycles and eight in the second two cycles—to learn what it takes to create a CD. Working under a deadline was challenging but very rewarding.

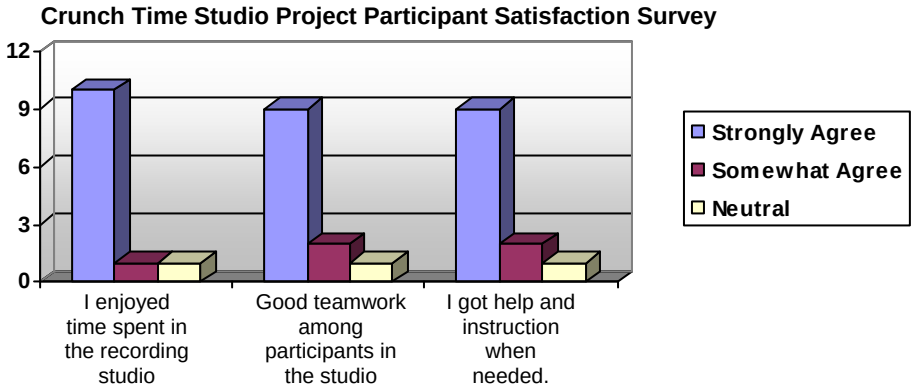
Crunch Studio LLC—What Is It?

Crunch Time Youth LLC, is a music studio in Hartford run by young entrepreneur Von Allen. He and his staff have committed to working with young adults from CRMHC. With their help, youth are learning how to create, record and produce CDs of their own. Through this venture, our young adults are also working on skills such as effective communication, cooperation, and managing conflict, which will enable them to feel more confident and prepared for the work place.

Demographics of Participants

Sixteen young adults from CRMHC ranging in age from 18-25 years participated in this venture. All expressed an interest in singing, creating music and/or learning something new. Through this project, they were able to be a part of the creative process, appreciating the patience of the instructors working with them; as well as realizing the time and effort it takes to create and produce something that was their own. Most importantly, it was a time to work together as a team and to have fun in the process. Plans for the next cycle include learning graphic arts skills and making a video.





Comments of Young Adult Participants

"I think this was a great project and would gladly participate again without pay."
"I think I benefited greatly from the project.
"I liked the hands on training and the patience of the instructors."
"It gave me a purpose to get up in the morning."

Comments of Clinicians

"I think it helped my client clinically to focus on something that was important to him."
"He really enjoyed making his music."
"I think it helped to motivate him and think about working now."

For more information, contact susan.e.simmons@po.state.ct.us or carl.shields@po.state.ct.us.

To view previous issues, visit www.ct.gov/dmhas/infobriefs

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

INFORMATION . . . *foundation for good policy*

The Department of Mental Health and Addiction Services
A Healthcare Service Agency

M. Jodi Rell
Governor

June 25, 2006

Thomas A. Kirk, Jr., Ph.D.
Commissioner

Young Adults Making Progress in Recovery

Individuals participating in the DMHAS Southeastern Mental Health Authority (SMHA) Young Adult Services (YAS) Program are generally 18 to 25 years old and have serious mental health and/or substance use conditions. The emphasis of the YAS program is on community integration. This is one of several YAS programs around the state and is indicative of DMHAS developing service options to promote recovery choices for a younger population. YAS staff provide individual trainings and offer varied recovery-oriented educational, health, recreational activities as well as evidence-based clinical interventions. A significant component involves age-appropriate approaches facilitating progress toward independent living. As such, a special focus is on helping the young adult to identify natural supports within the community so that their developing identities span well beyond the mental health system to include community and neighborhood organizations.

1 on 1 Trainings Focus on Successful Transition to Adulthood:

- ✓ Relaxation & Recreation
- ✓ Employment
- ✓ Creative Anger Management
- ✓ Independent Living Skills
- ✓ Cooking & Crafts
- ✓ Finances & Budgeting

EVIDENCE-BASED PRACTICES That Promote Recovery:

- ✓ TARGET Trauma Group
- ✓ Dialectical Behavior Therapy (DBT)
- ✓ Integrated Dual Disorder Treatment (IDDT)
- ✓ Illness Management and Recovery (IMR)
- ✓ Dartmouth Individual Placement & Support (IPS) Model

High marks on *Client Satisfaction Survey*:
Quality = **96%**, Satisfaction = **96%,** Recovery = **85%**

Decreased incarcerations, institutionalizations & teen pregnancies

YAS
Moving toward Recovery

45% of clients are employed!

What's New!

- A Relationship Group for young couples to promote healthy emotional relationships.
- Weekly Health & Wellness Group run by nurses geared to client needs and recovery.
- Larry, a trained Therapy Dog, provides animal assisted therapy.

PEOPLE DISCHARGED FROM YAS
April 1, 2003 – March 30, 2006

N = 25

Moved to be closer to family*	8	32%
Obtained full time employment**	9	36%
Joined the Armed Forces	1	4%
Dropped out of services	5	20%
Incarcerated	2	8%

*By choice, not dropout, with linkage to services, including out of state.
**One client was named Employee of the Year at his/her place of business.

For more information, please contact Caryl Horner, Ph.D. at *Caryl.Horner@po.state.ct.us*