
State of Connecticut

**Mental Health Transformation
State Incentive Grant (MHT SIG)**

Grant # SM57456



Annual Evaluation Report

Year 3 (October 1, 2007 - September 30, 2008)

Submitted to

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Submitted by

Yale Program for Recovery and Community Health

“When I am on the job, I do my job. I think everybody is capable of doing something. For many years, I did nothing. I was overmedicated and lay on the couch. That is the way I thought my life would always be.

Now, the whole thing of mental health is changing. It’s really wonderful to see all these changes. Years ago, you didn’t have much to look forward to. I thought I would spend the rest of my life in an institution.

Now look at what has happened. I had a lot of people who pushed me along the way. I still have issues with self-esteem but if you have people saying that you can, you can try little things at a time.”

- “Joe,” an adult in recovery

“There has been a lot of progress in the mental health field. I think that the mental health field has changed. I think it is very pro-client, pro-patient.

When I deal with people, I find that they are very concerned. They really want to help you. People say to me: “Why don’t you go to school?” I have 60 credits. I can go to school right now and take a course. I can’t do it. I can’t ride a bus to community college or tech. I can’t go through the crowds on the bus ... I know my limits.

Staff doesn’t push you to do things that you aren’t able to do. They help you do things that you can do. They help you find goals. I think that the profession has improved a million times.

- “Brian,” an adult in recovery

These quotes are from recent interviews that were conducted by adults with recovery with fellow consumers as part of the *Day in the Life* project.

Executive Summary

The third year of the Mental Health Transformation (MHT) grant was marked by significant progress in the achievement of the goals outlined in the 2007/2008 Comprehensive Mental Health Plan (CMHP). MHT partners have worked in a coordinated fashion to not only meet the majority of the stated goals for the 2007/2008 federal fiscal year, but have accomplished 28% more infrastructure changes than originally anticipated. These infrastructure changes—in the form of policies, trainings, organizational changes, and consumer, youth, and family networks—provide a foundation for sustaining MHT initiatives. Some of the most notable achievements of the past year from each of the domains outlined in Connecticut's CMHP include:

- *Community Education:* launching of a statewide anti-stigma social marketing campaign, a televised town hall meeting, ongoing efforts to educate the public about MHT, and exponential increases in the use of the Network of Care website.
- *Consumer, Youth, and Family-Driven:* development and launching of the Connecticut Quality Improvement Collaborative (QuIC) and the Connecticut Consumer/Youth/Family Research and Evaluation Network (CREN), and a more active Consumer, Youth, and Family Advisory Council in all areas of MHT.
- *Data-Driven Decisions:* signing of a Memorandum of Agreement between several state departments to conduct a data sharing pilot study that will assist with identifying and eliminating disparities in behavioral health care.
- *Workforce Development:* establishing the Wraparound Coordinating Center, the Connecticut Workforce Collaborative on Behavioral Health, and the Connecticut Recovery Employment Consultation Service (C-RECS).

Moreover, this past year, roughly \$1.3 million dollars was disbursed to 35 mini-grants, which generated considerable energy and enthusiasm in various stakeholder groups and planted seeds of innovation in numerous areas.

Embedded in these accomplishments has been a visibly more active and involved recovery community. Over the past year, consumers, youth, and family members have partnered in new ways to work towards quality improvement, employment, research and evaluation, training and education, advocacy, and leadership goals. For example, consumers, youth, and family members have been involved in developing and/or administering ten of the twelve MHT training and education activities over the past year. These activities resulted in the training of over 3,200 educators, persons in recovery, family members, youth, students, Department of Labor employees, and supervisors in recovery- and resilience-oriented practices. Consumers, youth, and family members are also centrally involved in leadership roles in the Consumer, Youth, and Family Advisory Council, the QuIC, the CREN, and C-RECS and had majority representation on almost all of the review committees which selected vendors for MHT initiatives.

The accomplishments from this past year confirm that the groundwork laid in the first two years of this project represented time and energy well spent. It has become evident, however, that for successes to continue beyond MHT, partners must begin to look closely at opportunities for new, and expanded, sources of funding, and at creative, low-cost ways to sustain initiatives. Moreover, with consumer, youth, and family member involvement being at unprecedented levels throughout the MHT, the challenge for the remaining years of the grant will be to further operationalize what a consumer, youth, and family-driven system of care looks like, and how to obtain it, throughout all of Connecticut.

Introduction

This annual evaluation report for Connecticut's Mental Health Transformation (MHT) focuses on the federal fiscal year 2007-2008. The purpose of this report is threefold. First, it describes the major achievements associated with each MHT initiative during the 4th quarter (July, August, and September of 2008). Second, it provides a year-end evaluation of each initiative in terms of process and outcome (see below for evaluation factors). Finally, it offers suggestions and potential areas for improvement in the coming years.

EVALUATION FACTORS	
<i>Timeliness</i>	Did activities occur according to the proposed timeline?
<i>Involvement</i>	Were consumers, families, and other key stakeholders involved?
<i>Inter-agency Approach</i>	Did activities involve multiple state departments or agencies?
<i>Implementation</i>	Were activities implemented as outlined in the plan?
<i>Culturally Responsive</i>	Did activities attend to cultural diversity?
<i>Lifespan Approach</i>	Were activities targeting individuals across the lifespan?
<i>Accessibility</i>	Were activities accessible to persons with disabilities (e.g., language, sharing of information, time of meetings, stipends)?
<i>Utility</i>	Did activities reach their target audience?
<i>Potential Impact</i>	How will the activities result in improvements?

OVERVIEW OF YEAR 3 MHT ACTIVITIES

1 st Quarter (Oct. 2007- Dec. 2007)	2 nd Quarter (Jan. 2008 – Mar. 2008)
<ol style="list-style-type: none"> 1) Consolidated 7 workgroups into 4 domains 2) Held event to celebrate workgroup accomplishments 3) Held two demonstrations of the Network of Care website 4) Attended annual SAMHSA meeting for MHT grantees 5) Presented on Network of Care at the Connecticut Psychological Association conference 6) Drafted proposal for Oversight Committee approval to allow Resource Investment Strategies sub-committee to disseminate funds to MHT initiatives 7) Received grant to implement strategies to continue reducing use of restraint and seclusion among young adults with serious mental illnesses 8) Received grant to provide training and technical assistance for statewide implementation of person-centered planning 9) Posted job position for Project Coordinator for Workforce Development 	<ol style="list-style-type: none"> 1) Received approval for funding for social marketing campaign 2) Released 4 competitive bids for Workforce Development initiatives 3) Met with Consumer, Youth, & Family Advisory Council about consumer-driven research 4) Released competitive bid for pilot program for Integration of Primary Care and Behavioral Health 5) Released competitive bid for Continuous Quality Improvement initiative 6) Began discussion about role/objectives of Consumer, Youth, & Family Advisory Council 7) Increased funding for Continuous Quality Improvement initiative 8) Presented final Comprehensive Mental Health Plan 9) Released competitive bids for MHT mini-grants 10) Held inter-agency meeting about surveying mental health curriculum in public schools 11) Held two demonstrations of the Network of Care website 12) Administered <i>Transformation Involvement Survey</i>
3 rd Quarter (Apr. 2008 - June 2008)	4 th Quarter (July 2008 – Sept. 2008)
<ol style="list-style-type: none"> 1) Met with SAMHSA to discuss MHT budgets and carry-forward dollars 2) Reviewed MHT mini-grant applications 3) Released competitive bids for Workforce Development, the Wraparound initiative, and training at Connecticut Valley Hospital 4) Televised town hall meeting “Opening Doors, Opening Minds” 5) Held strategic planning meeting with advertising agency for mental health awareness campaign 6) Held two demonstrations of the Network of Care website 7) Submitted Home and Community-Based Waiver application to Center for Medicare and Medicaid Services for approval 8) Presented results from <i>A Day in the Life</i> project 9) Distributed results from <i>Transformation Involvement Survey</i> 10) Initiated data interoperability pilot study 11) Held kick-off event for Behavioral Health Workforce Collaborative 12) Created youth workforce committee 13) Identified vendors for Workforce Development initiatives 	<ol style="list-style-type: none"> 1) Received site visit from Human Services Research Institute 2) Held focus groups for mental health awareness campaign 3) Implemented 35 mini-grant projects 4) Selected message for mental health awareness campaign 5) Created the Consumer Research and Evaluation Network 6) Held Connecticut Workforce Collaborative on Behavioral Health meeting focused on age and racial diversity 7) Began recruiting consumers for the Connecticut Recovery Employment Consultation Service 8) Held kick-off event for Quality Improvement Collaborative 9) Submitted 2008/2009 MHT Comprehensive Mental Health Plan to SAMHSA 10) Discussed consumer-driven care and results from the <i>Transformation Involvement Survey</i> about self-disclosure of lived experience at Oversight Committee 11) Presented Consumer, Youth, & Family Advisory Council <i>Composition and Functioning</i> document to Oversight Committee 12) Determined the two communities that will receive infrastructure support for Wraparound services

Launch a Mental Health Awareness and Anti-Stigma Social Marketing Campaign:

The purpose of the social marketing campaign is to increase public awareness of mental illness and to challenge the stigma and discrimination often associated with it.

4th Quarter Update: During this quarter, a series of focus groups were conducted with the general public (15 adults), consumers and advocates (9 adults), and young adults in recovery (6 young adults) to pilot test different messages for the media campaign. Based upon focus group feedback, different print and radio campaigns were created and presented to members of the Consumer, Youth, and Family Advisory Council, other family representatives, and MHT staff. This consumer-led group selected a campaign titled “So if I said...” which will include four print ads in local copies of *Time*, *Newsweek*, *U.S. News and World Report*, and *Sports Illustrated* (see samples in Figure 1) and radio advertisements on local stations. Both the print and radio messages include the web address for Connecticut’s Network of Care website (discussed further on page 8).

Figure 1: Examples of Social Marketing Campaign Print Ads



Year-End Evaluation: Consumers and family members were actively involved (with majority representation) throughout the six-month process of planning, creating, and making final decisions for the social marketing campaign. In terms of inter-agency collaboration, MHT staff chose a specific advertising agency, in part, because it also launched the *Connect-Ability* media campaign, a Department of Social Services’ (DSS) project that focuses on increasing employment by addressing discrimination of persons with disabilities. Earlier in Year 3, MHT staff reached out to DSS representatives to set the stage for ongoing coordination of the two media campaigns. The advantages of this inter-departmental collaboration and blending of priorities and projects include increased exposure to messages that challenge misperceptions of mental illness and focus positively on the contributions that persons in recovery can make in the workplace.

Increase Stakeholder and Citizen Awareness about MHT: This activity includes efforts to educate community members and other MHT stakeholders about MHT and broader topics related to mental health and recovery.

4th Quarter Update: The MHT Consumer Liaison gave 11 presentations about Transformation and stigma at consumer social clubs this quarter. Given the success of reaching out to stakeholders, the Consumer Liaison’s role was expanded to educate consumers and family members in the community about how they can get involved in specific MHT initiatives and their service system in general.

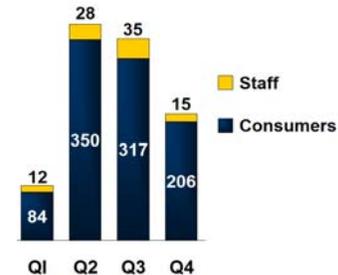
During this quarter, MHT staff began working with Connecticut Public Television (CPTV) on developing three documentaries about mental illness and recovery. In October 2008, CPTV will re-broadcast *Opening Doors, Opening Minds: A Town Hall Meeting on Mental Illness*, which remains available on the internet for online viewing on CPTV’s website, Connecticut’s Network of Care homepage, and the MHT grant web page of the Department of Mental Health and Addiction Services’ website. In October, the first documentary about young people living with mental illnesses will air on CPTV during Mental Illness Awareness Week (see page 33).

Year-End Evaluation: The goal to educate 500 stakeholders about MHT was surpassed by over 100% by the Consumer Liaison, whose presentations at social clubs and other consumer and

family groups reached 957 consumers and 90 staff during Year 3 (Figure 2). Additionally, other community education activities related to the Network of Care website were attended by over 300 individuals.

For the initial airing of *Opening Doors, Opening Minds* town hall meeting in June 2008, advertising efforts included e-mails to legislators, multiple agencies, and persons in recovery as well as over two dozen announcements on local National Public Radio stations, and a posting in *Connecticut Magazine*. The outcome of these efforts resulted in 288,000 gross impression ratings, which exceeded the average of 200,000 for CPTV broadcasts. Additionally, there have been over 550 online requests to view the town hall meeting on the CPTV website (www.cptv2.org/mentalhealth). These activities reached a large target audience and informed them about mental health, mental illness, system transformation, and recovery.

Figure 2: Attendance at consumer liaison presentations



Assess Mental Health Education in Schools: This activity focuses on gaining a better understanding of mental health education and suicide prevention in public schools.

4th Quarter Update: MHT staff continued to work with representatives from the Department of Public Health (DPH), State Department of Education (SDE), and the Garrett Lee Smith Youth Suicide Prevention initiative at the Department of Mental Health and Addiction Services (DMHAS) to develop questions about mental health education and suicide prevention in public schools. These questions will then be incorporated into the School Health Profiles Survey¹ which will be administered next in 2010. The group is scheduled to reconvene in November 2008.

Year-End Evaluation: Early in Year 3, MHT staff searched for effective approaches to navigating some of the challenges associated with implementing a statewide survey of mental health education in public schools, given that Connecticut's education system consists of 169 independent school districts/boards. A series of discussions about activities occurring at other State agencies resulted in the forging of an inter-departmental collaboration between the Department of Mental Health and Addiction Services (DMHAS), Department of Public Health (DPH), and the State Department of Education (SDE) to supplement the bi-annual School Health Profile survey with questions about mental health curricula. This approach has important advantages over the initially proposed strategy of having an outside agency assess the health curricula that are being used in schools. First, it builds upon an established survey that is already completed in public schools, thus assuring a higher response rate while reducing burden on school personnel. Second, this endeavor sets in motion a recurring assessment of students' education about mental health (rather than a one-time survey, as initially proposed), thus providing sustainability for the project and the ability to track changes over time. Lastly, the inter-agency approach sets the stage for potential collaborations for other projects in the future.

DMHAS representatives have been collaborating with other state agencies to incorporate questions about mental health education into an established, bi-annual statewide survey.

Given the shift in how the survey will be conducted, the anticipated completion date for this initiative was changed to October 2010, when the School Health survey will be re-administered.

¹ The School Health Profiles Survey is a system of surveys developed by the Centers for Disease Control and Prevention (CDC) to assess school health policies and programs in states and large urban school districts. These surveys are conducted biennially by state and local education and health agencies among middle and high school principals and lead health education teachers.

Until then, the inter-departmental group will continue to meet and determine which questions to add by reviewing standardized surveys and/or surveys used in other states.

Improve the Mental Health Care in School-Based Health Centers (SBHC): This activity focuses on improving access to, and the quality of, medical and behavioral health care in school settings.

4th Quarter Update: MHT staff continued to participate in quarterly meetings of an ad hoc committee for school-based health centers which was created by the Department of Public Health (DPH) Commissioner to improve access to, and the quality of, medical and behavioral health care in school settings. Over the course of Year 3, this committee identified a number of strategies for improving service delivery collaboration in SBHCs which were recently submitted to the DPH Commissioner for approval.

Year-End Evaluation: This initiative sets the stage for future MHT activities that will address primary and preventive health services in children and youth. MHT staff participation on this committee may help to ensure that principles of resilience are addressed in the recommendations and action steps. Involving youth/students and parents in future discussions would provide additional, valuable information about ways to enhance SBHCs.

Network of Care Website: Connecticut’s Network of Care (NoC) website (www.ct.networkofcare.org) is an online resource that includes directories of behavioral health services and supports (including advocacy groups) as well as links to articles, legislation, and insurance carriers. Visitors have the capacity to search for information at the local, state, and national level as well as to securely save and share health-related information

4th Quarter Update: Since the launch of the website in October 2007, there have been over 3,500,000 hits² and nearly 113,000 web sessions.³ Although the number of web sessions during the 4th quarter was 11.8% lower than the previous quarter (Figure 3), there has been a general trend towards more web sessions over time (Figure 4).

Figure 3: Total number of web sessions per quarter

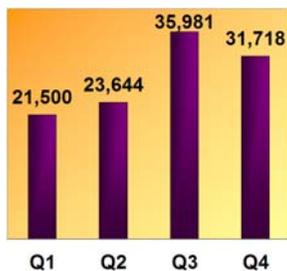


Figure 4: Total number of web sessions per month



Table 1: Average duration and depth of web sessions per quarter

Average Web Session	Q1	Q2	Q3	Q4
Duration (min : sec)	6:26	7:01	5:53	7:58
Number of pages viewed	6.4	7.5	5.7	10.1

A notable increase occurred this quarter in the average length of time and number of pages viewed by visitors (Table 1). The most commonly accessed web pages were ones providing contact information and details about different agencies.

² A “hit” is a successful request to the web server from a visitor's browser for any type of file, whether it is an image, a word, or an entire HTML page.

³ A “session” is a series of clicks on the website by an individual visitor during a specific period of time.

Some of the other achievements from this quarter included:

- the Department of Developmental Services (DDS) added a link to the Network of Care on its homepage
- the Department of Children and Families (DCF) added a second link to the Network of Care on its website
- The Network of Care Governing Committee met to discuss enhancements that could be made to the website, such as posting state and regional training opportunities.
- MHT staff held regular meetings with the advertising consultants responsible for the mental health awareness campaign to incorporate information about the Network of Care in radio and print materials.

Year-End Evaluation: All of the activities and outcomes related to this initiative were accomplished. Many groups, including consumers, family members, and representatives from multiple state departments (i.e., the Department of Children and Families, the Office of Multicultural Affairs at DMHAS, and the Commission on Aging) were involved in creating the website’s content, which helped ensure that the content was culturally-responsive and addressed issues across the lifespan. The Governing Committee meets quarterly and consists of representatives from six state agencies and consumer advocacy organizations. The Network of Care provides information in 14 languages (including American Sign Language), thus making it accessible to diverse populations.

The significant increase in the number of web sessions during the second half of the year may have been the result of efforts to reach a broad target audience. For example, MHT staff held a number of website demonstrations that were attended by over 300 individuals. Nearly half of demonstrations were conducted in March and April, which coincided with the increase in web usage in March, followed by peak use in April. Another contributing factor to the increased web usage may have been that other State departments added links to the Network of Care to their websites.

Shortly after launching the Network of Care, staff posted a brief survey on the website to gain feedback from visitors. Altogether, 93 people completed the survey (see Table 2). Despite the low response rate (roughly 1 out of every 1,200 visitors), the results provided valuable feedback about visitors’ perception of the website and subsequent changes to it.

Table 2: Characteristics of the respondents for the Network of Care survey (N=93)

Age	Q1 (n=24)	Q2 (n=17)	Q3 (n=25)	Q4 (n=27)
Under 18	10%	0%	4%	3%
18-30	0%	0%	4%	4%
31-45	40%	44%	38%	39%
46-64	50%	56%	54%	53%
65 and over	0%	0%	0%	1%
Gender				
Female	85%	69%	75%	77%
Male	15%	31%	25%	23%
Consumer Status				
Mental health	40%	24%	36%	34%
Addiction	0%	0%	0%	0%
Both	5%	13%	5%	6%
Neither	55%	63%	59%	60%
Family member				
Yes	60%	44%	55%	53%
No	40%	56%	45%	47%
Insurance				
Medicaid or SAGA	11%	6%	9%	10%
Medicare	0%	13%	4%	6%
Other	79%	69%	78%	76%
None	5%	6%	5%	6%
Don't know	5%	6%	4%	2%

A common criticism by website visitors during the first half of Year 3 was that it was difficult to find information because the search function was “confusing” and “rigid.” This feedback prompted MHT and Network of Care staff to enhance the search function. Subsequently, ratings for the website improved (Figures 5 and 6). Additionally, the percentage of respondents who were unable to find any of the information they were looking for decreased by 61% between the 2nd and 4th quarter (from 31% to 12%).

Figure 5: Ratings for informativeness

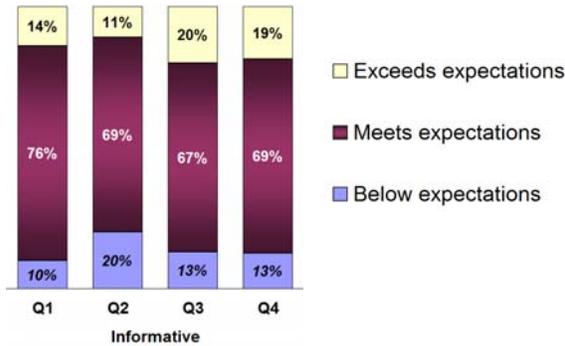


Figure 6: Ratings for ease of use

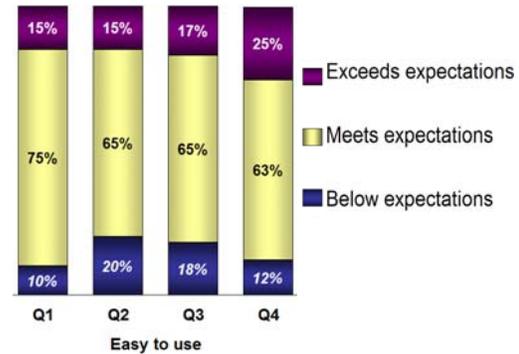
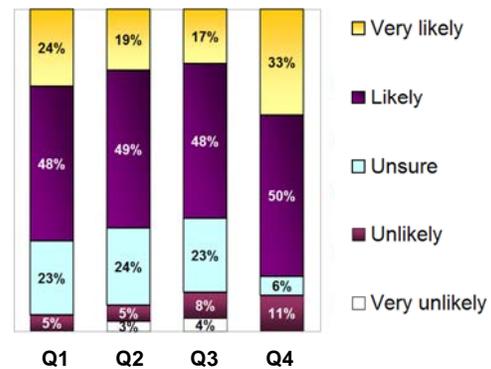


Figure 7: Likelihood of returning to website



Enhancements to the website also appear to have resulted in more visitors reporting they will return to use the Network of Care again in the future (Figure 7). Compared to previous quarters, a significantly greater percentage of respondents reported during the 4th quarter that it was “Very likely” they would return to the Network of Care, while fewer indicated they were “Unsure” whether they would use the website again.

Integrate Behavioral Health and Primary Care: This initiative involves educating pediatric, family medicine, and geriatric physicians on screening for mental health problems and coordinating with behavioral health providers.

4th Quarter Update: After a competitive bidding process, two vendors were selected to implement this initiative.

Year-End Evaluation: Because this is one of the newest MHT initiatives, it is in the very early stages of implementation. As more information becomes available, a more thorough evaluation will be possible. However, it is important to note that general medical settings are a common location of mental health treatment for individuals of all ages. Early identification of problems can be an important component of prevention as well as resiliency and recovery. This initiative will provide valuable tools to medical providers in the accurate and early recognition of behavioral health problems in diverse populations across the lifespan.

Year-End Summary and Suggestions

A number of objectives in the *Community Education* domain were accomplished during year 3. For example, usage of the Network of Care increased by 50% during the second half of Year 3

and twice as many consumers, youth, and family members were educated about MHT than were initially projected. As the statewide social marketing campaign rolls out with its information about the Network of Care, the number of people accessing the website will predictably increase. Another accomplishment was the televised town hall meeting, which received above average gross impression ratings. Activities to examine mental health curriculum in schools and to educate primary healthcare providers are underway.

Consumers, youth, and family members played a meaningful role in many of the *Community Education* activities. One point worthy of note is that although the print ads for the social marketing campaign depict persons of different cultures and ages, consumers and family members who participated in the development of the campaign said that they wished that more persons of color and of different ages had been involved during the development phases of the process. From this feedback, one suggestion for the forthcoming CPTV documentaries is to actively reach out to age- and racially-diverse groups of consumers and family members during the development of the films to help ensure that the messages of resilience and recovery sufficiently reflect the issues that are relevant to individuals of all cultures and ages.

Another recommendation is for MHT staff to offer presentations and demonstrations of the Network of Care at various locations within the mental health system (e.g., service agencies for adults and children, substance abuse treatment facilities, advocacy organizations), as well as to a broader range of audiences outside of the formal mental health system (e.g., public libraries, community centers, schools, senior citizen centers, and Veterans' hospitals). Finally, it is recommended that to reach a larger audience, state departments should add more prominent, accessible, and/or informative links to the Network of Care, such as the one depicted in Figure 8.

Figure 8: Example web link on state departmental website



As interpersonal interactions with a person in recovery, youth, or a family member who represents a success story has been shown to be *the* most effective antidote to stigma and discrimination,^{4,5,6} another suggestion is to supplement the social marketing campaign with opportunities for the general public to interact directly with people who are role models of resilience and recovery. This will, in part, be enhanced by the employment initiatives described later in this report. This can also be promoted through speakers' bureaus, such as the "Family-to-Family" and "In our Own Voice" programs offered by the National Alliance on Mental Illness (NAMI) and initiatives that are suggested and/or led by the Consumer, Youth, and Family Advisory Council.

⁴ Alexander, L. A. , & Link, B. G. (2003). The impact of contact on stigmatizing attitudes towards people with mental illness. *Journal of Mental Health, 12*, 271-289.

⁵ Corrigan, P.W. (2006). Mental health stigma as social attribution: Implications for research methods and attitude change. *Clinical Psychology: Science and Practice, 7*, 48-67.

⁶ Couture, S. M., & Penn, D.L. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of Mental Health, 12*, 291-305.

Create a Consumer-Run Continuous Quality Improvement (CQI) Process: As part of a long-term continuous quality improvement process, the purpose of this initiative is to establish an organized process by which consumers, youth, and family members identify and use recovery and resiliency-oriented performance measurements to evaluate the mental health service delivery system.

4th Quarter Update: A review committee, with majority consumer and family member representation, selected the North Central Regional Mental Health Board (NCRMHB) to serve as the CQI Coordinating Center. The Coordinating Center will work in partnership with the other four regional mental health boards and the advocacy organizations FAVOR, Advocacy Unlimited (AU), and the Connecticut chapter of NAMI (NAMI-CT)⁷ to oversee the statewide CQI process. The Coordinating Center will provide initial and ongoing support to the Connecticut Quality Improvement Collaborative (QuIC), which will carry out various evaluation activities to promote consumer-informed choice of programs and services.

In September, the CQI Coordinating Center hosted a kick-off event to celebrate the QuIC initiative and educate stakeholders about joining the QuIC. Over 150 individuals, most of whom were consumers, youth, and/or family members, attended the event, which included training about quality improvement and a group activity to identify strategies for improving the mental health system. Over two-thirds of the attendees signed up to participate further in the QuIC.

Year-End Evaluation: Consumers, youth, and family members have been involved in every stage of development and implementation of the CQI process. Furthermore, this initiative has established a substantial degree of inter-agency coordination with its formal Memorandum of Agreement (MOA) between advocacy organizations for adult consumers, family members, and the regional mental health boards.

The QuIC partners' commitment to the involvement of consumers, youth, and families is reflected in the high ratings from the attendees of the launch event (Table 3) and even more so in their open-ended feedback (Table 4, next page). Themes of feeling motivated, valued, and heard, and statements of appreciation for making the information accessible to attendees, were expressed.

Table 3: Quantitative survey results of CQI launch event

	YES	NO	SOMEWHAT
1) Do you feel you understand the Connecticut Quality Improvement Collaborative and its mission as a result of this meeting?	74.6%	1.5%	23.9%
2) Do you feel you have been able to participate in the Quality Improvement Collaborative meeting in a way that allowed your voice to be heard?	80.6%	1.5%	17.9%
3) Do you feel that the Collaborative is working towards a more consumer and family driven, culturally diverse, and recovery-oriented system of care?	93.8%	6.2%	0.0%
4) Do you feel that you learned more about quality improvement as a result of this meeting?	82.1%	3.0%	14.9%

⁷ A Memorandum of Agreement (MOA) was signed between the 5 regional mental health boards and 3 advocacy organizations (FAVOR, AU, and NAMI-CT) to spell out the responsibilities, shared resources, and commitment of each member to the establishment of the QuIC.

Table 4: Qualitative survey results of CQI launch event

Themes	Illustrative Quotes
Excitement about solidarity	"The enthusiasm about actually being able to do positive things to improve the mental health system"... "The way you motivated us to become involved in the QUIC"... "The dedication of providers, family members and consumers to the mission!"... "The energy...high energy and passion"... "The people getting together for this cause"
Recognizing the importance of our voices	"Being able to speak and being heard as a person"... "Real life stories of consumers"... "Our participation was important"... "The group brainstorming exercise"... "The offer to be involved"
Praise for the presenters	"Power point presentation was interesting, a difficult subject made easy to understand"... "Explanation of research, very concise yet understandable"... "Concise, clean, informative presentations"... "Priscilla and Larry (the presenters) were great"... "The emphasis on performance measurement"

Another example of how QuIC partners responded to the needs and wishes of consumers, youth, and family members was in the timing of the events. The QuIC meeting was scheduled in the early evening, a time which is less likely to conflict with school and work. The first meeting of the QuIC collaborative in late October will be held at a similar time, making participation more accessible to many consumers and family members.

Implement the Home and Community-Based Waiver: This initiative focuses on the implementation of the Home and Community-Based Waiver from the Center for Medicaid Services (CMS). This waiver will expand Medicaid coverage for non-traditional services in the community to include services for adults with serious mental illnesses who are being discharged or diverted from nursing home care.

4th Quarter Update: Connecticut recently learned that the Center for Medicaid Services (CMS) approved its application for this waiver. Once the formal approval processes are finalized, the waiver will be implemented on a statewide basis.

Year-End Evaluation: Each of the action steps for this initiative was completed in a timely manner, and the waiver was approved more quickly than expected. This waiver represents an important change in financing policy and is a significant achievement in Connecticut's ongoing attempt to diminish its reliance on institutional care. Early in Year 3, DMHAS created a Director of Older Adult Services position. Funding received for staff support has already enabled 40 adults to move from nursing home care to live with their families or independently in the community. The potential impact of this initiative is significant, as it makes "a life in the community" a true reality for more adults in recovery. Upon full implementation of the waiver, an even greater number of Connecticut adults will be able to either remain in, or return to, homes in the community.

Integrate the Recovery-Oriented Care Guidelines: This revised set of practice guidelines written by the Yale Program for Recovery and Community Health (Yale PRCH) incorporates best-practices for trauma-informed care, cultural-competence, gender-informed practice, physical health care, and co-occurring disorders treatment into a single, user-friendly document.

4th Quarter Update: The Yale Program for Recovery and Community Health (Yale PRCH) continues to work closely with the Department of Mental Health and Addiction Services (DMHAS) Commissioner to make final revisions to the new *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. Yale PRCH is also working with the DMHAS Office of the Commissioner to develop recovery-oriented practice indicators (measures) that are aligned with the revised practice standards and will become part of routine data collection.

Year-End Evaluation: Upon release, the updated *Practice Guidelines* will offer practical and accessible information to providers, policy makers, program directors, and persons in recovery about how services can be more comprehensive, culturally responsive, recovery-oriented, and consumer-driven. Moreover, the revised guidelines build upon many DMHAS policies and principles, as articulated in Policy #33 (*Individualized Recovery Planning*), Policy #76 (*Cultural Competence*), Policy # 83 (*Promoting a Recovery-oriented Service System*), and Policy #84 (*Serving People with Co-Occurring Mental Health and Substance Use Disorders*).

Employ Persons in Recovery: This section highlights some of the various MHT partners that are actively recruiting consumers, youth, and family members as employees.

Employment opportunities for consumers, youth and family members continue to increase.

4th Quarter Update: Two individuals were hired to assist with the Connecticut Recovery Employment Consultation Service (C-RECS) as part of a Workforce Development initiative (see page 25) and the position for the project coordinator of the Continuous Quality Improvement (CQI) initiative was filled by a young adult family member of a person in recovery. Furthermore, efforts are underway to recruit a youth coordinator for the Wraparound project (see page 22). Many other projects reimbursed consumers and family members for their participation in MHT activities on a per diem basis (e.g., evaluation activities and participation on review committees).

Year-End Evaluation: During Year 3, a total of 15 individuals in recovery and/or family members joined various MHT initiatives as employees. A number of these positions were full-time and many individuals who were previously employed on a part-time basis were able to increase their employment to full-time as a direct result of MHT.

Offer Standardized Training for Recovery Supporters: To help consumers navigate systems of care, a group of adults in recovery is being trained in providing peer support and advocacy services.

4th Quarter Update: This past quarter, the Yale Program for Recovery and Community Health (Yale PRCH) trained four adults in recovery to be group facilitators. These four individuals then began training other consumers to be recovery supporters (i.e., peers who are trained to help guide other consumers in their recovery journeys and with navigating systems of care). Furthermore, 10 previously trained recovery supporters received additional training in leadership and advocacy skills. A related but separate training activity that occurred this quarter was at Western Connecticut Mental Health Network, which received a MHT mini-grant to expand its existing training of peer support specialists (see page 36 for further details). A total of 26 adults graduated from the peer employment training this quarter.

Year-End Evaluation: Since March 2008, a total of 19 new recovery supporters were trained at Yale PRCH in conjunction with Focus on Recovery-United (FOR-U), a statewide consumer advocacy organization. Furthermore, a number of recovery supporters received additional training to help with their ability to advocate for fellow adults in recovery. Given that the anticipated completion date to train 25 recovery supporters is September 2010, FOR-U is ahead of schedule for achieving this goal, especially since a train-the-trainer approach has recently been adopted. This initiative not only provides a valuable, peer-based service to consumers in their recovery journey, it also has the potential impact of creating employment opportunities for peer supporters in advocacy and service settings.

Implement Policies and Procedures for Psychiatric Advance Directives: This multi-pronged initiative seeks to establish policies and practices around advance health care directives (including psychiatric advance directives) within the Department of Mental Health and Addiction Services (DMHAS). The Connecticut Legal Rights Project (CLRP) and the Yale Program for

Recovery and Community Health (Yale PRCH) designed a toolkit to help stakeholders create their own psychiatric advance directives and drafted a policy statement to be adopted by DMHAS.

4th Quarter Update: The Connecticut Legal Rights Project (CLRP) and Yale PRCH are continuing to design a train-the-trainer model for providing education about psychiatric advance directives to consumers, health care representatives, and behavioral health providers. This training incorporates changes that were made previously to the psychiatric advance directive toolkit and policy statement. The toolkit is currently available through the CLRP and was submitted to the Attorney General's Office, but has yet to be approved for incorporation into DMHAS practice. An electronic version of the psychiatric advance directive toolkit was also developed so that it can be linked to the Network of Care website.

Year-End Evaluation: All of the activities projected for completion during Year 3 were achieved. Over the course of the year, CLRP conducted 28 advance directive trainings at clubhouses and on inpatient units, training 262 persons in recovery and 30 staff. Adults in recovery played a substantial role in the development of the toolkit and in the training modules. Because advance directives incorporate end-of-life concerns and other medical directives, this initiative applies to adults of all ages. Once fully implemented, this initiative will provide a valuable resource that embodies the principles of person-centered planning to consumers and family members.

Ensure Compliance with the American's with Disability Act (ADA) in DMHAS Agencies: In late March, the Department of Mental Health and Addiction Services (DMHAS) submitted a revision of its policies relating to the ADA to the State Attorney General's office for review.

4th Quarter Update: The revised versions of the policies will be made available to all DMHAS-contracted agencies and will provide consumers and family members with information about their legal rights regarding workplace accommodations.

Year-End Evaluation: Once approved, the revision of the DMHAS ADA-related policies will provide information about protection against discrimination and the provision of reasonable accommodations in the workplace to persons with disabilities, including mental illnesses.

Assess Need for Legislative Changes of the Psychiatric Security Review Board: The purpose of the Psychiatric Security Review Board (PSRB) is to determine where individuals will receive treatment when they have been found not guilty of a crime by reason of mental disease. This board also determines when such individuals will return to the community.

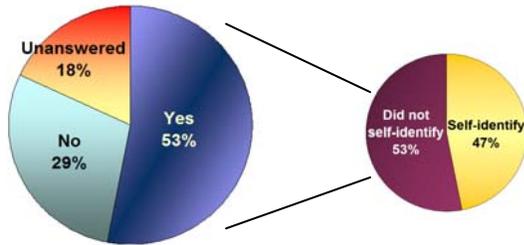
4th Quarter Update: Since October 2007, when the legislation was reviewed, there have been no proposed or anticipated changes to the statutes governing the Psychiatric Security Review Board.

Year-End Evaluation: There have been no proposed changes to the statutes.

Conduct Participatory Action Research: This initiative focuses on consumer, youth, and family-driven research and evaluation to inform system change.

4th Quarter Update: In August 2008, 12 adults in recovery and family members came together for the first meeting of the Consumer/Youth/Family Research and Evaluation Network (CREN). The CREN members joined evaluators at the Yale Program for Recovery and Community Health in analyzing the results of the *Transformation Involvement Survey* (which the Consumer, Youth, and Family Advisory Council assisted with creating) that was distributed to all of the people who had participated in the MHT grant process thus far. After being trained in qualitative research methods, members of the CREN identified themes in the survey responses and formulated recommendations for increasing recovery-oriented care in the mental health system.

Figure 9: Representation and self-identification of consumers and family members during MHT



Are you a person in recovery, a mental health consumer, or a family member of someone who has received mental health services?

Did you identify yourself as a consumer or family member during your MHT involvement?

An important finding from the survey was that 53% of survey respondents indicated they were a person in recovery, mental health consumer, and/or family member (left pie graph in Figure 9). However, more than half of these individuals chose not to self-identify or disclose this information during their participation in MHT groups (right pie graph).

Qualitative analysis shed some light on how people who disclosed being a consumer and/or family member felt about the experience. Results revealed

that half of the time, disclosure resulted in people feeling respected, empowered, and a “part of the process rather than an outsider.” Other respondents who self-identified, on the other hand, reported that they felt “like a token...not valued at all” or that people were “dismissive,” “condescending,” or “elitist” towards them. Many people indicated that their feelings about disclosing their own lived experience depended on the MHT group (e.g., it was a positive experience in a particular work group, but a negative one in others).

These data provide insight into some of the reasons people may feel reticent about self-identifying as a consumer or family member. In response, the Consumer, Youth, and Family Advisory Council is currently discussing how to foster an environment in which people with lived experience as a consumer and/or family member not only feel “safe” to self-identify, but feel valued in MHT groups.

Other activities relating to participatory action research included the *Day in the Life* project, which began with training eight adults in recovery in qualitative research methods. These eight co-researchers then interviewed 80 consumers about how mental health services helped them (or not) in living the kind of lives they want. In June 2008, this group of consumers presented their initial results to over 70 individuals at the North Central Regional Mental Health Board’s annual dinner. The *Day in the Life* participants are close to completing their qualitative analysis of all of the interviews and will present the final results during a meeting with the Department of Mental Health and Addiction Services (DMHAS) Commissioner.

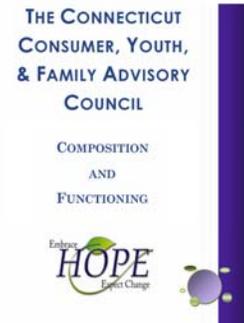
Year-End Evaluation: Ten of the 12 CREN participants expressed “great interest” in continuing in research and evaluation activities. Similarly, a number of the interviewers for the *Day in the Life* project described the experience as one of their “most meaningful” pursuits. These consumer-driven evaluation activities dovetail with other MHT activities, including the Quality Improvement Collaborative (QuIC), the Connecticut Recovery Employment Consultation Services (C-RECS), and the Consumer, Youth, and Family Advisory Council.

Consumer, Youth, and Family Advisory Council: The purpose of the Consumer, Youth, and Family Advisory Council is to provide input to all levels of the MHT process and to enhance its decisions, processes, and outcomes by amplifying the voice of consumers, youth, and families.

4th Quarter Update: The Advisory Council met each month and a number of members were actively engaged in the decision making process for the social marketing campaign. The Council also assisted with preparations for the evaluation site visit for the MHT grant.

One major accomplishment for the Advisory Council this quarter was the drafting of a *Composition and Functioning* document which details how the members define their role within the MHT grant (Figure 10). This document was the culmination of ongoing discussions among Council members as well as with MHT leadership and Yale PRCH about what “consumer-driven” means. The document specifies how the Advisory Council will be an active and equal partner to MHT leadership in all aspects of the planning, decision making, resource allocation, and related MHT grant processes. In September 2008, the Advisory Council presented the document to the Oversight Committee, who unanimously voted to approve it.

Figure 10: Advisory Council’s Composition and Functioning document



The Advisory Council established four priorities during this past quarter. First, because a number of consumers, youth, and family members became less involved in MHT activities after the consolidation of the work groups, the Advisory Council made it a priority to identify ways to keep consumers, youth, and family members involved in and informed about MHT activities.

Second, the results of the *Transformation Involvement Survey* about people’s experiences with self-identifying as persons in recovery and/or family members led to discussions about possible bias and the existence of discrimination relating to mental illness in MHT groups (including the Advisory Council itself). The distinction between feeling safe to disclose that one has lived experience versus having one’s lived experience be *value added* to the MHT process was highlighted. The Council agreed to continue to discuss possible strategies for creating a culture in which people with lived experience feel valued and unafraid of being viewed as less credible if they self-identify.

A third important goal identified by the Council was to expand the number of advisory council members and to diversify its membership by reaching out to consumers, youth, and family members in local systems of care. And finally, an overarching priority of the Council has been to develop strategies for the sustainability of consumer, youth, and family advisory council after the MHT grant ends.

Year-End Evaluation: When the Advisory Council was formed during Year 2 of the MHT grant, its purpose, according to the Oversight Committee, was to: a) serve as a vehicle to communicate Transformation efforts across the State; b) represent the perspectives of consumers, youth and families on MHT initiatives; and c) embed consumer, youth, and family input at every level of MHT. Since that time, many of the *Community Education* initiatives have served to share information about MHT (e.g., through the Consumer Liaison’s presentations and the Town Hall meetings). Moreover, this past year, a majority of the MHT activities had significant consumer, youth, and family member representation. This left the Advisory Council and MHT leadership with the most challenging task of establishing procedures that would embed consumer, youth, and family member involvement at each level of the rapidly evolving MHT grant during Year 3 and afterwards.

The Advisory Council and MHT leadership made many mid-course corrections this year to work towards achieving this difficult endeavor. For example, ongoing discussions between the Co-Chairs of the Advisory Council, MHT leadership, and evaluators from Yale PRCH helped clarify the Council’s role in the MHT process and identified opportunities for its involvement. Similarly, MHT leadership extended multiple opportunities for the Advisory Council to be involved in MHT activities (e.g., planning for the social marketing campaign). Furthermore, the Advisory Council created a *Vision and Purpose* statement early in the year, which it later refined with its *Composition and Functioning* document. In line with recommendations made in this document,

MHT staff offered to assist the Council with arranging for project directors and coordinators for the major MHT initiatives (e.g., the Quality Improvement Collaborative and the Connecticut Workforce Collaborative on Behavioral Health) to provide updates to the Advisory Council. This would give the Council an opportunity to consult with initiative leaders on ways to enhance consumer, youth, and family involvement.

A discussion has ensued among the Advisory Council members and MHT leadership regarding the clarification of what a “consumer-driven” process and system looks like. In recent months, a vision has emerged of a partnership characterized by shared decision making in which each party respects and values the contributions, perspectives, and roles of the other, with full understanding that the promotion of transformation requires the efforts of all parties. The point of reciprocal respect and value may be an important focus in light of the *Transformation Involvement Survey* results.

Year-End Summary and Suggestions

This year marked a turning point in MHT in which consumers, youth, and family members exhibited notable initiative to become active partners. Equally important, more doors were opened to them, and a more energetic and lively partnership across multiple levels is forming. A number of the initiatives in this domain make a “life in the community for everyone” more of a possibility by expanding the availability of community-based services and employment opportunities for persons in recovery.

To build upon the considerable momentum and energy that was generated over the course of the year, the Advisory Council may draft its own agenda for increasing consumer, youth, and family involvement, both within the MHT grant and the service system in general. Similarly, the unprecedented Memorandum of Agreement between the mental health advocacy organizations within the state that came about as part of the Quality Improvement Collaborative (QulC) offers a common platform for transformation from which greater consumer, youth, and family member involvement in the system of care can emerge.

Connecticut effectively reached out to consumers, youth, and family members to participate in the MHT process. However, according to the *Transformation Involvement Survey*, 41% of the respondents reported they became less involved in MHT over time. Therefore, identifying ways to re-engage consumers and family members (either in the MHT or other state incentive grants that Connecticut has received) may help expand the scope of consumer, youth, and family involvement. Similarly, the survey results suggest a need to explore further how persons in recovery, youth, and family members experience their involvement in MHT and identify potential ways to make their participation feel more valued.

Identify Health Care Disparities and Share Data Across State Agencies: The purpose of this initiative is to pool resources across state agencies and initiatives to enhance data sharing opportunities which will ultimately assist with identifying and eliminating behavioral health disparities.

4th Quarter Update: In August, a Memorandum of Agreement (MOA) was signed so that a pilot study could be conducted to examine the services individuals received from the Department of Mental Health and Addiction Services (DMHAS), the Department of Developmental Services (DDS), and the Bureau of Rehabilitation Services (BRS) of the Department of Social Services (DSS). The analysis of this 'population caseload overlap' study provided information about the demographic characteristics of individuals who are jointly served by at least two of these three agencies (i.e., DMHAS, DDS, and BRS) as well as their associated service costs. Preliminary results of this pilot study will be presented at a Commissioners' meeting in October 2008.

Year-End Evaluation: Over the course of Year 3, MHT staff met regularly with the Data Interoperability Workgroup which includes representatives from BRS, the Office of Workforce Competitiveness, and the Early Childhood Cabinet. Furthermore, meetings with multiple State Department Commissioners occurred regularly to discuss how to pool resources so that data interoperability can be achieved. In these meetings, an independent consulting group facilitated a discussion of the recommendations. Results from the pilot project demonstrated that data interoperability can be achieved. However, a number of barriers must first be overcome. These barriers include the variability in data collection instruments and processes across departments, missing data, and difficulties detailing costs associated with care in non-fee-for-service programs.

Year-End Summary and Suggestions

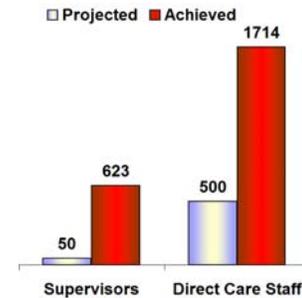
The objective of this initiative is to enable multiple state departments to collect, share, and analyze data to identify disparities in care. As a whole, significant progress towards achieving data interoperability occurred during Year 3. Accomplishing this objective will require an extraordinary level of inter-agency collaboration and significant changes in technology infrastructure. Although the true impact of data interoperability may not be felt for years to come, this initiative, once achieved, is likely to result in some of the most sustainable products associated with MHT. This is because data interoperability requires not only changes to the data infrastructure system, but also changes in associated practices (i.e., data collection tools and methods), policies and procedures, and data review and reporting systems. Moreover, once achieved, involved departments will be able to identify, and thus begin to eliminate, disparities in care according to age, gender, and race/ethnicity.

Train Staff in Person-Centered Planning and Rehabilitative Services: This initiative aims to enhance behavioral health services by providing skills-based training in recovery-oriented practices to direct care staff and supervisors at Connecticut Valley Hospital and outpatient Local Mental Health Authorities (LMHAs) throughout Connecticut. In addition to ongoing training in person-centered planning and psychosocial rehabilitation, training in trauma-informed care and alternatives to restraint and seclusion were added to the 2008/2009 Comprehensive Mental Health Plan.

4th Quarter Update: Direct care staff and supervisors at Connecticut Valley Hospital (CVH) continued to receive skills-based training in person-centered planning and psychosocial rehabilitation. Furthermore, staff and supervisors at CVH have started to receive training in providing trauma-informed care— which focuses on attending to a person’s need to be respected, informed, connected, hopeful, and empowered, while minimizing re-traumatization— and alternatives to seclusion and restraints. Efforts are also underway to increase the number of recovery-oriented groups and to begin a person-centered, trauma-informed, recovery-planning process to prevent the use of seclusion and restraint in conjunction with two grants (i.e., Real Choice System Change Person-Centered Planning Grant and The Alternative to Restraint and Seclusion Grant).

Year-End Evaluation: Cumulative attendance for these trainings during Year 3 greatly exceeded the initially projected goals (Figure 11). Examples of the training courses included: (1) *Overview of Psychosocial Rehabilitation in the Service of a Person-Centered, Recovery-Oriented Approach to Clinical Treatment*, (2) *Recovery-Oriented Assessment: Using Client’s Strengths, Interests, and Goals*, (3) *Healing Communications*, and (4) *Recovery to Wellness*.

Figure 11: Attendance at CVH trainings in person-centered planning and psychosocial rehabilitation



Attendees consistently gave high marks for the usefulness of the content and the instructors’ knowledge and teaching style (no less than 80% rated them as “Excellent”). As seen below, attendees’ often praised the opportunity to practice what was learned during the courses and to receive feedback from instructors.

Table 5: Sample of quotes from open-ended feedback for training	
“a fantastic trainer”	“excellent and relevant”
“role-playing excellent technique for teaching content and skills”	“[the instructor] has a lovely ability to use strengths as a feedback tool”
“great engagement skills”	“I appreciated all your modeling”
“highly experienced in the field, seemed genuine in his presentation of the topic”	“appreciate being able to sit in on the feedback and teaching”
“gave concrete examples of how to use the techniques”	“I felt privileged to have you both critique my skills”
“very engaging and enthusiastic”	“it was very helpful to our unit”
“gave staff both skills and confidence”	“Excellent - A new beginning!”

Train Staff in Prevention and Management of Dangerous Behavior: The purpose of this initiative is to revise the current behavior management training that is used at Connecticut Valley Hospital into one that incorporates principles of trauma-informed and recovery-oriented care.

4th Quarter Update: Last quarter, a Request for Information (RFI) was issued for appropriate vendors to submit proposals for training curricula that would replace the current Behavior Management System (BMS) used at Connecticut Valley Hospital. Unfortunately, only one proposal was received. To fulfill the desired goal of training staff in ways to more effectively prevent and respond therapeutically to aggressive behavior, two alternative approaches were used. First, a series of focus groups was conducted in outpatient and inpatient settings to receive input on how to revise the existing BMS training. Second, a diverse group of Department of Mental Health and Addiction Services (DMHAS) staff, representing multiple agencies, formed a committee to explore best-practices in therapeutic approaches to dangerous behavior. The revised BMS training will be provided to new and current CVH employees during the 1st quarter of Year 4. Furthermore, MHT staff will continue to work closely with this committee to ensure that the training adheres to the principles of trauma-informed and person-centered care, as described in the previous section.

Year-End Evaluation: Completion of this initiative was delayed due to the unforeseen challenges of identifying a replacement training curriculum by way of a competitive bidding process. Nevertheless, active efforts were made this year to address the need for a more effective approach to preventing and responding to dangerous behavior by involving key stakeholders and incorporating their input into the process of revising the existing curriculum.

Evaluate the Use of Seclusion and Restraints in the DMHAS System: In the 1st quarter of Year 3, Connecticut received an Alternative to Restraint and Seclusion State Incentive Grant (ARS-SIG), a federal grant to develop and implement a comprehensive strategy to reduce (and ultimately eliminate) the use of restraint and seclusion among young adults, ages 18-25, with serious mental illness.

4th Quarter Update: Both of Connecticut's state psychiatric hospitals have drafted a strategic plan that is currently undergoing revision based on the recommendations received in a consultation site visit by representatives from the National Association of State Mental Health Program Directors (NASMHPD). Part of this plan involves: a) conducting a trauma-informed assessment of every individual admitted to services, and b) training staff in the provision of trauma-informed care.

Year-End Evaluation: This project leveraged federal dollars from the ARS-SIG grant with existing resources to expand on the already significant efforts undertaken to address the needs of young adults in Connecticut. The overlap between ARS-SIG and MHT goals is substantial, thus staff from both projects are working closely together to ensure maximum results in an efficient and cost-effective manner. This project has widespread implications, not just for young adults, but for persons in recovery of all ages using inpatient psychiatric services. Moreover, because this project is embedded in other trauma-informed initiatives at the Department of Mental Health and Addiction Services, it ensures that inpatient treatment providers attend to critical personal, historical, and cultural aspects of every person they serve.

Implement the Family and Community Wraparound Project: The goal of this multi-pronged, inter-departmental initiative⁸ is to divert children and youth from involvement in the juvenile justice system through a focused implementation of Wraparound, an evidence-based

⁸ The Department of Mental Health and Addiction Services (DMHAS), the Department of Children and Families (DCF), and the Court Support Services Division (CSSD) of the Judicial Branch signed a Memorandum of Agreement (MOA) outlining the responsibilities and allocation of resources for the Wraparound initiative.

approach to helping youth with serious emotional disturbances and their families. The Connecticut Center for Effective Practice (CCEP) was selected to serve as the coordinating center for the Wraparound initiative.

4th Quarter Update: A major accomplishment this quarter was identifying the communities that will receive infrastructure support for providing Wraparound services. After reviewing the Request for Qualifications (RFQ) applications, Greater Bridgeport and Bristol/Farmington Valley were selected to receive a range of infrastructure supports (e.g., training and coaching in providing Wraparound services) to create systematic changes in how services are provided to youth and the families in the juvenile justice system.

Bridgeport and Bristol were selected as the communities to receive infrastructure support for Wraparound services.

Another important step that occurred this quarter was the procurement of dollars from the MacArthur Foundation, which will broaden the impact of the Wraparound initiative by linking it with a school-based juvenile justice diversion initiative designed to refer students who display disruptive behaviors in school to mental health services.

The CCEP oversaw a number of essential, preparatory activities that will serve as the foundation for implementing the Wraparound project during Years 4 and 5. For example, the CCEP actively recruited a youth coordinator and research assistants to help with data collection for the project. The CCEP also collaborated with FAVOR (a statewide family advocacy organization) and the two selected communities to hire a local coach to be a community expert on Wraparound as well as to identify technical assistance and administrative support needs. To facilitate this process, meetings were held with multiple stakeholders in both selected communities. An inventory was selected to assess supports needed for Wraparound services in the communities and to facilitate the identification of goals and training needs. The CCEP also finalized a uniform training curriculum to be implemented in the coming months.

Year-End Evaluation: In 2008, the CCEP was selected via a competitive bid to serve as the coordinating center for this project. A number of activities have been completed in a timely manner despite some delay in the identification of which communities would receive infrastructure support for Wraparound services. Multiple agencies/departments are working together to carry out this project (e.g., community collaboratives, state departments, universities, community organizations, and advocacy agencies) and a Memorandum of Agreement (MOA) was established between the Department of Mental Health Services (DMHAS), the Department of Children and Families (DCF), and the Court Support Services Division (CCSD) of the Judicial Branch to further this effort. The linking of the MacArthur funds will expand the positive impact of the Wraparound initiative by pooling resources. Although families and youth were involved in different aspects of the planning and preparatory phases of the initiative, continued efforts to increase the participation of consumers, youth, and families of diverse ethnic backgrounds in all aspects of the project will help ensure the relevance and sustainability of this initiative.

Establish the Connecticut Workforce Collaborative on Behavioral Health (CWCBH):

This initiative establishes a permanent infrastructure for behavioral health workforce development through coordinated planning with various agencies, consumers, youth, and family members. The CWCBH includes four councils⁹ and consists of 100 members (49% of whom are consumers,

⁹ The four councils in the CWCBH are: 1) the Executive Council; 2) the Council on the Workforce for Adults; 3) the Council on the Workforce for Children, Youth, and Families; and 4) the Council on Consumers, Youth, and Families in the Workforce.

youth, and/or family members) who represent multiple state agencies, private non-profit agencies, universities/community colleges, and advocacy organizations.¹⁰

4th Quarter Update: A second statewide meeting for the CWCBH was held in September 2008. Topics at this meeting included: a) how to recruit and support diverse membership of the Collaborative, b) the role of community colleges in educating the behavioral health workforce, c) how to develop youth leadership in the behavioral health workforce, and d) the creation of training and workforce development guidelines. At the September meeting, 15 individuals volunteered to create a work plan to further strengthen the Collaborative in regards to cultural diversity. In addition, each of the four Councils also convened.

As part of a special initiative to examine workforce strategies related to youth, a white paper devoted to youth initiatives in Connecticut and the United States was drafted and submitted to the Workforce Collaborative leaders. A statewide stakeholder meeting for the youth initiative was held this quarter where culturally and ethnically diverse men and women who have been involved with creative youth development and gang prevention activities came together to discuss youth leadership.

Year-End Evaluation: Since its inception, adults in recovery and family members have been involved in the CWCBH. For example, consumers and family members had majority representation on the committees that determined which agencies would implement the various Workforce initiatives described below. Furthermore, one focus of the Workforce Collaborative after its launch event in May 2008 was increasing the representation of consumers and family members, as well as the age and cultural diversity among its members. The results of these efforts were demonstrated by increased attendance of culturally, ethnically, and age-diverse individuals at the September 2008 meeting compared the one in May 2008. Recruitment and support of consumers, youth, and family members from diverse backgrounds continues to be a major focus of the Workforce Collaborative.

Expand the Workforce Skilled in Evidence-Based In-Home Family Treatment: This initiative focuses on faculty and curriculum development in university settings to train the future behavioral health workforce. Wheeler Clinic was awarded the sub-contract after a competitive bidding process to develop the curriculum and implement the faculty training, which will include parents and providers coming to speak to students about intensive home-based services.

4th Quarter Update: Wheeler Clinic finalized the training curriculum that will be offered to faculty in university settings. The first faculty seminar was held in September 2008. Six professors from Master's programs in psychology, social work, and marriage and family therapy at three universities (i.e., the University of Connecticut, Southern Connecticut State University, and Central Connecticut State University) have received 24 hours of instruction regarding implementation of the curriculum. Recruitment of graduate students for the Spring 2009 semester is underway.

Year-End Evaluation: All of the activities were completed according to schedule. Family members were involved in developing the graduate training curriculum, which includes a module in which family members will speak to students about their personal experiences of having a relative with mental illness. Furthermore, each module in the graduate training curriculum highlights the need to tailor services to individual family needs and to cultural background.

¹⁰ The CWCBH and its initiatives include representation from 30 private non-profit and advocacy agencies, the Community Colleges system, 10 state departments including the Department of Higher Education (DHE), 6 public and private universities, and 5 state provider agencies.

Provide Leadership Training to Parents: This project provides training in leadership skills to parents of children with emotional/behavioral difficulties to help increase their participation in treatment. The family advocacy organization, Families United, is responsible for implementing this initiative using the *Agents of Transformation (AOT)* curriculum. After completing training in leadership skills, parents can participate in ongoing alumni activities to build cohesion among parent advocates and complete additional instruction to become leadership trainers themselves. Training graduates are connected with advocacy opportunities through local systems of care and statewide advisory councils.

4th Quarter Update: After reviewing a number of applications in response to a Request for Proposals (RFP), the family advocacy organization, Families United, was selected to be the organization responsible for implementing the leadership training. In August, the first Parent Leadership training session was conducted with 71 parents. The following month, 21 individuals participated in the first of ten in a series of Advanced Leadership classes including 3 program staff, 7 parent trainers, and 11 parent participants. Finally, seven parent participants were accepted in the training-of-trainers component, two of whom are bilingual in English and Spanish.

Year-End Evaluation: All of the activities were completed according to schedule. Parents of children with special needs are providing all of the training and a family advocacy organization developed the training curriculum. The *Agents of Transformation* curriculum also includes specific modules about cultural competency. Furthermore, one out of every three trainings in Parent Leadership is offered in Spanish, thus making it both accessible and culturally responsive to a greater audience. Finally, an extensive inter-agency approach is represented in this initiative to help graduates of the program find advocacy opportunities (e.g., linkages with Systems of Care Collaboratives, the Connecticut Behavioral Health Partnership, the Department of Children and Family State Advisory Council).

Develop Supervision Competencies and Standards: The overarching goal of the Supervision Competency Development Initiative (SCDI) is to increase supervisory competencies in behavioral health settings through: a) training of supervisors and direct care staff, and b) developing standards for supervision. Training includes didactic and experiential lessons in managing supervisory relationships, managing job performance, and promoting professional development. As a result of this initiative, web-based learning resources will be developed to support continued education.

4th Quarter Update: The Council on the Workforce for Adults drafted supervision standards which will be submitted to the Executive Council in November 2008. These standards contain specific recommendations and suggested measures to assess the implementation of the standards and the sustainability of supervisory skills. Four agencies—three private non-profit and one Department of Mental Health and Addiction Services (DMHAS)-operated—were selected after a competitive bidding process to receive specialized training in supervision competencies.¹¹ To help facilitate this process, event calendars and electronic messages are being sent to direct care staff and supervisors as training reminders. To date, 83 supervisors and 119 direct care workers have been trained in methods of supervision by Dr. Lawrence Shulman, a national expert in this topic area. Beginning in January 2009, consultation on implementation and sustainability will be provided to each participating agency.

Year-End Evaluation: The initial goal of training 15 supervisors was exceeded by over 500%. Consumers and family members on the Adult Council were involved in the development of the supervision standards. Additionally, consumers who were not part of the Workforce Development initiative provided focus group feedback on two occasions during the development of the

¹¹ The four participating agencies are: 1) The Village for Families and Children, 2) Community Health Resources, 3) Chrysalis Center, and 4) Capital Region Mental Health.

standards. The supervision standards address the importance of adopting an inter-agency approach and mandate “culturally competent” care as part of a comprehensive effort to provide quality care across the life cycle. It is expected that the web-based approach to supervisory training will help increase training efficiency, reduced staff travel, contain training costs, and increase participation in training.

Train Health and Human Service Personnel: This initiative focuses on training persons in the workforce who are not mental health professionals, but who routinely provide services to persons with mental illness and substance use (e.g., direct care staff from the Department of Labor). The Connecticut Chapter of NAMI (NAMI-CT) was selected to provide a 6-hour course, with Yale Workforce Development staff, about the nature of behavioral health problems.

4th Quarter Update: Training of health and human service personnel began in September 2008. Sixty-seven providers from two Department of Labor (DOL) sites were trained. Draft procedures for how the health and human service organizations can access consultation were also presented to the DOL.

Year-End Evaluation: Consumers and family members were heavily involved in the training of the health and human service personnel. The Connecticut chapter of the National Alliance on Mental Illness (NAMI) conducted the trainings and persons in recovery served as guest speakers. Over twice as many health and human service personnel were trained than initially projected.

Create the Connecticut Recovery Employment Consultation Service (C-RECS): This initiative focuses on establishing a consumer-run program that helps adults in recovery find employment opportunities in behavioral health settings. Focus on Recovery-United (FOR-U), a consumer advocacy organization, was selected after a competitive bidding process to develop and manage C-RECS, which provides pre- and post-employment coaching to consumers as well as consultation and technical assistance to provider organizations.¹²

4th Quarter Update: In August 2008, Focus on Recovery-United (FOR-U), developed an online job bank and database for individuals who are interested in job placement supports in the field of behavioral health. Five adults in recovery were hired as staff to manage C-RECS and provide individualized coaching to consumers.¹³ In September 2008, C-RECS began training persons in recovery to facilitate their entry, retention, and job satisfaction in the workforce. Within 10 days of advertising the availability of C-RECS services, 60 applicants applied to the program. Thirty-six of them received at least one coaching session. Four individuals are now employed and seeking follow-up support. As of late September, there were over 50 individuals on the wait-list for C-RECS training. Using Appreciative Inquiry (a strengths-based approach to organizational development), focus groups have been conducted with staff at four organizations (one hospital, one state-run Local Mental Health Authority (LMHA), one private non-profit LMHA, and a private non-profit residential program) to learn about training, consultation, and technical assistance needs in order to support and sustain individuals in recovery in the workforce.

Year-End Evaluation: The C-RECS is an entirely consumer-run initiative. All aspects of development, implementation, and evaluation are conducted by persons in recovery. C-RECS participants range in age from young adults to seniors, are from diverse cultural and ethnic backgrounds, and have a variety of educational and professional credentials. The number of program participants enrolled in C-RECS exceeded the expectations and goals for the entire year in a one-month time period.

¹² The Yale Program for Recovery and Community Health (Yale PRCH) and other individuals have been sub-contracted through C-RECS to provide technical assistance and consultation.

¹³ Approximately 20% of C-RECS staff are persons of color and approximately 40% of the individuals providing technical assistance to C-RECS are persons of color.

Year-End Summary and Suggestions

Over the course of the past year, the Connecticut Workforce Collaborative on Behavioral Health made significant efforts to involve consumers, youth, and family members in all of their initiatives. The Collaborative has also focused on increasing the cultural and ethnic diversity of its membership. Nearly all of the implementation activities for the different Workforce Development initiatives have been completed according to schedule. Furthermore, the May and September meetings of the Collaborative brought together a diverse group of representatives from private non-profit and advocacy agencies, state departments, provider agencies, and educational institutions.

Persons in recovery continue to experience a great need for employment opportunities and assistance. The response to the launching of the Connecticut Recovery Employment Consultation Service (C-RECS) is indicative of this need. The number of people who applied for employment assistance within the first week of the launching of C-RECS significantly exceeded the number of people that were projected to be served in the entire year. The momentum created by the MHT grant for employment opportunities for adults in recovery will be sustained by creating more employment opportunities for consumers and family members in the mental health system that are not directly linked to the MHT grant, as well as working with other state departments that are outside of the traditional mental health system.

As for other efforts to enhance the behavioral health workforce, the most common suggestion made by attendees of the person-centered planning training at Connecticut Valley Hospital (CVH) was to provide it to a more diverse group of providers, including direct care staff (e.g., Mental Health Associates). While many individuals have noted the beginnings of a culture change at CVH, the importance of expanding the scope of training in recovery-oriented care and providing ongoing reinforcement and feedback to staff is vital to sustained system change.

Overall, the initiatives in this domain address the needs of individuals across the lifespan, involve multiple inter-agency collaborations, and have consumer, youth, and family member involvement at most stages of development and implementation. Efforts to enhance the age, ethnic, and cultural diversity of members will certainly bolster the sustainability of these initiatives. These efforts should ensure that people of diverse backgrounds and life experiences are seen as valued contributors to the process, rather than token members of the groups. Asking participants about their experiences on the committees and responding to suggestions for improvement may enable them to feel more comfortable with sharing their opinions, thus increasing the consumer, youth, and family voice in shaping MHT initiatives.

Review of Reports: To continue to build upon the MHT resource inventory and needs assessment that was completed in 2006, an ongoing review of reports from various state departments and organizations was conducted. This review identifies additional transformational activities in Connecticut and potential areas of focus and collaboration for future MHT endeavors.

- The August 2008 edition of the DMHAS *Recovery Times* highlighted several person-centered planning initiatives across Connecticut. These initiatives included Automated Recovery Planning, Employment and Vocational services, Pathways to Recovery, courses to help people write their own recovery-oriented treatment plans, peer-led self-care and wellness programs, warm-lines, recovery educators, and recovery coaches, among others. These initiatives all share the philosophy that persons in recovery can and should be involved in leading their own recovery efforts, persons in recovery can serve as role models to others, and approaches should be holistic and strengths-based.¹⁴
- Information briefs published by DMHAS during this past quarter highlighted efforts of two initiatives related to the MHT goals: a) the Co-Occurring Practice Improvement Collaborative, designed to increase capabilities to better serve individuals with co-occurring disorders,¹⁵ and b) Connecticut's Military Support Program, which addresses mental health and substance abuse needs of National Guard and Reserve Personnel affected by deployment in recent Operations. 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.
- In September 2008, the Office of Policy and Management (OPM) held a Cross-Training Conference in which representatives from Department of Corrections (DOC), Court Support Services Division (CSSD), and Department of Mental Health and Addiction Services (DMHAS) gave a joint presentation on Promising Practices of community re-entry that outlined research, program, and evidence-based practices and collaborative strategies of the three departments to span the period of pretrial intervention to post-incarceration and transition into the community.¹⁶
- In recent months, the Child Health and Development Institute (CHDI) released a report on Multisystemic Therapy (MST) for high-risk children and youth¹⁷ that outlines MST as a cost-effective intervention to helping high-risk children and youth stay in their homes. CHDI also released the *Connecticut Juvenile Justice System: A Guide for Youth and Families*¹⁸, which explains the juvenile justice system and helps parents understand and access needed services for their children. The guide was a collaborative effort of experts in mental health and juvenile justice. Finally, in their biennial report released in July 2008¹⁹, CHDI presents several initiatives that directly address the goals of Connecticut's MHT, including: Early Childhood Consultation Partnership (ECCP), Extended Day Treatment (EDT), Behavioral Health and Primary Care demonstration projects, Innovation Fund Grants, Trauma-focused Cognitive-Behavioral Therapy, and a study of the use of emergency departments in Connecticut.
- In their Fall 2008 newsletter and September 2008 Executive Brief, the Department of Developmental Services (DDS) highlighted several initiatives that are related to MHT goals. For example, DDS and the North Central Area Agency on Aging have co-sponsored a Caregiver Education Program, a six-week series that provides residential, legal, and financial information to plan for loved ones' futures. DDS has also hired a new Aging Services

¹⁴ DMHAS *Recovery Times*, August 2008

¹⁵ DMHAS, InfoBrief, *Increasing co-occurring capability: progress being made*, September 4, 2008

¹⁶ Connecticut Criminal Justice Cross-Training Conference, September 4, 2008, agenda

¹⁷ CHDI, *Unlocking Doors: Multisystemic Therapy for Connecticut's High Risk Children and Youth*, May 2008

¹⁸ CHDI, *The Connecticut Juvenile Justice System: A Guide for Youth and Families*, May 2008

¹⁹ CHDI, *Biennial Report*, July 2008

Coordinator. DDS continues their Waiting List initiative, which provides funding for people on residential waiting lists to access residential and enhanced family supports. DDS has Self Advocacy Coordinators in several regions to promote self-determination and self-advocacy. The Birth to Three Program continues to grow with the addition of 10 new programs to serve children with Autism. As of October 1st, DDS's two waivers were renewed with additional services including health care coordination. This year, 31 new providers enrolled to offer Home and Community Based Waiver services, bringing the total number of qualified providers to 184. DDS also continues with their extensive employment initiatives, including Employment First and Employment Idols.^{20,21}

- In the Summer of 2008, the Department of Children and Families (DCF), Channel 3 Kids Camp, and Wheeler Clinic sponsored *Sibling Connections*, a weeklong summer camp for children in foster care to reunite with their siblings who may be placed in separate foster homes. This camp allows children the opportunity to preserve sibling relationships which are "critical to a child's sense of permanency and emotional well-being."²²
- In the September edition of the Court Support Services Division (CSSD) Chronicle²³, the Division presented information on the Connecticut Collaboration Model (CCM)—a collaborative endeavor between CSSD, the Center for the Treatment of Problem Sexual Behavior, and the Connecticut Sexual Assault Crises Services. This team approach to sex offender management combines the Victim-Centered Approach, the Collaboration Model, and the Containment Models of effective sex offender supervision practices.
- In the 2008 Sanctions Update²⁴, Court Support Services Division (CSSD) highlights four projects targeting court-involved adults who have been identified as high risk for violating court-ordered supervision. One of these initiatives is a pilot project providing Specialized Mental Health Supervision and Treatment Units (Mental Health Probation). This project provides supervision, monitoring and services that address the high correlation between mental health issues and recidivism rates in high risk probationers.
- In the Department of Correction's (DOC) June 2008 P.R.I.D.E. at Work report²⁵, information is presented about an all day Re-entry Summit which focused on the successful reintegration of offenders into their communities. DOC also created a job developer position in the Offender Programs and Victims Services Unit at Central Office.
- On their webpage, the Department of Social Services (DSS) has a link to Governor Rell's announcement regarding the Charter Oak Health Plan.²⁶ As of September 24, 2008, Charter Oak has enrolled over 1,000 members in one of the three managed care organizations and over 2,000 people were eligible for coverage under Charter Oak. This plan offers affordable health insurance, including coverage for behavioral health services, to individuals in Connecticut who cannot otherwise afford it.
- On August 25, 2008, DSS released their *Plan to Implement a Primary Care Case Management Pilot Program*²⁷, which details the implementation plan for alternative approaches in the delivery of health care services through a system of primary care case

²⁰ Direct to Families: Fall 2008

²¹ DDS, *Executive Brief*, September 19, 2008

²² DCF, *Camp Connecting Brothers and Sisters in Foster Care*, Summer 2008

²³ CSSD Chronicle, Sex Offender Units. The Connecticut Collaboration Model (CCM), September 2008

²⁴ CSSD *Sanctions Update*, 2008

²⁵ Connecticut Department of Correction, P.R.I.D.E. at Work newsletter, June 21-July 15, 2008

²⁶ <http://www.ct.gov/dss/cwp/view.asp?Q=423900&A=2345>

²⁷ DSS, *Plan to Implement a Primary Care Case Management Pilot Program*, August 2008

management. The plan was developed with “significant input from representatives of the provider, client advocacy, and legal services communities.” DSS carved out three major services of the family Medicaid program, including behavioral health services provided by the Connecticut Behavioral Health Partnership (CT BHP). The DCF and DSS have formed CT BHP to plan and implement an integrated public behavioral health system for children and families.

- In March, 2008, the *Connecticut Long-Term Care Needs Assessment: Focused Report II: Identifying the long-term care needs of people with mental illness* was released.²⁸ This study found that most people with mental illness reported their greatest needs to be transportation and homemaker services. Just under two-thirds of the people with a mental illness surveyed reported using community long-term care services and more than half reported needing more services. Not being able to afford services was the main barrier to accessing care among people with a mental illness disability. Forty-one percent of the respondents with a mental illness indicated that they had no one they could count on for social support and 46% reported not having enough money to make ends meet at the end of the month. Recommendations for the supportive services are presented. In a follow-up report, researchers indicate that depressive symptoms were high among individuals at most of the state programs assessed.²⁹
- The Connecticut State Department of Education and the Department of Public Health secured a grant of approximately \$3 million over the next five years to address health and educational issues in Connecticut’s public schools.³⁰ This is the first time Connecticut has received federal support to implement Coordinated School Health. This approach “provides the framework for families, communities, and schools to work together to improve students’ health and capacity to learn.”
- In June 2008, Governor Rell announced that several state colleges and universities have received grants from the Connecticut Department of Higher Education to continue their efforts in increasing minority enrollment and retention.³¹

Year-End Summary and Suggestions

In this quarter, several departmental publications focused on jail-diversion and community re-entry after incarceration. Other themes seen throughout these reports were the need to improve access to and the affordability of services. Earlier in Year 3, a number of reports and updates addressed employment opportunities. For example, the Department of Developmental Services (DDS) launched its “Medicaid for the Employed Disabled” program.³² The Department of Social Services (DSS) granted ten organizations and non-profit agencies up to \$200,000 to implement creative ways to help people with disabilities join the workforce.³³ Finally, the Department of Veterans’ Affairs (DVA) opened a center to provide outreach and counseling on employment.³⁴ Additionally, Walgreens Pharmacy opened a distribution center in Windsor, CT with a goal of having one-third of its workforce being persons with disabilities.³⁵

²⁸ University of Connecticut Health Center, *Connecticut Long-Term Care Needs Assessment, Focused Report II: Identifying the Long-term care needs of People with Mental Illness*, March 2008

²⁹ University of Connecticut Health Center, *Connecticut Long-Term Care Needs Assessment, Focused Report IV: Experiences of People Using Disability Programs*, June 2008

³⁰ Department of Education, News, Tuesday June 17, 2008

³¹ <http://www.ct.gov/governorrell/cwp/view.asp?A=3293&Q=418314>

³² DDS, *Direct to Families Newsletter*, Winter 2008.

³³ <http://www.connect-ability.com/newsDetail.php?id=10>

³⁴ <http://www.ct.gov/ctva/cwp/view.asp?Q=419198&A=2088>

³⁵ <http://www.connect-ability.com/newsDetail.php?id=13>

A need for increased and coordinated recruitment, training, and retention of the health care workforce was one of the recommendations from a multi-agency task force that examined access to health care and emergency room use³⁶ and was identified as a need for further development in the first annual evaluation of the Connecticut Behavioral Health Partnership (BHP).³⁷ Two statewide examples that resulted in increased access to behavioral health services included the BHP and the Charter Oak Health Plan. The BHP is an inter-departmental collaboration between the Departments of Social Services (DSS) and Children and Families (DCF) designed to provide integrated public behavioral health services to children and families. The Charter Oak Health Plan, which provides affordable health care insurance to uninsured individuals, includes coverage for behavioral health services.³⁸ Over 316,000 individuals have already enrolled in the BHP (71% of whom were 18 years or younger) and up to 47,000 people are expected to enroll in the Charter Oak Health Plan.

³⁶ Hospital System Strategic Task Force, *Findings and Recommendations*, January 2008

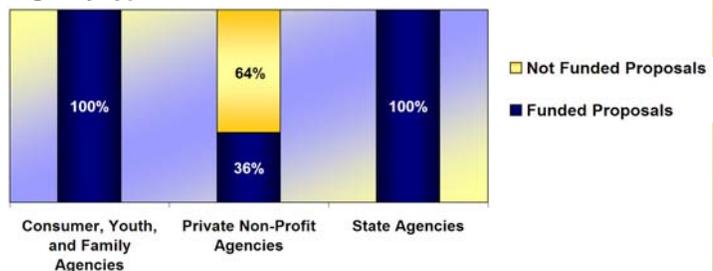
³⁷ Connecticut Behavioral health Partnership, *First Annual Evaluation: Calendar Year 2006*, December 2007

³⁸ <http://www.charteroakhealthplan.com/coh/site/default.asp>

MHT Request for Proposals and Mini-Grants: Over 70 applications were received from qualified state and local government agencies, private nonprofit organizations and consumer, youth, and family organizations in response to the Request for Proposals (RFP) that was issued by MHT staff in April 2008. The purpose of the RFP was to expand the scope of transformative infrastructure changes to state and local government agencies, private non-profit organizations, and consumer, youth, and family member organizations throughout Connecticut.

Seven review committees were assembled and training was provided to those who were unfamiliar with the process of reviewing and ranking applications. As a result of a conscientious commitment to consumer and family involvement and assistance from the Consumer, Youth, and Family Council and the Director of Recovery Community Affairs at the Department of Mental Health and Addiction Services, 52% of the reviewers were adults in recovery and/or family members.

Figure 12: Mini-grant funding approval according to agency type



Overall, 35 successful applications were identified, resulting in the disbursement of roughly \$1.3 million dollars. As can be seen in Figure 12, all of the projects that were submitted by consumer, youth, and family organizations or state agencies were approved.

The 35 projects reflected a range of activities that built upon and extended current MHT initiatives including: a) consumer-driven quality improvement and organizational change, b) recovery-oriented supports (e.g., the creative arts, wellness, community- and peer-based services), c) training of persons in recovery and providers, and d) technological enhancements (e.g., telephone and computer upgrades at service agencies, telemedicine).

Overall, roughly three-fourths of the projects focused on consumer, youth, and family involvement. Furthermore, nearly 550 individuals received training in various recovery-oriented practices. The following sections provide a brief description of each project and what was accomplished as a result of this unique opportunity.

ALSO-Cornerstone: Behavioral Care Management System

This community-based social services agency established an electronic infrastructure that will enable it to provide a comprehensive Behavioral Care Management System (BCMS). This system will ensure the quality of services provided to consumers of supported housing, clinical, prevention, and education programs, and compliance with Federal and state mandates. The BCMS will track the number and type of client treatments and interventions, and desired outcomes.

Artreach - Second Step Players: Mindfulness Based Stress Reduction and Skill Building/Artistic Development

Stress management and meditation are important components of wellness for many individuals in recovery. In support of innovative approaches to recovery, individuals from this local performing arts program for persons in recovery received funding for two projects. The first project involved sending three members to receive formal training in Mindfulness Based Stress Reduction (MBSR, an evidence-based practice). These trained members then developed a “train the trainer” program for Artreach members.

The second project involved implementing a series of artistic development professional workshops to facilitate paid employment at community theater groups. This pilot program paired professional artists from the community with persons in recovery at Artreach, offering the possibility of reducing stigma within the local arts community. Altogether, 15 individuals completed a training series in improvisational theater skills and 18 individuals received guitar lessons. Artreach held a number of shows displaying the works of the project participants.

Birmingham Group Health Services (BGHS): Family Advisory Council/Common Ground

As part of the ongoing efforts to restructure service delivery at BGHS to achieve a greater level of recovery-oriented care, this project had three primary activities: a) the formation of a Family Advisory Council with over 30 members; and b) the training of 34 providers and consumers on using Dr. Pat Deegan's Common Ground program, which is a software program designed to engage consumers in shared decision-making about medication.

Bridgeport Hospital: Child FIRST

The Child FIRST program at Bridgeport Hospital is planning a replication of its Early Childhood System of Care model in Connecticut. The goal of this program is to develop a family-driven system of care to prevent serious emotional disturbances, abuse and neglect, and developmental and learning problems in the most at-risk children. Numerous interagency meetings have been held (e.g., with the Connecticut Commission on Children, the Department of Social Services, legislators, and the Connecticut Center for Effective Practice) and a Memorandum of Agreement (MOA) has been signed by members of the Early Childhood Education Cabinet to support the Child FIRST system of care as a model for replication. Other achievements included the development of a website and training manuals that will be used with early care and education providers and family workers.

Bridges... A Community Support System: Jail Diversion Program and Open Door Social Club

To expand upon the various jail diversion programs in Connecticut, this local mental health authority developed a peer-based Consumer Advocacy program comprised of individuals with prior involvement in the criminal justice system. Nine individuals were trained in interpersonal effectiveness, public speaking, prevention planning, and knowledge of the legal system including the challenges of becoming a Consumer Advocate. They received weekly supervision and gave a number of presentations to police staff, Milford Superior Court Prosecutors, and graduate students in social work at Southern Connecticut State University.

Bridges also received funding to obtain technical assistance to further the development of leadership and growth at the Open Door Social Club. As a result of three full-day retreats, with approximately 25 attendees per day, the social club developed a strategic plan that will increase the independence and autonomy of social club members and the Officer's group.

Central Connecticut State University (CCSU): Transforming Educational Opportunities

In partnership with Laurel House (a self-help organization), CCSU facilitated a train-the-trainer program to create a climate and statewide planning process that encourages local initiatives to establish supported education collaboratives. Fifty individuals received training in how to deliver and disseminate information about supported education in their regions.

Charlotte Hungerford Hospital: Consumer Support Group

The primary goal of this project was to provide consumers with training that would allow them to initiate and continue support groups. Eleven adults in recovery attended a 6-week training program in how to facilitate consumer-run support groups.

Community Mental Health Affiliates: ACE Initiative

This project was designed to allow access and triage to appropriate services and appointments to clients across a 30 community service area via an integrated call center. Funds were used to plan for and purchase the technological components of the integrated call center.

Community Renewal Team: Software Upgrades

For this project, two software programs (SIGMUND and CAPTAIN) were installed to integrate data collection and tracking methods, thus increasing the level of staff efficiency. This infrastructure upgrade will facilitate communication between Community Renewal Team and service recipients by generating letters and reminders to family members on a monthly basis to invite them to weekly family groups.

Connecticut Alliance to Benefit Law Enforcement (CABLE): From Crisis to Opportunity

To address the gap in mental health services in hospital emergency rooms, project staff formed an advisory committee (made up of persons in recovery, family members, healthcare workers, and police officers) to develop a Crisis Intervention Training (CIT) curriculum to be used by Emergency Department staff in general hospitals across the state. The advisory committee developed: a) a CIT curriculum and b) a marketing plan to recruit general acute care hospitals to participate in the CIT training.

Connecticut Mental Health Center (CMHC): Be HIP and Handbook Transformation

Two separate projects were completed at CMHC. The first, *Be Hip*, focused on the expansion of existing peer support programs at CMHC to help reduce the high rates of physical health problems (e.g., obesity, diabetes) in persons in recovery. Seven consumers were trained to become “health coaches” who would then work with other consumers to promote and sustain healthy lifestyles. This peer-based project also provided adults in recovery with access to health monitoring equipment (pedometers) and computers to track their health goals (e.g., body mass index), as well as informational booklets about health promotion.

The second project was devoted to revising the CMHC handbook, which is given to all consumers. Three adults in recovery were trained in interviewing skills before conducting six focus groups with diverse individuals (e.g., young adult service recipients, substance abuse treatment recipients, family members, and consumers receiving outpatient and assertive community treatment). The purpose of the focus groups was to learn what information to include in the handbook and how it could be presented in a manner that is meaningful to consumers, youth, and families. Additionally, artwork by consumers and stories of recovery were collected to include in the handbook. Consumers had majority representation on the committee overseeing the revision of the handbook.

Connecticut Public Television (CPTV): Broadcasting: Resilience, Recovery and Respect

As part of Connecticut’s ongoing efforts to reduce stigma by increasing public understanding of mental illness, CPTV developed and televised *Opening Doors, Opening Minds: A Town Hall Meeting on Mental Illness*. During this live and interactive town hall meeting, over 200 viewers called or emailed in questions, some of which were answered by young adults in recovery as well as Pat Rehmer (MHT Project Director and Deputy Commissioner of DMHAS), Dr. Ezra Griffith (Yale University), Dr. Karen Kangas (Acting Director of Advocacy Unlimited), and Dr. Bert Plant (Department of Children and Families). As described previously, the town hall meeting had an above average gross impressions rating for CPTV broadcasts.

CPTV is also developing three 30-minute documentaries about mental illness and recovery. The production team convened a diverse group consisting of adults in recovery, families, providers,

and representatives of state agencies to identify potential documentary topics. The first documentary about young people living with mental illnesses will air in October 2008. The second documentary (adults with serious mental illnesses) will air in January 2009 and the third one (the impact of mental illness on families) will be broadcast in February 2009. CPTV is seeking additional funding from other sources to create more documentaries that focus on a range of topics, such as recovery and treatment, returning military personnel, substance abuse, mental illness and employment, and older adults

Day Kimball Hospital: Common Plan

This project sought to strengthen the local community child and adolescent mental health delivery system and its relationships with the Day Kimball Hospital Pediatric Center by designing and developing a format for a “common plan” of individualized care. This project will enhance access to care in rural communities by building collaborative relationships between Day Kimball Hospital and various agencies of the children’s mental health system.

Department of Children and Families (DCF): Peer Leadership Initiative

To support peer-based services for youth, this project enriched an existing Peer Leadership group at a residential treatment facility for youth in the DCF system. This project trained eight peer leaders in how to help peers identify their strengths and reinforce their recovery. Also, a series of Grand Rounds lectures about health and recovery was created by the peer leaders for fellow residents. Finally, a number of enhancements to existing aspects of the program, such as welcoming and graduation ceremonies for residents, were developed.

Department of Corrections (DOC): Workforce Development

Integration of medical services with addiction and mental health services has been linked to improved outcomes for individuals with co-occurring disorders. This initiative sought to institute a holistic treatment philosophy of a system-wide scope within DOC through staff training in integrated treatment and technical assistance regarding coordinated care. As a result of this project, DOC staff consulted with experts and conducted site visits with “model” states to learn about strategies for implementing integrated care. Additionally, consultants provided an assessment of agency infrastructure to help DOC move towards adoption of an integrated care model. Based upon what was learned from these activities, a training curriculum on treating co-occurring disorders was created and a conference was held for DOC staff. Fourteen supervisors were trained in integrated care to assist providers with adopting and sustaining the new treatment approach.

Families United for Children’s Mental Health: Family and Youth Driven Networks

The goals of this project were to: a) increase awareness with families, youth, and system of care partners in regards to children’s mental health; b) strengthen telecommunications; and c) conduct a family and youth-driven system of care needs assessment. Families United held a “kick-off” luncheon where information was provided to over 70 families, youth, and system of care partners about their *Campaign for Transformation* activities planned over the course of the next year. Families United also updated their electronic technology so that they could better communicate with stakeholders via electronic mail and their website. Finally, Families United conducted an electronic survey with over 88 family members, youth, and partners, and held focus groups in five regions of the state.

Focus on Recovery- United (FOR-U): Picnic, Intentional Peer Support Trainers, Snap It!

FOR-U is a statewide consumer- and family-run advocacy group. To extend the scope of its existing activities, FOR-U completed three projects. First, it hosted a statewide picnic in which 411 consumers, youth, and family members came together to celebrate recovery, network, and share

information. Second, FOR-U hosted the first Train the Trainer Intentional Peer Support (IPS) training in the United States. Twenty-three consumers attended the five-day IPS Train the Trainer workshop. Seventeen individuals subsequently trained 114 people in IPS. Third, FOR-U worked with 20 young adults (age 18-25) to teach them how to use photography and other creative forms of expression to document their life experiences. Snap It! has had several showings of their work through the state and the young adults have reported an increase in self-esteem, creativity, and recognition that they have an important story to tell.

Greater Bridgeport Area Continuum of Care (GBACoC): Homeless Needs Assessment

GBACoC focuses on developing permanent supportive housing for persons in recovery. As part of a 10-year plan to end homelessness, GBACoC has developed a Wraparound approach to address the needs of homeless and recently housed individuals. This project sought to transform the existing Wraparound services framework by designing and implementing a consumer-based and consumer-driven needs assessment. GBACoC conducted focus groups with homeless and recently homeless individuals in Greater Bridgeport to hear their experiences in finding and using local resources to remediate their homelessness.

InterCommunity Mental Health Group: Recovery Enhancement Initiative

Over the last two years, InterCommunity Mental Health Group has been enhancing its recovery-orientation by creating and distributing the Recovery Resource Guidebook, hiring individuals in recovery in staff roles (not peer positions), and having trainings led by persons in recovery for staff members. This project included multiple training, resource development, and educational activities, which served to increase the level of consumer and family involvement in the program and enhanced community education about recovery.

Some examples of this project's achievements included the training of 26 individuals (21 staff persons, 4 adults in recovery, and 1 family member) in psychiatric rehabilitation, a revision of the Recovery Resource Guidebook, and the purchase of computers and educational videos for program participants to use.

Khmer Health Advocates: Telemedicine Implementation Plan and Cambodian Information Management System

Khmer Health Advocates completed two projects. The first one addressed the need to treat the increasing number of individuals of Cambodian descent seeking care by expanding its telemedicine initiative (the Cambodian Information Management System, CIMS). The project adapted the Cambodian Survivors Health Assessment to be used on the CIMS and developed assessment reports for mental health clinicians to use in making treatment recommendations. The second project established policies and procedures for the delivery of services, including identifying the training needs of staff related to telemedicine and linking additional assessment measures to the CIMS.

Living in Safe Alternatives (LISA): Citrix Software

To improve the ability to share, track, and analyze client and performance outcome data, LISA, which provides safe and supportive housing, installed network software that enabled secure network file sharing and remote access. Ten staff persons were trained in using the upgraded computer system, as well as new outcome measurement tools that are available on the network.

Mental Health Association of Connecticut (MHAC): Creative Strokes Network

In conjunction with Education and Community Resource Associates, MHAC formed the *Creative Strokes Network* which provided peer-driven community services to help persons in recovery improve their homes and living situations. After developing a number of partnerships with

organizations in the community, this project created teams comprised of peers to help other peers with upgrading their homes.

National Alliance on Mental Illness (NAMI): Developmental Project

Teaching family members and caregivers about ways to help their children with mental health needs has been one of the many educational programs that have been provided by the Connecticut chapter of NAMI (NAMI-CT). To reach a greater number of Spanish-speaking families, NAMI developed a curriculum that blends mental health knowledge with training in a best-practice parent education program to serve a greater number of Hispanic and Latino families. A total of 50 bi-lingual community mental health workers from around the state have been identified to participate in the project.

Reliance House: Technology and Community Education

The purpose of this project was twofold: a) to educate the community about mental health and form partnerships between Reliance House and agencies in the community, and b) to maximize the capacity of the on-line electronic health record by obtaining additional technology. As part of this initiative, Reliance house hired a Community Educator, who arranged for a number trainings at Eastern Connecticut State University designed to increase empathy and understanding of individuals with auditory hallucinations (i.e., the “Hearing Voices That Are Distressing” training), and organized a walk-a-thon to increase public awareness of mental health. Furthermore, two new consumer members were recruited to participate in agency events and boards in the community. As for the second goal of this project, Reliance House purchased new laptops and other equipment to enhance access to, and the security of, the computers used by consumers and staff. Finally, Reliance House also posted a link to Connecticut’s Network of Care website on its homepage.

Southwest Connecticut Mental Health System (SCMHS): Strengths-Based Case Management

The long-term goal of this project is to transform the core service of case management into a more recovery-oriented, strength-based activity. To achieve this goal, SCMHS held two days of training in a strengths-based approach to case management for 63 providers and 17 supervisors and has begun systematic implementation of this approach throughout their system.

Southwest Regional Mental Health Board (SRMHB): The Caring Network

To expand upon efforts to educate the public about mental health and recovery, *The Caring Network* of SRMHB created four videos that depict the personal accounts of recovery in older adults and families of school-aged children. The videos were developed with direct involvement of a consumer advisory group and are being translated into Spanish.

Western Connecticut Mental Health Network (WCMHN): Peer Employment Project

To further the development of a recovery-oriented system of care, WCMHN, in collaboration with local private nonprofit providers and advocacy groups, trained 25 adults in recovery in peer employment and sent six consumers to immersion training at Recovery Innovations. To help with the transition from training to gainful employment, 32 consumers received training in supervision skills. To assist with sustaining peer employment, 32 graduates received refresher training in “Keeping Recovery Skills Alive.”

Wheeler Clinic: Staff Training

Significantly enhancing the core clinical skills of providers with knowledge of best practices is an important component of promoting recovery and resilience. To improve the capacity of a private nonprofit agency to provide such services, the Wheeler Clinic arranged for one person to attend a

two-day training to become a certified trainer in Motivational Interviewing. This person will then train other staff persons at Wheeler Clinic.

Yale Program for Recovery and Community Health (Yale PRCH): Taking the Wheel

With an emphasis on person-centered planning, this initiative developed a web-based consumer toolkit to provide information and materials to persons in recovery so that they can prepare for the treatment planning. Nine adults in recovery were trained in interviewing skills before they then conducted 12 focus groups with consumers around the state (including two focus groups with mono-lingual Spanish-speaking individuals) to gain input on the web-based toolkit. Efforts are underway to post the toolkit on the Network of Care website.

Year-End Summary and Suggestions

As a result of this unique opportunity, many organizations throughout Connecticut gained the ability to initiate or expand efforts for transformative system change. The mini-grant process was itself transformative in that it provided funding for many consumer and family-run grassroots projects that otherwise would not have sufficient dollars for development.

A review of the mini-grant recipients reveals a range of novel and recovery-oriented projects, including those that helped adults in recovery improve their homes, taught creative arts skills, addressed physical health, helped people to return to school, and taught skills at providing peer-based services. A number of projects expanded workforce development efforts by introducing more recovery-oriented practices in the judicial system and emergency departments as well as community mental health and private nonprofit settings. Furthermore, there were projects that focused on providing services to persons of different ethnicities and others that sought to increase public awareness of mental illness and recovery.

A celebration event to bring together all of the mini-grant recipients and to celebrate their successes will be held in December 2008. This may provide an opportunity to see what lessons can be learned from their efforts to transform their local systems of care. There are also plans to use pictures, videos, and narratives from the mini-grants in a manner that may increase community education about MHT and the mini-grant activities and provide momentum for further MHT activities.

Oversight Committee: 4th Quarter Update: At the September meeting of the Oversight Committee, the Yale Program for Recovery and Community Health (Yale PRCH) presented the findings from the *Transformation Involvement Survey*. This survey was the impetus for a discussion around self-disclosure of lived experience with mental illness. The ensuing discussion mirrored those that were occurring in multiple venues around the State. Common themes that

were expressed in the Oversight Committee meeting and elsewhere included the belief that self-disclosure was not necessary, or even relevant, for individuals to impact and drive the system. For example, if “Joe” suffers from Major Depression and is a member of one of the MHT initiative committees, his voice and opinions remain the same regardless of who knows about his personal history. On the other side of the coin was the viewpoint that while an individual’s opinions, values, and voice may not change, the way in which the listener perceives and responds to those expressed viewpoints, may in fact change, with knowledge of the speaker’s lived experience. Thus, some believed that self-disclosure was essential to a consumer-driven system of care. From this perspective, one of the true signs of transformation would be when individuals with personal experiences with mental illness are not just brought to the table, but are seen as essential to the process and valued for their contributions. These themes were frequently heard around the State, including in discussions about ways in which the MHT leaders can ensure that not only a substantial percentage of membership on planning and decision-making bodies are consumers, youth, and/or family members, but that persons with lived experience of mental illness feel as though they are a valued part of the process—one that could not occur without their voices.

A timely follow-up to this discussion at the Oversight Committee meeting was the presentation of the *Role Composition and Functioning* document by the Consumer, Youth, and Family Advisory Council. This document received a unanimous vote for approval by the Oversight Committee.

The Oversight Committee also approved a proposal for increased funding for Yale PRCH to evaluate the MHT mini-grant process, to develop the Consumer/Youth/Family Research and Evaluation Network (CREN), and to offset increased costs of the SAMHSA required “Proof of Concept” studies (discussed in the next section). Finally, updates were provided about the MHT mini-grant process, the communications campaign, and the Human Services Research Institute (HSRI) site visit. Members were reminded about the Transformation celebration luncheon on December 4, 2008, where highlights from the MHT mini-grant projects will be shared.

Year-End Evaluation: Oversight Committee meetings during the first half of the year were devoted to reviewing funding decisions, discussing what to do with goals and projects which were not chosen for implementation, and deciding what to do with carry-forward funds that were available. The mini-grant mechanism was chosen to stimulate and support more grassroots involvement, particularly of consumer, youth, and family groups and local organizations. In addition to setting priorities and making funding decisions, the Oversight Committee began later during this period to tackle some of the more substantive issues involved in moving to a consumer, youth, and family-driven system of care, namely, the active roles consumers, youth, and families could play beyond that of service recipient. This began with a discussion of the nature of the partnership that practitioners and system leaders had been hoping to forge with the recovery community, with an extensive discussion of whether and how such a partnership could be among equals. The sentiment of this discussion was aptly captured by the consumer chair of the Consumer, Youth, and Family Advisory Council, who suggested that his vision for the partnership was that of a “bicycle built for two”. Progress was made through the drafting, presentation, and unanimous approval of a document produced by the Advisory Council which spelled out their role with the transformation process in detail.

MHT Evaluation: 4th Quarter Update: The Yale Program for Recovery and Community Health (Yale PRCH) evaluation team continued the ongoing process evaluation of all MHT activities. Over the past quarter, Yale PRCH has also been involved with the evaluation of the mini-grant projects, training of Consumer/Youth/Family Research and Evaluation Network (CREN) members, attending regular MHT meetings, and preparing for the “Proof of Concept” study. This study is a randomized, control longitudinal study that will occur during Years 4 and 5 of the MHT grant to evaluate the impact of two MHT initiatives on promoting the resilience in youth and recovery in

adults. This evaluation project, which is another component of the MHT cross-site evaluation, will involve 150 youth with serious emotional disturbances and their families, 150 adults with mental illness and their families, and providers in both the child and adult mental health system. All participants will be interviewed at two time periods—baseline and 12-months post-baseline. The Family and Community Wraparound Project will serve as the basis for the youth component of this project. Adult participants will be recruited from a project that focuses on person-centered planning in community-based agencies. In July 2008, the evaluators at Yale PRCH, along with MHT project staff, also coordinated a two-day site visit from Human Services Research Institute (HSRI), the agency responsible for conducting a cross-site evaluation of the MHT Grant. HSRI evaluators interviewed representatives from multiple state departments and conducted focus groups with consumers and family members to gain a better understanding of how Connecticut has used the MHT grant to transform mental health services.

Year-End Evaluation: Over the past year, the Yale PRCH evaluation team has been involved in a number of routine evaluation activities, and has engaged in new avenues of research. Data from the evaluation component of the MHT have been integrated into monthly reports and is discussed routinely in weekly evaluation/project meetings. Standardized reporting templates have been developed to facilitate the gathering of information about MHT activities and performance indicators (GPRAs). This information serves as a guide and feedback loop to the MHT project and initiative leaders that allows for corrective adjustments to be made in plans and activities. For example, a significant project this year was the *Transformation Involvement Survey*. The findings from this survey (described in detail on page 15) served as the impetus for numerous conversations across all levels of the MHT.

Year-End Summary and Suggestions

The Consumer, Youth, and Family Advisory Council's *Composition and Functioning* document introduced the notion of shared decision-making between the Advisory Council and the Oversight Committee and began to flesh out in a more substantive way how the bicycle built for two might be operated. It was within this context that the findings of the *Transformation Involvement Survey* became even more relevant to ongoing discussions within all levels of MHT. The issue of self-disclosure, both within and beyond the MHT, became a point of conversation. At the final Oversight Committee meeting of the year, lengthy and emotional discussions ensued about the function, dangers, and importance of self-disclosure as a way of addressing stigma and discrimination, resulting in an acknowledgement that stigmatizing and discriminatory attitudes were more prevalent than previously realized. The Oversight Committee resolved to remain aware of these issues, to keep the discussion ongoing and open, and to look to the Advisory Council for its continued advocacy efforts in this regard. Many participants involved in this dialogue commented on how this discussion was itself a transformative moment and process, and that they looked forward to learning more about the ways in which consumers, youth, and families could become more actively involved. The Yale PRCH evaluation team continues to work alongside the MHT project team to determine the most appropriate questions to ask so that we can gain a greater understanding of what it means to have a consumer, youth, and family-driven system of care.

The objective of the MHT grant is to promote resiliency and recovery by making fundamental changes in the mental health system through infrastructure and service delivery improvements. One of the ways infrastructure changes that directly result from MHT activities are being monitored is through seven performance measurements (known as GPRA indicators³⁹) which are provided to SAMHSA on a regular basis (see table below).

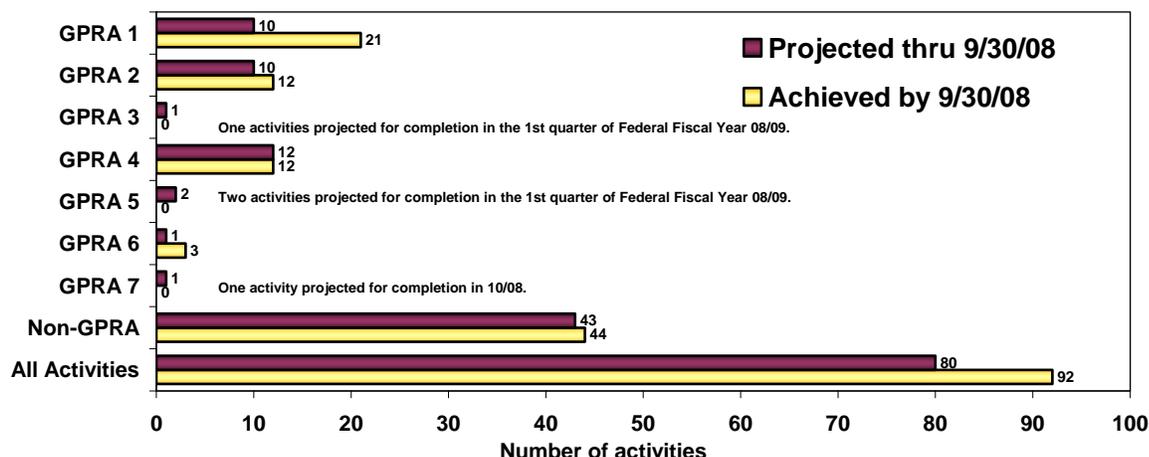
MHT activities that do not directly result in infrastructure changes (even if they are necessary steps for such changes to occur) are also tracked. These action steps and outcomes are categorized as Non-GPRA activities.

For example, identifying a vendor and creating a curriculum are prerequisites to training people in service improvements (GPRA 2) but do not directly result in infrastructure changes, thus they are categorized as Non-GPRA data. Other examples of non-GPRA activities that set the stage for Transformation and infrastructure enhancements included certain public awareness efforts (e.g., presentations and meetings at consumer youth, and family organizations), performing literature reviews for practice guidelines, forming sub-committees, and conducting consumer-driven evaluation and research (e.g., participatory action research).

An assessment of Connecticut’s progress during Year 3 reveals a high degree of success towards transforming the mental health system through infrastructure enhancements (Figure 13). Thirty-seven infrastructure changes were anticipated to be completed by the end of Year 3; this projection was surpassed by 30% as 48 GPRA activities were achieved. This was largely due to a greater than expected number of policy changes (GPRA 1), exceeding the initial goals for training activities (GPRA 2), organizational changes (GPRA 4), and membership in statewide networks for consumers and families (GPRA 6).

GPRA PERFORMANCE INDICATORS	
1)	Policy changes (administrative or legislative), which include regulations, clinical practice guidelines, or similar documents that are significant at the State level;
2)	Persons trained in service improvements;
3)	Financing policy changes, which include increases/decreases in appropriations that are significant at the State level;
4)	Organizational changes, including inter-organization agreements, that are significant at the State level and not time-limited or temporary by design;
5)	Organizations that collect and analyze data on a regular and ongoing basis;
6)	Increased membership of statewide consumer or family run networks;
7)	Programs implementing treatment, rehabilitation, prevention, and supportive practices

Figure 13. MHT Progress Through September 30, 2008



³⁹ GPRA stands for “Government Performance and Results Act.” GPRA’s are performance measurements that are chosen by the federal government to determine what was actually achieved as a result of a federal grant.

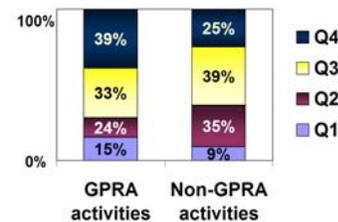
As can be seen in Figure 14, over one-third of all of the infrastructure changes that were made during Year 3 occurred during the 4th quarter. Furthermore, most of the completed activities overall (GPRAs and Non-GPRAs) occurred during the second half of Year 3. This is because the 1st and 2nd quarter were largely devoted to planning and setting the stage for implementation of the MHT initiative.

The following sections provide further details about the various infrastructure enhancements that occurred during Year 3.

GPRA 1 (Policy changes): Thirteen bills were passed that support transformative systems change in the 2008 legislative session and 8 policy changes occurred as a result of MHT.

- 1) H.B. 7007 (An Act Renaming the Department of Mental Retardation). This act renamed the Department of Mental Retardation as the Department of Developmental Services (DDS).
- 2) S.B. 977 (An Act Concerning Restraints and Seclusion in Public Schools). This act created regulations regarding the use of physical restraints and seclusion on special education students in public schools.
- 3) S.B. 260 (An Action Concerning Health Assessments for Adolescents). This act required public school students to have health assessments in either 9th or 10th grade, instead of 10th or 11th grade, in addition to grades 6th or 7th under existing law.
- 4) S.B. 1500 (An Act Implementing the Provisions of the Budget Concerning General Government). Sections 30 – 32 and 37 of this act expanded diversion services and court options for Families With Service Needs (FWSN). Generally, these are families with children under age 16 who have engaged in behavior such as running away or truancy (i.e., status offenses). Section 79 of this act made 16- and 17-year olds eligible for the FWSN program.
- 5) S.B. 561 (An Act Concerning the Money Follows the Person Project). This bill increased the number of individuals who can be served under the Money Follows the Person program from 700 to 5,000. This bill facilitates individuals moving out of institutional settings into less-restrictive, community-based settings.
- 6) S.B. 678 (An Act Establishing a Community-Based Health and Human Services Strategy Board). This bill established a 4-year, 25-member Cabinet to assess health and human services provision.
- 7) S.B. 681 (An Act Establishing a Minority Health Advisory Commission). This bill established a 32-member commission to work on eliminating disparities in health status based on race, ethnicity, and linguistic ability.
- 8) H.B. 5701 (An Act Concerning Revisions to Statutes Pertaining to the Department of Public Health). Section 509 increased from 3 to 8 hours the minimum hours of annual training for all direct patient care staff in Alzheimer's special care units or programs, which will increase their operational costs. Section 528 required the DPH to compare recommended services to actual services provided to nursing home residents having a level-2 assessment as well as for nursing homes to notify DMHAS of individuals they admit with a confirmed psychiatric diagnosis.
- 9) S.B. 467 (An Act Concerning Security Protocol at the Constituent Units). This bill required state higher education constituent units and private colleges and universities to submit a plan to the Department of Higher Education that identifies procedures to heighten (through

Figure 14: MHT progress by quarter



effective educational strategies) faculty and staff awareness of students and other individuals who may pose a risk to themselves or others.

- 10) S.B. 2 (An Act Concerning the Next Steps Initiative). This bill authorized DMHAS to provide up to 1000 additional supportive housing units for persons in recovery.
- 11) S.B. 414 (An Act Concerning the State-Funded Home Care for the Disabled). This bill increased the asset limits for persons with disabilities who are in or at risk for inappropriate institutionalization to match the asset limits of the Connecticut home care program for the elderly.
- 12) S.B. 167 (An Act Concerning Benefits for Inpatient Treatment of Serious Mental or Nervous Conditions). This bill expanded the benefits payable under a group health insurance policy for treatment received in a residential treatment facility by (1) eliminating a three-day hospital stay prerequisite for a child or adolescent with a serious mental illness and (2) extending benefits to adults.
- 13) H.B. 5666 (An Act Concerning Expansion of the Pilot Program for Persons with Autism Spectrum Disorders). This bill increased access to the autism spectrum disorders pilot project and ensured that the pilot project remains in effect through June 30, 2009.
- 14) Standardization of policies for data integrity for the Network of Care website.
- 15) Revision of the DMHAS policies regarding the American's with Disabilities Act.
- 16) Signing of a Memorandum of Agreement (MOA) between DMHAS, DCF, and CSSD for the Family and Community Wraparound project.
- 17) Creation of the Connecticut Workforce Collaborative on Behavioral Health.
- 18) Integration of recovery-oriented care practice guidelines.
- 19) Creation of written procedures for health and human service organizations to access workforce consultation via the Connecticut Behavioral Health Workforce Collaborative.
- 20) Creation of written directives and/or guidelines for school-based health centers regarding mental health service delivery.
- 21) Development of web-based learning standards for supervision.

GPRA 2 (Training in service enhancements) Twelve separate initiatives resulted in the training of over 3,200 individuals, which exceeds the initial goals for individuals trained by close to 400%. Specific training activities included:

- (1) adults in recovery to facilitate employment (n=36)
- (2) adults in recovery to manage employment initiative (n=5)
- (3) adults in recovery to become recovery supporters (n=19)
- (4) health and human service personnel to work with persons in recovery (n=67)
- (5) parents in leadership training (n=18)
- (6) consumers and family members in continuous quality improvement (n=150)
- (7) consumers in supported education (n=50)
- (8) supervisors at the Department of Corrections in integrated treatment (n=14)
- (9) supervisors in the community in functional, competency-based supervision (n=264)
- (10) staff at Connecticut Valley Hospital in person-centered planning (n=2,337)
- (11) persons in recovery and staff on advance directives (n= 292)
- (12) persons in recovery and family members in qualitative research methods (n=12)

GPRA 3 (Financing policies) One financing policy change was projected to be completed this year—the implementation of the Home and Community-Based Waiver. As described previously,

implementation of the Home and Community-Based Waiver was delayed slightly due to the time it took for its application to be reviewed and approved by the Centers for Medicaid Services.

GPRA 4 (Organizational changes) Connecticut met its initial goals with the completion of 12 activities that resulted in changes to 24 organizations across the state. The number of organizations impacted by these activities exceeded the original projection of 17 organizations. Activities accomplished so far include the creation and/or expansion of several new positions at State departments for persons in recovery, family members, and youth consumers of mental health services and positions specifically designed to address the needs of high priority populations, such as older adults (for example, DMHAS and DDS both have hired persons to oversee older adult care in their agencies).

Furthermore, several new contracts were executed that established new recovery-oriented initiatives, including the development of the coordinating center for the Wraparound Project; the Consumer-Recovery Employment Services (C-RECS); leadership training and other workforce projects; healthcare integration projects; a Consumer/Youth/Family Research and Evaluation Network (CREN); a consumer, youth, and family quality improvement collaborative, Connecticut Quality Improvement Collaborative (QuIC); and an interdepartmental commitment to data interoperability through the signing of a Memorandum of Agreement (MOA).

Several State departments have also made the significant organizational change of providing a link to the Network of Care website on their Departmental websites. This final point demonstrates a significant departure from routine in that agencies whose goals are typically seen as divergent from mental health are beginning to make the linkages more public and provide information about mental health to their constituents.

GPRA 5 (Organizations that collect and analyze data) Two GPRA 5 activities were not completed as planned, due to unforeseen delays. Both activities are expected to be completed during the 1st quarter of Year 4. The first GPRA 5 activity—increasing the number of organizations that collect fidelity data—was postponed due to delays in identifying the communities that would receive support for Wraparound Services. The second activity—to collect and analyze demographic data at seven state departments to identify disparities in care—was deferred until the recommendations from the data interoperability workgroup become available.

GPRA 6 (Membership of statewide consumer- and family-run networks) As noted in the summary of GPRA 4 achievement, Connecticut made significant strides in the development of new organizations and programs that increase the number of consumers and family members in statewide networks. Three new networks were created this year (i.e., the CREN, the QuIC, and C-RECS), resulting in new network membership of 217 members. Furthermore, other existing consumer and family member networks throughout the state have reported an increase in their membership by 356 members, resulting in a cumulative total of 573 new network members throughout the state.

GPRA 7 (Programs implementing treatment, rehabilitation, prevention, and supportive practices) Connecticut's one GPRA 7 activity—to implement a revised training curriculum to prevent and manage dangerous behavior—was not achieved according to schedule. As described previously, an attempt to identify a superior replacement through a competitive bidding process was unsuccessful.

CONCLUSIONS

This has been a very productive and inspiring year in the Mental Health Transformation (MHT) process. In what was essentially the first year of implementation of MHT initiatives, nearly every one of the planned activities were completed according to schedule with the majority of the progress being achieved during the second half of Year 3 of MHT.

This year a turning point was reached in terms of the involvement of youth, people in recovery, and family members, with the recovery community taking notable initiative to become active partners across all levels of transformation, including project planning, decision-making, and research/evaluation.

Additionally, the presence of majority representation of persons in recovery, youth, and families on a number of review committees helped make the MHT process more consumer, youth, and family-driven. Additional efforts to a) increase the valued involvement of consumers, youth, and family members in general, and b) increase participation of ethnically diverse individuals across the lifespan, will fortify Connecticut's already impressive accomplishments.

Significant progress was also made in each of the domains outlined in the CMHP and in activities targeted by MHT leadership and the Oversight Committee. In addition to launching a statewide anti-stigma social marketing campaign, over 3,200 individuals were trained in various recovery-oriented practices this year alone as a result of MHT initiatives and the mini-grants.

It appears likely at this time that the momentum generated during this year will be sustained for the remainder of the grant. Many activities are underway and even more are planned for the upcoming year. It has already become evident, however, that the limited resources provided by the grant are only able to address the proverbial tip of the iceberg, with expectations and demands increasing exponentially and beginning to outstrip available resources. Thus, a prioritizing of which MHT objectives to pursue during the remaining years of the MHT grant may become necessary.

As one prime example, during the first week of the operation of the Connecticut Recovery Employment Consultation Service (C-RECS), the newly hired staff fielded more applications for assistance with employment than were anticipated for the entire year. On the opening day alone, over 70 applications were received. A similar degree of enthusiasm and interest was evident in the first meeting of the Quality Improvement Collaborative (QuIC), with over 150 people attending, many of whom expressed an interest in participating in future activities.

With the doors now fully open to consumer, youth, and family involvement, a major challenge of the remaining two years of the MHT grant and beyond will be to catalyze, channel, and make optimal use of this resource in creating a fully consumer, youth, and family-driven system of care.

As the quotes from the participants in the *Day in the Life* project at the beginning of this report illustrate, Connecticut's mental health system is being transformed.