
State of Connecticut
Comprehensive Mental Health Plan Update



Mental Health Transformation
State Incentive Grant (MHT SIG)
Grant # SM57456

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Submitted to

The Substance Abuse and Mental Health Services Administration

Submitted by

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INTRODUCTION

In response to the President's New Freedom Commission on Mental Health and released federal action agenda, Connecticut has been actively transforming all mental health services and associated systems through a multi-stakeholder partnership, including 14 key state agencies and the Judicial Branch, consumers, youth, and family members, and community-based providers. **Transformation efforts and activities are broad based and far reaching** as they have been implemented **across multiple state agencies**- offering the state's citizens an array of accessible services and supports that are culturally responsive, person and family-centered.

Successful transformation to a recovery-oriented system of mental health care requires that consumers of mental health services have meaningful choices regarding effective services and supports are responsive to diverse cultural backgrounds and across the lifespan. Connecticut's Comprehensive Mental Health Plan (CMHP) reflects the strategies identified by the State to achieve its primary aim- the promotion of resilience, recovery, and inclusion in community life. The strategies and activities outlined within CT's CMHP support the goals of Connecticut's Mental Health Transformation State Incentive Grant (CT MHT SIG) and build on personal, family, and community assets. Foremost in CT's planning is that the strategies are integrated and coordinated within the context of locally-based and managed systems of care, thereby ensuring continuity of care both over time and across agency boundaries.

The goals and objectives of Connecticut's Mental Health Transformation State Incentive Grant (CT MHT SIG) are consistent with the six goals recommended by the New Freedom Commission. These are:

- 1) Connecticut's citizens will understand that mental health is essential to overall health and will treat it with the same urgency as physical health;
- 2) Mental health care will be person and family-driven and oriented to promoting resilience and recovery;
- 3) Disparities in mental health care that are based on culture, ethnicity, race, or gender will be eliminated so that all citizens will be able to participate equally in the promise of recovery;
- 4) Early mental health screening, assessment, and referral to services will become common practice;
- 5) Excellent mental health care, supported by research, will be provided;
- 6) Technology will be used to increase access to care and information.

In addition to these, Connecticut has added an **additional goal of workforce transformation**.

Connecticut's efforts to transform its mental health service delivery system have been organized around these goals since the project's inception in 2005.

The purpose of this year's CMHP is to provide a blue print of activities to take place in the final year of Connecticut's Mental Health Transformation State Incentive Grant. This is not to imply that Connecticut's transformation efforts are coming to a halt. Transformation is a process toward culture change. MHT-SIG funding has enabled Connecticut to formalize its efforts to a recovery-oriented system of care. Now with that foundation securely laid, we move steadfastly toward achieving this vision.

The structure of this report has not changed since its last iteration. Readers are provided with the results of strategies identified for completion in year 4. Progress to date and changes

needed to continue working toward achieving Connecticut's transformation goals are identified. The CMHP has been instrumental in engaging CT's Consumer, Youth and Family (C/Y/F) Advisory Council, CT's Transformation Work Group, the Oversight Committee, and other stakeholders including consumers, youth and family members in a process that has been flexible, responsive and evolutionary. The updated CMHP will also be useful in demonstrating the progress of our mental health transformation from inception to end, to all stakeholders, including our federal funding source, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS). The opportunity presented by the MHT SIG has been transforming in itself. At no other time has such a large and diverse group of people with a stake in our mental health system come together to discuss a need as critical and exhilarating as transformation.

HISTORICAL CONTEXT

Connecticut's Mental Health Transformation Initiative has evolved. In October of 2005, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) awarded Connecticut and six other states a five-year Mental Health Transformation State Incentive Grant (MHT SIG) to be used to make fundamental structural changes to the system of delivering services to people with mental health concerns.

Connecticut's efforts have received strong support, with Governor Rell, 14 state agencies and the Judicial Branch designing the state's first Comprehensive Mental Health Plan in 2006. Scores of other partners, including people who use mental health services, their families, the agencies that advocate for individuals in recovery and many other stakeholders contributed to this process.

In project years 1 and 2, over 200 consumers, family members, non-profit providers and state agency representatives participated in seven workgroups designed to identify recommendations related to each of the New Freedom Commission goals and Connecticut's seventh goal, workforce development. From this process, over 48 recommendations were identified. A list of prioritized recommendations was identified by the project's Oversight Committee, and in year 2, the workgroups developed a strategy for implementation of their recommendations. In April 2007, workgroups finalized their strategies based on feedback from a newly formed Consumer, Youth and Family Advisory Council and the Oversight Committee.

Also in year 2, building on technical assistance provided by Martin Cohen through the National Technical Assistance Center, MHT SIG leadership consisting of individuals from the Consumer, Youth, and Family Advisory Council and members of the Oversight Committee, reached consensus to consolidate our efforts focusing on four domains: 1) increasing consumer and family involvement; 2) using data to evaluate effectiveness and inform practice; 3) educating the community about mental health and Transformation; and 4) training the workforce.

Beginning in project year 3 and continuing throughout project year 4, Connecticut MHT-SIG initiatives have gained a foothold in the existing mental health system. MHT-SIG leadership has worked to strongly encourage initiatives to identify which activities are essential to on-going transformation efforts and explore how to embed them so that they continue post-MHT-SIG.

The State of Connecticut experienced significant budget challenges during project year 4. Facing a projected deficit of over \$6 billion over the next biennium, the state was unable to pass a budget until September 2009, three months into the 2010 state fiscal year. The details of how the budget will be implemented are not yet final.

In an effort to save costs, a retirement incentive program was offered to state employees meeting age and years of service requirements. Over 3,000 state employees took advantage of the retirement incentive program effective July 1, 2009 including three Commissioners representing Mental Health Transformation state agency partners: the Department of Mental Health and Addiction Services; Department of Social Services; and Department of Correction. A hiring freeze, effective over a year ago remains in place, thereby prohibiting most position refills. Strict restrictions on new and existing contractual services have been in place for the past year.

The challenges described above have led to delays both in the implementation of Transformation initiatives as described in later sections of the CMHP and contract renewals and/or implementation of new contracts. Despite these challenges, MHT leadership was able to contract with a consulting group to assist in sustainability planning through the use of the Results Based Accountability model.¹

Results Based Accountability (RBA) is a way of thinking and taking action that can be used to improve the quality of life in communities and to improve the performance of programs, agencies and service systems. RBA uses budget and performance baseline data to evaluate quality of life indicators and outcomes using plain language that is easily understood.

Results Based Accountability has been widely embraced and endorsed by the CT Legislature for approximately five years. Each year, state agencies are asked to present a program or programs using the RBA framework to demonstrate outcomes and effectiveness. According to a report published in August 2007 by the Office of Fiscal Analysis in the State of CT entitled *Implementing Results Based Accountability in the General Assembly*, RBA “supports two primary levels of discussion: how the constellation of efforts across programs affects a particular quality of life result, and then, through the reporting of key performance measures for each program, how each program is performing for its customers, the citizens of Connecticut. Programs share a common goal, and RBA allows decision-makers to determine each program’s contribution to the larger goal. RBA provides a critical tool for determining whether and how the public is better off because of the expenditures that have been made and where future appropriations may have the most positive impact.”

In project year 5, the final year of the Mental Health Transformation Grant, teams representing Workforce Development, Wraparound and the Quality Improvement Collaborative (QuIC), three of CT’s major Transformation initiatives, will work with consultants to develop an RBA framework for their initiative. Using this framework will allow the Project Leaders to demonstrate the effect on quality of life and performance measures and demonstrate the return on investment. This plan can then be used as a basis for discussion with potential funders, both public and private, as each project strives for sustainability beyond September 2010.

Connecticut’s Comprehensive Mental Health Plans reflect the evolution of Connecticut’s transformation process. The CMHP in 2006 presented the detailed recommendations identified by each of the seven workgroups. The 2007 Plan introduced the four domains and presented the strategies and activities to be completed to promote transformation within these priority areas. In 2008, the Plan represented the development, implementation and in some cases outcomes of MHT-SIG strategies. This current plan builds upon the previous plans. Much of it will be familiar to the reader as we view the plan, much like Transformation, a continuous process that builds upon the groundwork laid in previous years. The 2009 CMHP demonstrates the processes put in place to support successful continuation of activities within the priority areas to ensure sustainability beyond the grant period.

¹ Friedman, M. (2005). *Trying Hard Is Not Good Enough*. FPSI Publishing, Victoria, British Columbia, Canada.

UNDERSTANDING CONNECTICUT'S CMHP REPORT STRUCTURE

Connecticut's CMHP 2009 builds on previously submitted CMHPs. This plan expands on the format developed and introduced in February 2008 in order to capture and demonstrate Connecticut's progress toward a transformed system of care. As previously noted, Connecticut has identified four key priorities to achieve transformation: Consumer, Youth and Family (CYF) Involvement, Community Education, Data-driven Decisions and Workforce Development. These serve as the sections or chapters of the Plan. Within these we describe how priorities will be implemented through communication and coordination with consumers, youth, family members and other state, regional and community stakeholders and articulate implementation activities and strategic integration of key principles of transformation, i.e., integration of CYF across the system; leverage of financial resources; expansion of services via policy and legislation; elimination of disparities; and other milestones.

Throughout the plan, we have attempted to demonstrate how CT's MHT-SIG process is:

- Committed to the involvement of, and responsive to consumers, family members, and other key stakeholders and includes a Consumer, Youth and Family Advisory Council that reviews activities to ensure resilience and recovery-oriented strategies and principles;
- Culturally sensitive and competent;
- Sensitive to establishing links between MHT-SIG activities and other state priorities;
- Coordinated across multiple State agencies, including identifying what actions other State agencies will take to make the activities successful, and the subsequent relationships and formal agreements;
- Accessible to individuals with disabilities and designed to reduce disparities for special populations.

The following section describes the components of Connecticut's CMHP. Each section: Community Education, Consumer, Youth and Family Involvement, Data-Driven Decisions, and Workforce Development are organized and presented in similar fashion.

The diagram below will help the reader understand how the report is structured. Following the diagram is a narrative description of each of the components.

Description of the Domain or Priority.

COMMUNITY EDUCATION (CE)
 DESCRIPTION: Community Education encompasses Connecticut's anti-stigma campaign as well as other initiatives focused on reaching out to citizens....
 SYSTEM TRANSFORMATION: Connecticut's efforts in the area of Community Education are in the context of Social Marketing. Social Marketing is a process....

How will the domain transform the system?

Domain or Priority specific GANTT Chart.



The New Freedom Commission Goal addressed by the activity.

Explanation of the strategy to achieve the goal.

NEW FREEDOM COMMISSION GOAL / END OUTCOME:
 We understand that mental health is essential to overall health.
 1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.
 Address mental health with the same urgency as physical health.

Measurable steps to achieve the goal. These are labeled with the domain code and objective number.

OVERVIEW: Connecticut has initiated a statewide multi-faceted Social Marketing Campaign to reduce stigma and increasing awareness of mental health issues. ...

OBJECTIVE CE 1: Develop an anti-stigma media campaign delivered via television, radio, and print with the assistance of consumers, youth, and families.

Accountability, Capacity and Effectiveness (ACE) Goals

Date: January 2007
 Increase access to mental health services
 Average/Realistic Goal
 Across the lifespan

How we will know we have achieved the objective.

Performance Measurement:

Project Year 2007/2008 Implement one statewide anti-stigma media campaign (GPRA 7).

Action Steps to achieve the objective.

Action Item	Parties Responsible	Completion Date	Status
Align anti-stigma campaign with media campaign initiated through the Department of Social Services' Medicaid	Mental Health Transformation (MHT) Staff	December 2007	Completed

Project Year 2007/2008 Progress: Connecticut completed...

Project Year 2008/2009 Progress: All action items...

Progress completed according to project year.

The components within each priority area or section are:

- **Description:** Each domain or priority area is described in a dark blue box at the beginning of each section.
- **System Transformation:** A statement explaining how Connecticut will concentrate efforts within each domain to change the State's mental health system.
- **GANTT chart:** A Gantt chart has been added to better represent Connecticut's progress toward transforming its mental health system within each domain. The Gantt chart lists each objective and associated timeframe - illustrating the start and finish dates of each. A second, more comprehensive Gantt chart reflecting all of the domains and earlier activities, that are the foundation of CT's transformation evolution, can be found at the end of the document.
- **New Freedom Commission (NFC) Goal/End Outcome:** All activities identified within CT's CMHP are required to promote achievement of a New Freedom Commission Goal. As noted, the NFC goals are also CT's Mental Health Transformation State Incentive Grant (MHT-SIG) goals. Each objective within a domain has a related NFC goal or sub-goal associated with it, ensuring that as objectives are met, CT is that much closer to its end outcome-achieving the NFC goal.
- **Overview:** An explanation for the objective's rationale and the activities that have been identified to achieve it.
- **Objective(s):** The concrete, measurable steps to achieve system transformation within each domain. There are multiple objectives within each domain which contribute both independently and in concert with others to the ultimate goal of system transformation.
- **Accountability, Capacity and Effectiveness (ACE) goals:** For each objective, a start date and ACE goals have been indicated. Impact, Ease of Completion and Population responses are listed below.
 - Impact: Improved accountability; increased service effectiveness; increased service capacity; other specified response.
 - Ease of Completion: Stretch goal (high risk of non-completion); average/realistic (neither high risk nor sure bet); sure bet (high likelihood of completion)
 - Populations Affected: Children; Adolescents; Adults; Older Adults; Across the life span.
- **Performance measurement:** When completed as indicated, the identified Action Steps will contribute to the completion of a product that will represent achievement of the objective. In other words, the performance measurement tells us how we will know we have achieved the objective. Included in the performance measurement is an associated Government Performance Results Act (GPRA) measure indicating the type of system change achieved. In this plan, performance measures are designated by project year in which they were achieved or are projected to be achieved.
- **Action Item Table:** Each objective and performance measure has activities required to achieve it. These are listed in the Action Items table with the party or parties responsible for completing the action as well as the date that the action is expected to be completed. It is important to note that the Action Tables contain activities that have been identified

either in previous plans and project years, or as part of this year's (2009-10) planned activities. In addition, some tables have been significantly revised to more accurately reflect implementation activities.

- **Status:** The following terms reflect the status of each action item in CT's CMHP: Initiated, On-target, On-going (with timeframe indicated), Revised, or Completed. These terms are defined as:
 - Initiated: Steps to complete the action item have been taken although the action item is not yet completed.
 - On-target: Indicates that although specific steps to complete the action item are not yet initiated, ancillary efforts leading to the action item are proceeding and no delays in the proposed completion date are anticipated.
 - On-going: Many action items though completed by the proposed completion date will continue or be on-going for an extended amount of time (i.e., throughout the life of the MHT-SIG). As best as possible, we have indicated a date until which the action item will be taking place.
 - Revised: In the case that a proposed action item was not carried out in the manner originally proposed or intended, we have indicated that it is revised. An explanation for the revision and if appropriate, the new plan for addressing the performance measure are provided in the "Progress" section.
 - Completed: The action item has been achieved. When all action items are completed, the objective has been met.

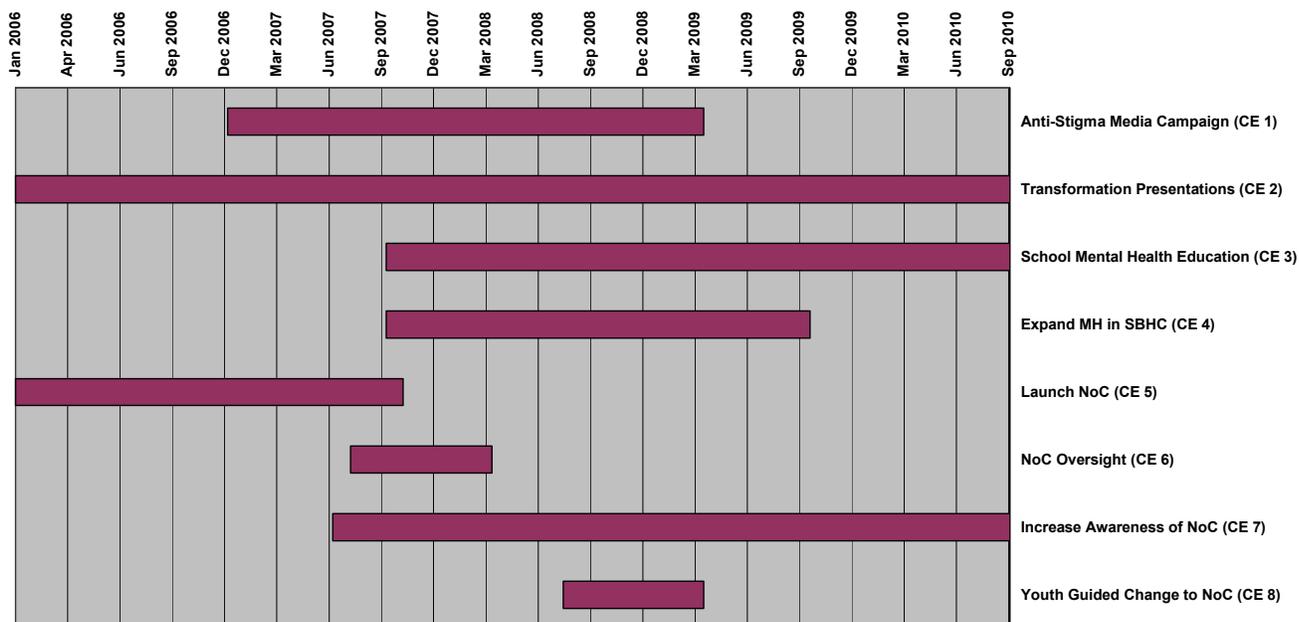
- **Progress:** After each Action Item Table, a brief explanation has been provided to specify where we are in our process toward completing each performance measurement. The progress section is further divided by project year to allow the reader to follow the progress as described in previous plans to the present. Additionally, within this section, the reader will learn how the proposed activities will further progress CT's efforts towards transformation and what plans have been made, if appropriate, to sustain efforts to achieve the objective after the grant ends. It is in this section that any modifications to previously identified activities or adjusted completion dates will also be explained.

COMMUNITY EDUCATION (CE)

DESCRIPTION: Community Education encompasses Connecticut’s anti-stigma campaign as well as other initiatives focused on reaching out to citizens in multiple settings to impart information related to mental health and illness. Community education underscores the importance of mental health to overall wellbeing.

SYSTEM TRANSFORMATION: Connecticut’s efforts in the area of Community Education can be described in the context of Social Marketing. Social Marketing is a process designed to influence or change attitudes and behavior about a particular issue. It employs many elements of standard marketing such as utilizing a multi-faceted, multi-media approach to reach the desired audience. The reduction of stigma, the promotion of mental health and the understanding that mental health is part of overall health, once achieved, represent a significant shift in attitude and the removal of one barrier that individuals in recovery and their families face every day.

Community Education Timeline



NEW FREEDOM COMMISSION GOAL / END OUTCOME:

Americans understand that mental health is essential to overall health.

- 1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.
- 1.2 Address mental health with the same urgency as physical health.

OVERVIEW: Connecticut has initiated a statewide multi-faceted Social Marketing Campaign aimed at eliminating stigma and increasing awareness of mental health issues. The major components of the campaign include implementing a community awareness/anti-stigma media campaign; developing and disseminating materials and information on Connecticut's Mental Health Transformation (MHT) Initiative and Network of Care web site; and creating marketing materials for distribution at public events. In project year 2008-09, CT added public television to its media and community education activities.

OBJECTIVE CE 1: Develop an anti-stigma media campaign delivered via television, print, and radio with the assistance of consumers, youth, and families.

Begin Date: January 2007
Impact: Increase access to mental health services
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2008/2009 1) Implement one statewide anti-stigma media campaign by December 2008 (GPRA 7).

Action Item	Parties Responsible	Completion Date	Status
Align anti-stigma campaign with media campaign initiated through the Department of Social Services' Medicaid Infrastructure Grant focusing on employment for persons with disabilities	Mental Health Transformation (MHT) Staff	December 2007	Completed
Initiate contact with an advertising agency	MHT staff	March 2008	Completed
Evaluate stigma-reducing intervention for students and teachers	Yale University Program for Recovery and Community Health (Yale PRCH)	May 2008	Completed
Advertising agency develops message and identifies target populations with input from persons in recovery	Communications Sub-Committee	June 2008	Completed
Assist with designing and evaluating projects for improving attitudes of mental health (e.g., public awareness campaign, staff training, Brain Dance evaluation)	Yale PRCH	October 2008	Completed
Continue to work with MIG partners to leverage the Connect- Ability marketing in ways specific to each agency's mission	MIG staff and state agency partners	December 2008	Completed

Disseminate messages through television, print, and radio advertising	Mintz and Hoke	October 2008	Completed
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Project Year 2007/2008 Progress: Action steps for anti-stigma social marketing efforts (October 2007-September 2008) were completed according to anticipated completion dates. Highlights of progress for activities within objective CE1 include:

- In spring 2008, CT’s MHT-SIG staff, with approval from the Oversight Committee, began working with Mintz and Hoke, the advertising agency responsible for the creation of the MIG’s Connect-Ability campaign. Working with members of the Consumer, Youth, and Family Advisory Council, the Communications Sub-Committee and other key stakeholders from the Oversight Committee an anti-stigma social marketing campaign to educate CT residents ages 25-55 about the stigma associated with mental illness. Target population was identified; draft messages were crafted and tested in four focus groups in July and August 2008. Mintz and Hoke is currently finalizing the message which will be aired on radio and printed in magazines throughout the state and region beginning in October 2008.
- Anti-Stigma campaign with Medicaid Infrastructure Grant (MIG): CT’s MIG and MHT-SIG have partnered to promote the MIG’s successful Connect-Ability campaign launched in 2007-08 and MHT-SIG anti-stigma campaign launched in spring 2008. The two initiatives meet regularly to plan on-going efforts aimed at addressing the stigma and discrimination associated with mental illness and other perceived limitations to the vision, a life in the community for everyone. The benefit of this collaboration is increased awareness among community members about mental health and the contributions persons in recovery can make within CT’s workforce.
- In 2008, CT’s social marketing campaign was expanded to include the evaluation of “BrainDance” a social marketing effort by the Institute of Living, a private CT mental health provider. “BrainDance” academic competition is designed to decrease the stigma of mental illness. The BrainDance Awards encourage students to gain knowledge about psychiatric diseases and develop a more tolerant and realistic perspective toward people with severe psychiatric problems. The competition also aims to promote students’ interest in careers in mental health care.

Project Year 2008/2009 Progress: 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 who were asked to make a final selection. This consumer-led group selected a campaign titled “So if I said...” which included four print ads in local copies of *Time*, *Newsweek*, *U.S. News and World Report*, and *Sports Illustrated* and four 30-second radio advertisements on local stations. Both the print and radio messages included the web address for Connecticut’s Network of Care website.

ALL ACTION ITEMS ASSOCIATED WITH THIS OBJECTIVE HAVE BEEN COMPLETED.

NEW FREEDOM COMMISSION GOAL / END OUTCOME:

Americans understand that mental health is essential to overall health.

- 1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.
- 1.2 Address mental health with the same urgency as physical health.

OVERVIEW: Frequent communication among MHT staff and the public, agencies in the community, and various State Departments about the Mental Health Transformation Grant will enhance inter-departmental collaboration as well as consumer, youth and family involvement. These forums will provide information to assist with transforming the mental health system in a way that is responsive to the needs of the people it serves.

OBJECTIVE CE 2: Increase stakeholder and citizen awareness by providing information about Transformation activities.

Begin Date: January 2006
Impact: Improved accountability
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2007/2008 1) By September 2008, inform 500 stakeholders about mental health transformation (GPRA 2).

Project Year 2008/2009 1) By September 2009, an additional 400 persons will receive education about mental health transformation through meetings, presentations, and classes (GPRA 2).
 2) By September 2009, 450 persons will receive education by viewing mental health related documentaries (GPRA 2).

Project Year 2009/2010 1) By September 2010, an additional 225 persons will receive education about mental health transformation and how to use the Network of Care web site (GPRA 2).

Action Item	Parties Responsible	Completion Date	Status
Broadcast a Town Hall meeting live via the internet and/or local access television to provide updates on progress and activities related to the Transformation process and to receive input from citizens and stakeholders	MHT Staff	June 2008	Completed
Explore opportunities for placing Town Hall Meeting video on You Tube or other widely viewed web sites	MHT staff with CPTV	November 2008	Completed
Produce and air three half hour documentaries on mental health issues	CT Public Television (CPTV)	February 2009	Completed
Present information at meetings with other state and community agencies related to the Transformation process	MHT Staff	September 2010	On-going
Provide MHT presentations to social clubs and other consumer and family groups	Consumer Liaison	September 2010	On-going
Demonstrate Network of Care website at state and community agencies	MHT Staff	September 2010	On-going

Project Year 2007/2008 Progress: CT met the performance measurement for this objective in June 2008. However, activities to increase stakeholder and citizen awareness about CT's progress toward a transformed mental health system will continue throughout the life of the project, as presenting and sharing information on Transformation and Network of Care is regarded as part of our everyday responsibility. Progress toward achievement of the action items above are as follows:

- In project year 2007-08, MHT-SIG staff conducted presentations to over 1000 people: Staff presented information on the Network of Care to more than 300 people and the Consumer Family Liaison has presented to more than 950 Consumers and 90 staff in consumer organizations and social clubs.
- CT Public Television (CPTV) aired "Opening Doors, Opening Minds": A Town Hall meeting on Mental Illness on June 26, 2008 yielding 280,000 gross impression ratings. The next broadcast is scheduled for October 28, 2008 and will include a screening for invited guests. An additional re-broadcast will occur in the next project year.
- Advertisements for the Town Hall meeting were aired 26 times between June 20 and June 25, 2008 on National Public Radio and printed in *Connecticut Magazine*.
- The Town Hall meeting was adapted for online streaming and posted on CPTV, DMHAS and Network of Care web sites. CPTV reports 574 online viewing requests.
- A Production Planning Committee was created and met with CPTV producers in August 2008 to identify a strategy for airing three half-hour documentaries to educate the public on issues related to living with mental illness. The first episode in the series focusing on children and families will air during Mental Illness Awareness week in October 2008. CPTV plans to leverage MHT funding to secure private foundation funds to expand the series to a total of ten episodes.

Project Year 2008/2009 Progress: Activities designed to increase stakeholder and citizen awareness about CT's progress toward a transformed mental health system continued over the past year. Progress includes:

- Connecticut Public Television (CPTV) broadcast the first documentary of a three-part series "Opening Doors, Opening Minds" about mental illness and recovery in October 2008. Through compelling personal stories and insightful interviews with experts, *Opening Doors, Opening Minds* illustrates how mental health is part of overall health. "Growing Up with Mental Illness" tells the story of four young persons in CT with mental illness describing both the challenges they face and more importantly, their hope for the future. The second episode, which aired in January 2009, "Adults Living with Mental Illness" looked at how mental illness impacts the lives of two adults from very different backgrounds, who struggle with very different illnesses. In May 2009, the third and final episode aired. "Family Impact," examined the ways in which family members are affected when someone is suffering from mental illness. Collectively, this three-part documentary series has reached over 152,000 individuals since October 2008, far surpassing CT's goal of 450 persons. Further details about the *Opening Doors, Opening Minds* documentaries, and video clips from all three episodes, are available at <http://www.cptv2.org/mentalhealth/>.
- CPTV received a Mental Illness Awareness Media Award for the documentary series *Opening Doors, Opening Minds* from the Connecticut Psychiatric Society, National Alliance for Mental Illness, and DMHAS.

- In recognition of May as Mental Health Awareness Month, MHT staff partnered with local mental health authorities (LMHAs) to distribute *Opening Doors, Opening Minds* via public libraries, advocacy organizations, state agency partners and websites. In total, 73 DVD copies of the series were distributed across the state.
- The Southwest Regional Mental Health Board, a mini grant recipient produced the Caring Network series that included four documentaries related to mental health issues and distributed 100 copies of the series across the state.
- The MHT staff, specifically the Consumer and Family Liaison and Program Manager educated individuals in recovery, providers, and students on a variety of topics throughout the year including demonstrations of the Network of Care website. In total, they reached 401 CT stakeholders.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Early mental health screening, assessment, and referral to services are common practice.

- 4.1 Promote the mental health of young children.
- 4.2 Improve and expand school mental health programs.

OVERVIEW: Mental health education is critical to facilitating an understanding that mental health is part of overall health. Information about suicide prevention and mental illness is an essential part of a comprehensive health curriculum that includes information regarding wellness, physical and mental health, suicide prevention and mental illness. A necessary first step is to ensure that health curricula in schools include modules on mental health and suicide prevention. In order to better understand how local school districts are addressing mandates related to health education, mental health and suicide prevention, a formal survey is needed to identify barriers that may prevent school districts from meeting these mandates. Connecticut's educational system is comprised of 169 independent school districts/Boards of Education. Efforts to assess and/or modify school health curricula will require the cooperation of each of these separate school systems.

OBJECTIVE CE 3: Questions related to mental health and suicide prevention curricula will be added to 2010 School Health Profile.

Begin Date: October 2007
Impact: Improved effectiveness
Ease of completion: Stretch Goal
Population: Adolescents

Performance Measurement:

Project Year 2009/2010

1) By October 2010, at least 50 school districts will respond to the two questions related to mental health and suicide prevention contained in the 2010 School Health Profile (GPRA 5).

Action Item	Parties Responsible	Completion Date	Status
Conduct a review of curriculums and educational offerings related to mental health and suicide prevention currently utilized in Connecticut schools	Yale University Program for Recovery and Community Health (Yale PRCH)	June 2008	Revised
Continue to meet with representatives from SDE, DPH and GLS to develop a CT supplement to the School Health Profile	SDE, DPH, GLS and MHT-SIG staff	September 2010	Revised
Collect coordinated data set through School Health Profile	SDE	October 2010	Revised

Project Year 2007/2008 Progress: An initial meeting was held to engage multiple state agencies and other federally funded initiatives with interests in enhancing health education in schools. Representatives from the State Department of Education (SDE), Department of Public Health (DPH), Garrett Lee Smith (GLS) Suicide Prevention Initiatives, MHT-SIG staff and evaluators from GLS and MHT-SIG met in April and determined that the best strategy for Connecticut is to assess what mental health content is currently provided by school health educators. This will be accomplished by modifying the biennially conducted Center of Disease Control and Prevention (CDC) School Health Profile. The group plans to have the supplemental question set and process identified for the next administration of the survey which is scheduled for fall 2010.

Project Year 2008/2009 Progress: Adding supplemental state specific questions related to mental health to the 2010 School Health Profile appeared feasible when this topic was initially discussed. During the past year however, CT has faced a significant budget crisis. Over 3000 state employees took advantage of a retirement incentive program. Consequently, it does not appear that this goal will be achieved in the last and final year of the Transformation Grant as the resources required to do so are no longer readily available.

THIS OBJECTIVE WILL NOT BE CONTINUED IN PROJECT YEAR 5.

NEW FREEDOM COMMISSION GOAL / END OUTCOME:

Americans understand that mental health is essential to overall health.

- 1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.
- 1.2 Address mental health with the same urgency as physical health.

OVERVIEW: Primary and preventive medical and behavioral health services, along with age appropriate health promotion/education activities, are the cornerstone services provided at each school based health center to address the many threats affecting the health of Connecticut's youth. In response to § 51, Committee to Improve Health Care Access of Senate Bill 317, An Act Concerning Revisions to Connecticut's Department of Public Health Statutes, the Commissioner of the Department of Public Health (DPH) established an Ad Hoc Committee for assistance in improving health care through access to School Based Health Centers (SBHC).

OBJECTIVE CE 4: Improve mental health care in school-based health centers.

Begin Date: October 2007
Impact: Improved accountability
Ease of completion: Average/Realistic Goal
Population: Children and Adolescents

Performance Measurement:

Project Year 2008/2009 1) By September 2009, create directives and/or guidelines for school-based health centers regarding mental health service delivery (GPRA 1).

Action Item	Parties Responsible	Completion Date	Status
Continue to participate on the Department of Public Health Ad Hoc Committee for SBHC to ensure increased access to mental health services for school-aged children	DMHAS/MHT Staff	September 2009	Completed
Contribute to the evaluation and reporting of recommendations necessary to improve resources, access to care, and fiscal support to achieve the DPH Standard Model (Level V) for SBHC	DMHAS/MHT Staff	September 2009	Completed

Project Year 2007/2008 Progress: The MHT-SIG staff participate on the DPH coordinated Ad Hoc Committee. The group met quarterly throughout the year to identify strategies to achieve three priorities: Service delivery collaboration, changes in standardization in licensing of school based health centers, and standardization of mechanisms to expand school based health center services including mental health services. A draft of the legislatively mandated annual interim report of progress has been submitted to the Commissioner of Public Health. This document, once approved, will guide the direction to be taken in 2008-09

Project Year 2008/2009 Progress: A report resulting from the Committee’s work was submitted to the Commissioner of the Public Health. Given the state budget crisis and significant reduction in state personnel, it is unclear how the information in the report will be used in the future.

THIS OBJECTIVE WILL NOT BE CONTINUED IN PROJECT YEAR 5.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

- Technology is used to access mental health and information.
- 6.1 Use health technology and tele-health to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
 - 6.2 Develop and implement integrated electronic health record and personal health information systems.

OVERVIEW: The New Freedom Commission identified the Network of Care for Mental Health as a valuable, user-friendly resource for access to national, state, and local information, secure storage and sharing of health-related information, and evaluation of services. Connecticut’s Network of Care (NoC) is a single resource web site that provides access to mental health and Connecticut CMHP 2009-10

substance abuse treatment information and resources for children, adolescents and adults of all ages. The NoC is one element in a larger process designed to transform Connecticut's mental

health system, by empowering people in recovery and others (youth, families, and public and private providers) to seek sound information about accessing effective mental health and substance abuse services in a timely manner. Access to current information about mental health, services and supports, and local groups can serve an important function in educating the public, providers, and persons in recovery.

The following three objectives will be achieved through the implementation and use of the Network of Care website.

OBJECTIVE CE 5: Develop and launch Network of Care website tailored to Connecticut's needs.

Begin Date: January 2006
Impact: Improved accountability, service capacity and service effectiveness
Ease of completion: Sure bet
Population: Across the lifespan

Performance Measurement:

Project Year 2007/2008 1) By October 2007, launch Network of Care website (GPRA 7).

Action Item	Parties Responsible	Completion Date	Status
Develop a project staffing structure, define roles/responsibilities of Implementation Advisory Committee, and identify Executive Business Sponsor	Department of Mental Health and Addiction Services (DMHAS)	November 2006	Completed
Identify sub-workgroup of consumers and providers to establish website content	MHT Work Group (WG) 6	March 2007	Completed
Contract negotiations/final signing with vendor, gain access to software product, and identify support from vendor	Department of Information Technology(DOIT)	December 2006	Completed
Identify sub-workgroup to pilot software product prior to launch	DMHAS Mgmt./MHT	September 2007	Completed
Conduct a Governor's launch event	Communications and Public Relations Directors at DMHAS, DPH, DOIT, and MHT Staff	October 2007	Completed

Project Year 2007/2008 Progress: Since launching Connecticut's Network of Care (NoC) in October 2007, there have been over 2,500,000 hits to the web site and over 81,000 web sessions. There has been a general trend towards more web sessions each month with the average number of monthly visitors increasing each quarter, especially between the 2nd and

3rd quarter of 2007-08, when there was a roughly 50% growth in visitors was realized. In March 2008, approximately 90 community-based providers received training in the use of the site. In April, the training was featured at the annual conference of the local chapter of the National Association of Social Work. Also in April, 15 members of the Connecticut Legal Rights project received training. Greater awareness of the web site through these presentations may be associated with the spike in web usage in April 2008.

Shortly after launching the NoC, a survey was posted on the site to gain feedback from visitors. As of June 2008, a total of 66 visitors completed the survey. Though this converts to a limited response rate of 1 out of every 1,200 visitors, respondents continue to rate the NoC favorably overall. One notable improvement this quarter was a nearly 100% increase in the percentage of visitors who reported that the information on the NoC “Exceeds expectations.”

All of the activities and outcomes relating to the NoC implementation have been achieved during project year 2008/2009 including:

- Inter-agency content development;
- establishing oversight and policies to ensure data integrity;
- conducting a launch event hosted by the Lieutenant Governor with nearly 200 people in attendance; and,
- increasing web traffic through community education activities.

Project Year 2008/2009 Progress: Funding for the maintenance of the Network of Care site is secured within the Department of Mental Health and Addiction Services (DMHAS) budget. The DMHAS Communications Specialist Manager has assumed responsibility for the ongoing development and maintenance of the site ensuring that the Network of Care website will be a valuable resource to citizens in CT well beyond the grant period.

ALL ACTION ITEMS ASSOCIATED WITH THIS OBJECTIVE HAVE BEEN COMPLETED

OBJECTIVE CE 6: Establish oversight of Network of Care website.

Begin Date: August 2007
Impact: Improved accountability, service capacity, and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2007/2008 1) Evidence of policies designed to ensure data integrity by March 2008 (GPRA 1).

Action Item	Parties Responsible	Completion Date	Status
Define membership of Network of Care advisory body and enlist representatives from agencies via Oversight Committee and Consumer, Youth, and Family (C/Y/F) Advisory Council	DMHAS Mgmt. and MHT Staff	March 2008	Completed

Identify ongoing administration of system responsibilities	DMHAS Mgmt. and MHT Staff	February 2008	Completed
Create policies to ensure data integrity and standardization	211 Info Line, Trilogy, and MHT staff	February 2008	Completed

Project Year 2007/2008 Progress: The NoC Governing Committee has been established to oversee NoC activities. Representatives from six state agencies and other consumer advocacy programs have participated on the committee and have completed the following tasks:

- Assessing committee membership and identify gaps;
- Determining roles, responsibilities and commitment of group members;
- Convening quarterly meetings; and,
- Identifying tasks for next year (see Objective CE 7 below).

Project Year 2008/2009 Progress: Under the leadership of the DMHAS Communications Specialist Manager, the Network of Care Governing Committee has met and will continue to meet on a quarterly basis to ensure that the Network of Care website provides accurate and current information for CT citizens. In the Spring of 2009, the Governing Committee membership expanded to include consumer representatives.

ALL ACTION ITEMS ASSOCIATED WITH THIS OBJECTIVE HAVE BEEN COMPLETED

OBJECTIVE CE 7: Increase marketing and advertising of Network of Care website to stakeholders and the public through at least three different types of media (e.g., print, radio, internet, television).

Begin Date: July 2007
Impact: Improved accountability, service capacity, and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2008/2009

- 1) Increased number of different state agencies and providers listed on the Network of Care website between launch date and one year follow-up by September 2009 (GPRA 4).
- 2) 50% increase in the number of state departmental agencies that provide links to Network of Care on their agency website by September 2009 (GPRA 4).
- 3) Increased number of hits on the website from launch to one year follow-up (Non-GPRA).

Action Item	Parties Responsible	Completion Date	Status
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Gain buy-in from agencies affected as well as others across the state so that this site is included across a whole range of sites	MHT Staff and Content Sub-committee	July 2007	Completed
Incorporate information about the website in the larger media campaign focusing on community education and awareness	C/Y/F Advisory Council, Communications Sub-Committee	March 2008	Completed
Use culturally diverse and recovery-oriented messages to educate state residents about website	C/Y/F Advisory Council, MHT staff	March 2008	Completed
Increase the number of agencies that post a link to the NoC site	NoC Governing Committee	September 2009	Completed
Increase the number of services and resources listed by programs supported by participating state agencies	NoC Governing Committee	September 2009	Completed
Establish a process that implements NoC training opportunities for other state agencies' stakeholders	NoC Governing Committee	September 2010	Revised
Review findings, assess the applicability and modify as needed the NoC user survey	NoC Governing Committee	September 2009	Completed

Project Year 2007/2008 Progress: The NoC Governing Committee activities have resulted in the following:

- As of June 30, 2008, four agencies had links to the NoC site (a 300% increase);
- Inclusion of NoC awareness activities within CPTV and Mintz and Hoke media campaigns.

Project Year 2008/2009 Progress: Since the NoC was launched in October 2007, the website has received 288,594 visitors, with a daily average of 400 visitors, and over 8 million hits. Other highlights include:

- Both the time visitors spend on the site and the number of pages viewed has increased over time. For example, when the NoC was first launched, the average visit was 6 minutes, 36 seconds whereas for the most recent quarter it was 17 minutes, 28 seconds. Similarly, the average number of pages viewed per visit increased from 6.4 pages to 13.4 pages during the same time period.
- In recent months, the number of monthly visitors to the NoC increased notably. Beginning in July 2009, the number of visitors grew by 50% from the previous month followed by an 87% increase in August 2009. This upturn in the number of NoC visitors may be associated with greater awareness of the web site as a result of the MHT Consumer Liaison's presentations about the NoC at social clubs for consumers and staff, which occurred mostly in July and August of 2009.
- During the first and second quarters of project year 5, trainings were offered through the DMHAS Education and Training Catalogue, a regional mental health board, to pastoral counseling students, and persons in recovery. In total, over 125 persons were trained in the use of the website.
- The Network of Care user survey has been revised over the course of the last year to gather feedback that has been used to enhance the site.

Given the recent retirement of over 3,000 state employees, there are no plans to pursue Network of Care trainings in other state agencies.

ALL ACTION ITEMS ASSOCIATED WITH THIS OBJECTIVE HAVE BEEN COMPLETED

OBJECTIVE CE 8: Enhance the NoC to be more youth-friendly as determined by a NoC youth workgroup.

Begin Date: October 2008
Impact: Improved accountability and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Adolescents

Performance Measurement:

Project Year 2008/2009 Modify NoC website to address recommendations received from youth work group by September 2009 (Non-GPRA).

Action Item	Parties Responsible	Completion Date	Status
Recruit youth to serve as consultants to NoC	MHT Staff	October 2008	Completed
Meet with youth consultants to review existing site	MHT Staff with Youth Consultants	October 2008	Revised
Youth identify changes to site	MHT Staff with Youth Consultants	December 2008	Revised
Request to Trilogy (NoC Contractor) for youth-proposed changes to site	MHT Staff with Youth Consultants	March 2009	Revised

Project Year 2007/2008 Progress: A new and exciting partnership has evolved between the MHT-SIG staff and a group of youth from the Young Adults United (YAU) who have agreed to serve as consultants to the NoC. Meetings have been scheduled for October when interested youth and MHT staff will discuss the expectations of the consultants and proceed with a review of the site.

Project Year 2008/2009 Progress: Efforts to reach out to youth were unsuccessful in project year 4; therefore, a decision was made to invite persons in recovery of all ages to a forum where feedback on the site could be provided. Persons in recovery, primarily adults attended the meeting and enhancements to the site were made. Three individuals from that meeting joined the Network of Care Governing Committee to ensure that persons in recovery contribute to the ongoing enhancement of the site.

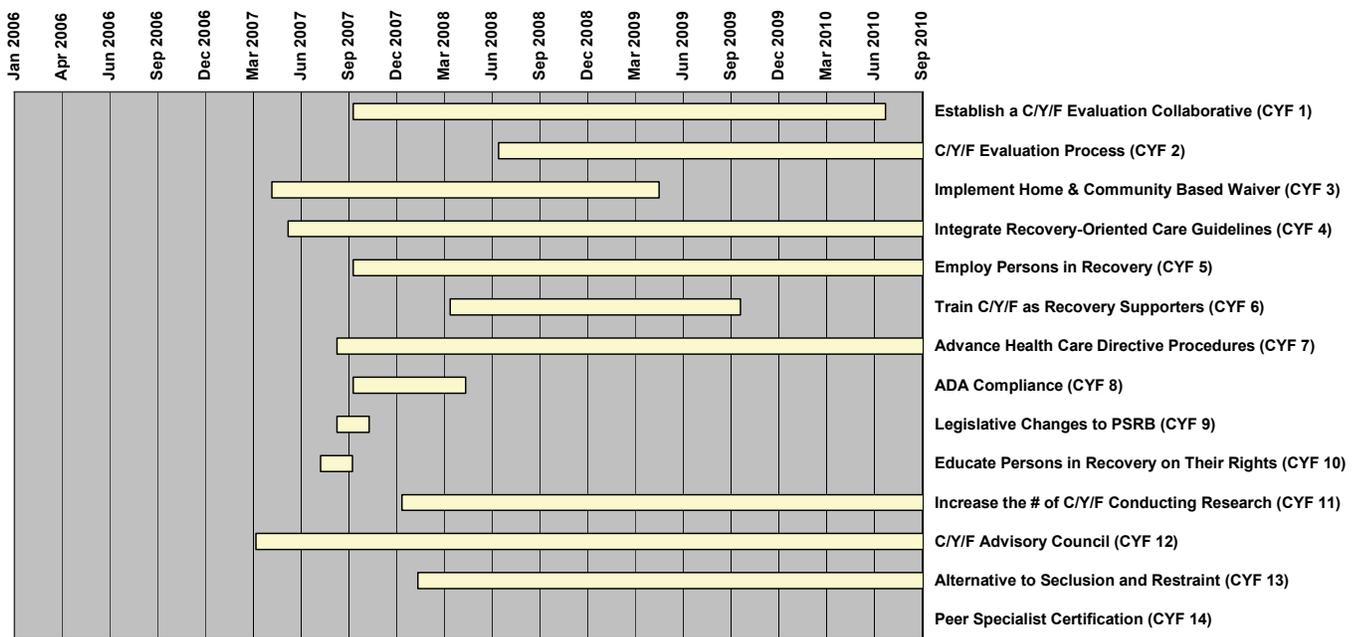
THIS OBJECTIVE WILL NOT BE CONTINUED IN PROJECT YEAR 5

CONSUMER, YOUTH, & FAMILY INVOLVEMENT (CYF)

DESCRIPTION: Systems transformation efforts must involve at all levels and in all respects the active participation and leadership of people in recovery and their loved ones. Besides offering hope and role models for the possibility of resilience and recovery, this community possesses the primary source of wisdom about recovery. According to the New Freedom Commission vision, individuals in recovery, with service providers, will actively participate in designing and developing the services they need and use.

SYSTEM TRANSFORMATION: Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. Fundamental components of recovery include: self direction; holistic, strengths-based and individualized and person-centered approaches to care; empowerment of service users; peer support; respect; responsibility; and hope. Objectives outlined in this domain/priority area are intended to engage and embrace the contributions of consumers, youth and family members in the process of promoting informed choice of services and moving CT's mental health service delivery system toward individual self-determination.

Consumer, Youth and Family Involvement Timeline



NEW FREEDOM COMMISSION GOAL / END OUTCOME
Mental Health Care Is Consumer and Family Driven.

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: In their work in the early phases of CT's transformation process, a very passionate and committed group of consumers, youth representatives, family members and provider stakeholders served on Work Group 2 (Mental health care is consumer and family driven) and firmly stated that in order to achieve a transformed mental health system, there needs to be a strong consumer base of advocacy and self-promotion. A critically important aspect of this first step is the development of a structure that supports this vision - one that promotes a high degree of collaboration both within the existing mental health advocacy structure but also extends beyond to include partnerships with funders and providers of mental health care. The overall aim of this vision is the empowerment of consumers to be well-informed of their choices and possibilities beyond those presently available.

OBJECTIVE CYF 1: Establish an independent consumer-run organization comprised of advocacy organizations that is integral to program evaluation and continuous quality improvement of treatment and support services by further orienting the mental health system towards recovery-based care.

Begin Date: October 2007
Impact: Improved accountability and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2008/2009

- 1) By March 2008, develop and execute a Memorandum of Agreement (MOA) with Partners forming Coordinating Center in answer to RFP (GPRA 4).
- 2) By September 2009, create a statewide consumer, youth, and family (CYF) continuous quality improvement - collaborative (QuIC) (GPRA 4, 6).
- 3) By September 2009, 100 new CYF members will join the QuIC (GPRA 6).
- 4) By September 2009, create a CYF Central Coordinating Council (GPRA 4, 6).

Action Item	Parties Responsible	Completion Date	Status
Issue a Request for Proposals (RFP) to contract with a Coordinating Center for the purpose of creating and managing the Consumer, Youth and Family Collaborative	DMHAS staff	August 2008	Completed

Develop and execute a Memorandum of Agreement (MOA) with Partners forming Coordinating Center in answer to RFP	NCRMHB With Partners (Advocacy Unlimited, NAMI-CT, FAVOR, Regional Mental Health Boards (RMHBs))	March 2008	Completed
Identify and convene state, regional, and local consumer, youth, and family advocacy organizations to discuss the formation of the Consumer, Youth, and Family Collaborative	Coordinating Center	September 2008	Completed
Recruit CYF and other stakeholders to join the Consumer, Youth, and Family Collaborative and develop process to continuously recruit and add new CYF members to serve on CYF Collaborative for duration of grant	Coordinating Center	September 2008	Completed
Develop a CYF statewide leadership group (hereafter referred to as the Central Coordinating Council or CCC) with the role of ensuring a CYF-driven process and decision making	Coordinating Center	July 2009	Completed
Establish schedule for regular CCC meetings, monthly or more frequently if needed, to guide process	Coordinating Center	July 2009	Completed

Project Year 2007/2008 Progress: The purpose of the Quality Improvement Collaborative (QulC) is the promotion of choice and self-determination of appropriate, quality, mental health services based upon a consumer, family, youth driven performance measurement and continuous quality improvement process. In January 2008, a Request for Proposals (RFP) was released seeking a coordinating center to lead this effort. A consumer-majority review committee awarded the contract for the coordinating center to the North Central Regional Mental Health Board who will partner with Advocacy Unlimited (AU), four additional regional mental health boards, FAVOR, a DCF funded family advocacy agency, and NAMI-CT.

The purpose of the Coordinating Center is to provide logistical and other supportive services in the development and ongoing management of the Consumers/Youth/Family (C/Y/F) Quality Improvement Collaborative. The goals of the Collaborative include:

- 1) Establishing a consortium of stakeholders who access, advocate or fund mental health services for adults and children and their families for the purpose of directing the objectives of the C/Y/F Quality Improvement Collaborative.
- 2) Developing performance measures that are consumer- (children, adolescents, and adults) and family-focused and that are based upon a recovery/resiliency-oriented system of care.
- 3) Assessing the capacity of state agencies and other organizations funding or providing mental health services to conduct a continuous quality improvement process that is fundamentally consumer/youth/family driven.

- 4) Designing and implementing an information dissemination process based upon evaluative information obtained through qualitative and quantitative continuous quality improvement methods that is consumer and family friendly.
- 5) Exploring funding opportunities to expand and sustain the C/Y/F Quality Improvement Collaborative beyond the MHT-SIG grant.

Project Year 2008/2009 Progress: As of June 2009, over 450 consumers, youth, and family members have been involved with the QuIC. The overwhelming interest to participate prompted the Coordinating Center Partners to expand their organizational structure to include the Central Coordinating Council (CCC), a statewide leadership group consisting of consumers, youth and family ages 16 to 60 who receive services from both public and private providers. In February 2009, 60 individuals attended the first meeting of the CCC to receive training in continuous quality improvement (CQI) and begin developing CQI standards for consumer, youth, and family involvement. Spanish translation services were provided at the meeting. The demographic composition of the CCC is:

- Gender: 67% male; 33% female;
- Race/Ethnicity: 60% Caucasian, 25% African-American, 15% Latino / Hispanic;
- Consumers: 32% adult, 12% young adults (ages 18-25), 5% youth; and,
- Family members: 30% youth, 16% adult, 5% young adult

The CCC in collaboration with the Coordinating Center, Providers, CYF Collaboratives and State Agencies is responsible for developing draft standards, performance measures and disseminating reports and plans, and will continue to meet on a monthly basis. Together these groups serve as the QuIC infrastructure.

ALL ACTION ITEMS ASSOCIATED WITH THIS OBJECTIVE HAVE BEEN COMPLETED

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Mental Health Care Is Consumer and Family Driven.

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: Work Group members, early on in the MHT-SIG process, articulated several key factors that should guide the development of a recovery/resiliency-oriented; consumer/youth/family- focused performance measurement and continuous quality improvement system. They are:

- The survey process should be only one component of each provider (State, public and private) agency's system of accountability supported by a continuous quality improvement (QuIC) process. Commitment to a process of consumer/youth/family satisfaction surveys implies planning for ongoing change based on continual feedback.
- Sustainability of such processes must be a consideration, and therefore, an understanding of the current level of commitment to a QuIC process based upon consumer, youth and family input, and ongoing involvement is critical. In the end, such a

process of system change will permit real transformation to occur only if consumers and those that support consumers participate routinely in quality improvement activities.

- System assessment is different than individual/family service assessment and requires a different survey approach. Therefore, advocacy organizations and organized family and consumer groups should be surveyed about systemic issues since they have familiarity with navigating the service system.

OBJECTIVE CYF 2: Develop a continuous quality improvement process that is consumer/youth/family-driven in which resilience and recovery-oriented performance data are used to inform service delivery.

Begin Date: July 2008
Impact: Improved accountability and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2008/2009

- 1) By September 2009, 100 consumer, youth, and family members will be trained in continuous quality improvement methods (GPRA 2).
- 2) By September 2009, standards for CYF involvement in CQI at the individual, agency, and system-level will be finalized (GPRA 1).

Project Year 2009/2010

- 1) By September 2010, 100 consumer, youth, and family members will be trained in methods of assessing recovery/resiliency-oriented mental health services (GPRA 2).
- 2) By September 2010, two agencies will establish policies and/or procedures for CYF involvement in CQI or the assessment of recovery/resiliency-oriented mental health services as created by the QuIC (GPRA 1, 4, 5).

Action Item	Parties Responsible	Completion Date	Status
Develop and implement initial training for Collaborative members on QuIC project, standards, performance measures, and continuous quality improvement methods	Coordinating Center, Yale University Program for Recovery and Community Health (Yale PRCH)	November 2008	Completed
Develop Draft Standards for CYF involvement in CQI at the individual, agency, and system level based upon input from QuIC and review of standards across the country	Coordinating Center, Yale PRCH	March 2009	Completed

Develop and implement training for CCC members regarding review of Draft Standards for CYF involvement in CQI at the individual, agency, and system levels	Coordinating Center, Yale PRCH	June 2009	Completed
CCC members finalize and approve draft Standards for CYF involvement in CQI at the individual, agency, and system level	CCC	July 2009	Completed
Develop and implement training to prepare CCC members to review the Draft Performance Measures for CYF involvement in CQI at the individual, agency, and system levels	Coordinating Center, Yale PRCH	July 2009	Completed
Develop Draft Performance Measures for the CCC's approved Standards for CYF involvement in CQI at the individual, agency, and system level	Coordinating Center, Yale PRCH	July 2009	Completed
CCC members finalize and approve performance measures for CYF involvement in CQI at the individual, agency, and system level	CCC	August 2009	Completed
Finalize instruments to conduct survey based on established performance measures	CCC	August 2009	Completed
Train CYF to administer the final evaluation instrument	Coordinating Center, Yale PRCH	September 2009	On-target
Develop a process for conducting surveys with two state agencies, their providers, and consumers and family members	Coordinating Center, CCC	October 2009	On-target
Conduct assessment of CYF involvement in CQI	Coordinating Center, CCC, Yale PRCH	November 2009	On-target
Develop report describing results of agency assessment	Coordinating Center, CCC, Yale PRCH	December 2009	On-target
Disseminate report of results via multiple methods (including print, electronic methods, and website, use of libraries, large group meetings, etc)	CCC	January 2010	On-target
Develop and implement training to CCC on methods and instruments for CYF to assess quality of recovery/resiliency-oriented mental health services	Coordinating Center, Yale PRCH	January 2010	On-target
Select survey instrument to assess quality of recovery/resiliency-oriented mental health services	CCC	March 2010	On-target
Identify a sample of agencies in each of five geographic service areas willing to participate in an assessment of the quality of recovery/resiliency-oriented mental health services	CCC	April 2010	On-target
Train CYF to administer the survey	CCC, Yale PRCH	April 2010	On-target

Administer survey using trained peer surveyors or interviewers to assess recovery/resiliency based quality of services	Coordinating Center, CCC, Yale PRCH	May 2010	On-target
Develop report describing results of agency assessment	Coordinating Center, CCC, Yale PRCH	September 2010	On-target
Disseminate report of results via multiple methods (including print, electronic methods, and website, use of libraries, large group meetings, etc)	CCC	September 2010	On-target

Project Year 2007/2008 Progress: The effort to implement a consumer youth and family developed and implemented quality assurance measure continued to be overseen by workgroup participants in 2007-08. Accomplishments include:

- The development, release and review of a RFP to identify a program or programs to coordinate and be accountable for the establishment of a collaborative group of consumer, youth and family organizations and individuals to carry out the goals of the project.
- In the early summer of 2008, a successful applicant was selected by a RFP review committee with a majority of consumer and family member participants.
- The Coordinating Center sponsored a successful kick off event in September 2008 and has begun to engage consumers, youth and families and other stakeholders to assess the capacity of organizations to adopt the QuIC process.

Project Year 2008/2009 Progress: With the QuIC structure established as described in CYF 1, a number of trainings were provided to QuIC members regarding continuous quality improvement and principles of consumer, youth, and family involvement. The Coordinating Center and the Central Coordinating Council worked with multiple stakeholders to conduct a national review of standards for continuous quality improvement. Based on their review as well as feedback from stakeholders, a set of standards for consumer, youth and family involvement in the continuous quality improvement process was drafted. The standards are aligned within four domains: Consumer and Youth; Family Member; Agency; and System. Survey Instruments were developed for each domain. Thirty consumers, youth and family members were trained to administer the survey. As of late September 2009, more than 200 consumer surveys were conducted. The QuIC will compile and analyze the results and disseminate a report of the findings.

In the final year of the grant, the QuIC will replicate the process outlined above to evaluate the quality of recovery/resiliency-oriented mental health services throughout the system.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

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- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: During the 2005 legislative session, the Connecticut General Assembly passed PA 05-280 (HB 7000) “*An Act Concerning Social Services and Public Health Budget Implementation Provisions.*” Section 85 of the act called for the Commissioners of Social Services and Mental Health and Addiction Services to jointly convene a Taskforce to study the feasibility of obtaining a Medicaid Home and Community-Based Services Waiver for adults with serious mental illness being discharged or diverted from nursing home care. Such a waiver would allow the state to provide non-traditional Medicaid services to better support individuals in the community and would enable these services to become reimbursable under Medicaid.

A fiscal analysis found that the Medicaid cost neutrality requirement was met. Compared with the net cost of their nursing home stay, all five people profiled had lower Medicaid costs for each of the three years following discharge from the nursing home.

The General Assembly did support the Taskforce proposal to move forward with the federal waiver application and it is estimated that a wavier program will be implemented in FY 2009. Money was appropriated into the Department of Mental Health and Addictions Services budget to allow for this implementation and the Department of Social Services, in collaboration with the Department of Mental Health and Addiction Services, has begun the process for implementing the waiver.

OBJECTIVE CYF 3: Implement the Home and Community Based Waiver to expand Medicaid coverage to reimburse the cost of community care for selected adults with serious mental illness being discharged or diverted from nursing homes.

Begin Date: May 2007
Impact: Improved accountability and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Adults and older adults

Performance Measurement:

Project Year 2007/2008 1) Hire a Director of Older Adult Services to provide oversight of the Home and Community Based Waiver Program by December 2007 (GPRA 3, 4).
Project Year 2008/2009 1) Approval of Medicaid Home and Community Based Waiver by December 2008 (GPRA 3).
 2) Implement the WISE program to reduce the number of persons with psychiatric conditions living in nursing homes by June 2009(GPRA 4, 7).

Action Item	Parties Responsible	Completion Dates	Status
Hire a Director of Older Adult Services responsible for oversight of the Home and Community Based Waiver Program	DMHAS	October 2007	Completed
Draft application to be reviewed by the Department of Mental Health and Addiction Services and Department of Social Services Commissioners and then publish in the Connecticut Law Journal for public comment	DMHAS and DSS Commissioners	March 2008	Completed

Submit Draft application to the state legislature in accordance with newly enacted state law	DMHAS Legislative Liaison	April 2008	Completed
Revise as needed and submit application to Center for Medicare Services for review	DMHAS Senior Policy Analyst	May 2008	Completed
Receive approval of application from the Center for Medicare Services	DMHAS	January 2009	Completed
Implement the Home and Community Based Waiver Program	DMHAS	April 2009	Completed
Implement the WISE program	DMHAS	April 2009	Completed

Project Year 2007/2008 Progress: The Medicaid Home and Community-Based Services (HCBS) waiver represents an historic opportunity to divert and discharge adults with serious mental illness from Connecticut nursing homes. CT's waiver builds on two decades of work that CT has undertaken to reduce our reliance on institutional long term care services, in favor of community based services and housing supports. Significant progress toward the goals of the waiver have been realized in a very short amount of time:

- DMHAS created a position for a Director of Older Adult Services in October 2007.
- DMHAS received funding through the state to begin to evaluate individuals with behavioral health disorders who are residing in nursing homes.
- Five hundred evaluations have been done to date in project year 2007-08.
- 40 persons have been successfully moved to live with either their family or in independent living situations as a result of this effort.
- A number of social workers and a housing coordinator have been dedicated to work on this initiative.
- Achievements in systems work has resulted in diverting individuals from entering nursing homes to more appropriate, less restrictive placements.
- In March 2008, an application for the home and community-based waiver was drafted by DMHAS, DSS and Office of Policy and Management.
- In May 2008, the application for the waiver was submitted to the state legislature and was approved.
- The application was submitted to the Center for Medicaid Services (CMS) in June 2008.
- It was recently announced that the waiver has been approved.

Project Year 2008/2009 Progress: The waiver program, authorized in §1915(c) of the Social Security Act, permits the State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutional care. Waiver services complement and/or supplement services available to participants through the Medicaid State plan and other federal, state and local public programs, as well as natural supports that families and communities provide.

The Waiver will serve 216 individuals (72 new participants each year) who are currently in nursing facilities or who are at risk for this level of care. The Waiver will be operated by the DMHAS with oversight by the Department of Social Services (DSS).

In order to reduce the number of people with psychiatric conditions in nursing homes, DMHAS has initiated the WISE Program. WISE stands for **Working for Integration, Support and Empowerment**. WISE will help people with serious mental illness avoid being placed in nursing homes and will help many others with the transition back to a fulfilling life in the community. WISE services are delivered in accordance with a Person-Centered Recovery Plan developed by the program participant with his/her Recovery Team. In the six month period before the Connecticut CMHP 2009-10

official start of the WISE Program in April 2009, DMHAS staff diverted and discharged 136 people from nursing homes.

Most WISE services are provided in the home or in other community settings and focus on rehabilitation and skill building. Services include: Assertive Community Treatment (ACT); Community Support Program (CSP); Supported Employment; Peer Support; Recovery Assistant; Short-Term Crisis Stabilization; and Transitional Case Management. WISE also covers Non-Medical Transportation, Specialized Medical Equipment, and Home Accessibility Adaptations. The State of CT helps program participants find a safe, affordable place to live and supports the cost of housing for them. The implementation of the Home and Community Based Waiver supports the Recovery Model and CT's vision of a life in the community for everyone.

ALL ACTION ITEMS ASSOCIATED WITH THIS OBJECTIVE HAVE BEEN COMPLETED

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Disparities in Mental Health Services are eliminated.

- 3.1 Improve access to quality care that is culturally competent.
- 3.2 Improve access to quality care in rural and geographically remote areas.

OVERVIEW: The Department of Mental Health and Addiction Services Commissioner Policy #83 states that the concept of recovery shall be the guiding principle and operational framework for the system of care provided by the partnership of state and private agencies and consumer-run services that comprise the Department's healthcare system. Services within this system shall identify and build upon each recovering individual's strengths and areas of health in addressing his or her needs. The environment for this system shall encourage hope and emphasize individual dignity and respect.

The recovery-oriented service system shall be notable for its quality. It thus will be marked by a high degree of accessibility, effectiveness in engaging and retaining persons in care such that they can achieve the highest degree of stability and recovery, and its effects shall be sustained rather than solely crisis-oriented or short-lived. To attain this level of quality, the recovery-oriented service system shall be age and gender appropriate, culturally competent, and attend to trauma and other factors known to impact on one's recovery. Whenever possible, services shall be provided within the person's own community setting, using the person's natural supports. The service system shall help the person to achieve an improved sense of mastery over his or her condition and assist the person to regain a meaningful, constructive sense of membership in the community.

OBJECTIVE CYF 4: Integrate recovery-oriented care guidelines with principles of trauma-informed, culturally competent, gender-specific, primary medical care, and co-occurring treatment.

Begin Date: June 2007
Impact: Improved service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2008/2009 1) By September 2009, develop a comprehensive set of integrated standards for recovery-oriented care, trauma-

Project Year 2009/2010

informed cultural competence, gender-specific, primary health care, and co-occurring treatment (GPRA 1).
1) By September 2010, 100 providers will receive training in the implementation of the integrated standards for recovery-oriented care (GPRA 2).

Action Item	Parties Responsible	Completion Date	Status
Conduct an expert review of existing practice guidelines for recovery-oriented care	Yale University Program for Recovery and Community Health (Yale PRCH)	January 2008	Completed
Complete literature review on current state of knowledge in each trauma-informed, culturally competent, gender-specific, primary health care, and co-occurring disorders treatment	Yale PRCH	March 2008	Completed
Draft and integrate comprehensive guidelines that address all topic areas	Yale PRCH	April 2008	Completed
Upon approval, disseminate guidelines with a letter from the DMHAS Commissioner	Yale PRCH	September 2009	Revised
Develop and disseminate web-based training on implementation of the revised guidelines	Yale PRCH	September 2010	On-target

Project Year 2007/2008 Progress: The Yale Program for Recovery and Community Health (PRCH) submitted a draft of the revised guidelines to the DMHAS commissioner for approval. This new version of the *Practice Guidelines for Recovery-Oriented Behavioral Health Care* integrates trauma-informed care, culturally-competent, gender-informed practice, primary health care, and co-occurring disorders treatment.

PRCH continues to work with the DHMAS Office of the Commissioner on developing recovery-oriented practice indicators that are aligned with the revised practice standards and will become part of routine data collection.

Project Year 2008/2009 Progress: The plan for the first year of implementation of the new edition of the DMHAS Practice Guidelines is to distribute the guidelines to each of the state-operated and private non-profit agencies funded by DMHAS along with a letter that emphasizes that implementation will begin in a focused way with the third domain, that of person-centered care. This will allow agencies to consolidate their efforts on implementing the practice guidelines with the efforts that are already underway through the Centers for Medicare and Medicaid person-centered care planning grant. Training and technical assistance are being provided to state-operated agencies on the implementation of person-centered recovery planning in conjunction with the roll out of the electronic Recovery Management System. The effort to implement person-centered care will be expanded to include the private non-profit sector, and person-centered care planning will be framed as the cornerstone to recovery transformation at the level of the individual service recipient and his or her family.

As previously stated, the Commissioner of the Department of Mental Health and Addiction Services retired from state service. Once a successor has been appointed, the dissemination of the integrated guidelines will move forward under his/her leadership.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Mental Health Care Is Consumer and Family Driven.

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: An effective infrastructure is required to promote and sustain persons in recovery from diverse cultural backgrounds in the workforce through paid employment and volunteer roles.

OBJECTIVE CYF 5: Employ persons in recovery of various ages at different agencies and organizational levels.

Begin Date: October 2007
Impact: Improved service capacity and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2008/2009 1) Increase by 50% the number of consumer/youth/family employed by state agencies by September 2010 (GPRA 4).

Action Item	Parties Responsible	Completion Date	Status
Post positions for consumer, youth, and family liaisons and representatives	DMHAS	September 2010	Revised

Project Year 2007/2008 Progress: In August 2007, the MHT-SIG welcomed to their staff a Consumer and Family Liaison to cultivate relationships between, and encourage involvement from, individuals in recovery and their families for active and meaningful participation in the Mental Health Transformation process. To date, twelve adults in recovery and family members have been hired as a direct result of Transformation.

Project Year 2008/2009 Progress: In 2008, large-scale workforce initiatives focused on preparing and supporting persons in recovery in securing and retaining employment. As part of this effort the Connecticut Recovery Employment and Consultation Service (C-RECS) will absorb and track the progress of CMHP activities related to the number of persons in recovery who become employed. For more information, see objective WD 13 in the Workforce Development section.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Mental Health Care Is Consumer and Family Driven.

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- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: Persons in recovery and family members provide unique insight and experience into the process of recovery and effective strategies for navigating systems of care and support. Employment opportunities for consumers and family members should exist at all levels in Connecticut’s mental health advocacy and service systems.

OBJECTIVE CYF 6: Offer standardized training to individuals to become recovery/peer supporters.

Begin Date: April 2008
Impact: Improved service capacity and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2008/2009 1) Train 25 individuals to become recovery/peer supporters by September 2010(GPRA 2).

Action Item	Parties Responsible	Completion Date	Status
Provide standardized training to individuals to become recovery/peer supporters	Focus on Recovery-United (FOR-U), Yale University Program for Recovery and Community Health (Yale PRCH)	September 2009	Completed

Project Year 2007/2008 Progress: Multiple statewide efforts are underway to increase the number of trained and certified persons in recovery who are uniquely qualified to assist other consumers in successfully navigating CT’s mental health service system.

- By May 2008, the Yale Program for Recovery and Community Health (PRCH) trained 15 persons in recovery as recovery supporters.
- In August 2008, the Western CT Mental Health Network was awarded funding through an MHT-SIG RFP to transform the mental health system within communities, state agency and consumer-run organizations. Western’s project resulted in the successful implementation of a 72 hour peer specialist training program completed by 26 individuals in recovery.

Project Year 2008/2009 Progress: Last year, a total of 19 new recovery supporters were trained at Yale University Program for Recovery and Community Health (Yale PRCH) in conjunction with Focus on Recovery-United (FOR-U), a statewide consumer advocacy organization. Between October 2008 and June 2009, an additional 22 adults in recovery were trained to become recovery supporters, bringing the total number of recovery supporters trained at Yale PRCH and FOR-U to 41 individuals. Of these 41 recovery supporters, seven of them received additional training to become group facilitators to enable them to train other consumers to be recovery supporters. Western CT Mental Health Network, a recipient of a MHT mini-grant trained 26 persons to become recovery supporters. Overall, 67 individuals in recovery were trained as recovery supporters at Yale PRCH, FOR-U, and the Western CT Mental Health Network.

While we continue to train people to become recovery/peer supporters, CT has taken a further step to develop a process for peer certification. During 2009, Connecticut issued an RFP to develop a statewide process to certify Peer Specialists. Efforts to certify peer supporters/specialists are captured under objective CYF 14.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

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- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: In accordance with the General Statutes of Connecticut² and other federal legislation,³ it is the policy of the Connecticut Department of Mental Health and Addiction Services (DMHAS) that all DMHAS clients be afforded the same “personal, property, and civil rights”⁴ as other citizens. These rights include, but are not limited to, the right to informed consent⁵ and the right to create Advance Directives.

² Connecticut General Statutes Section 19a-585a, *Form of document re Health Care instructions, appointment of Health Care agent, attorney-in-fact for Health Care decisions, designation of conservator of the person for future incapacity and anatomical gift*; Section 19a-576, *Appointment of Health Care agent*; Sec. 19a-577, *Form of document re appointment of Health Care agent*; Sec. 17a-541, *Deprivation of Rights Prohibited*; Sec. 17a-542, *Humane and Dignified Treatment Required*; Sec. 1-54a, *Health Care decisions*; Sec. 1-55, *General authority of agent*; Sec. 1-56, *Additional provisions authorized in form*.

³ Patient Self-Determination Act of 1991; American with Disabilities Act; Rehabilitation Act and 1992 Amendments; and Title 42- Public Health, Chapter IV- Health Care financing administration, Department of Health and Human Services, Subchapter G- Standards and certification, subpart b- administration.

⁴ Connecticut General Statute Sec. 17a-541. *Deprivation of Rights Prohibited*.

⁵ Connecticut General Statutes Section 17a-540, Informed consent is “permission given competently and voluntarily after a patient has been informed of the reason for treatment, the nature of the proposed treatment, the advantages or disadvantages of the treatment, medically acceptable alternative treatment, the risks associated with receiving the proposed treatment and the risk of no treatment.”

OBJECTIVE CYF 7: Create and implement policy and procedures on advance health care directive, including psychiatric advance directives.

Begin Date: September 2007
Impact: Improved service accountability and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2008/2009 1) Create advance health care directive policy (GPRA 1).
 2) Create procedures on advance health care directives (GPRA 1).
 3) Train 60 persons in recovery/family members and 60 providers in implementing advance health care directives including psychiatric advance directives (GPRA 2).

Action Item	Parties Responsible	Completion Date	Status
Integrate new legislation into draft policy on advance health care directives, including psychiatric advance directives	Connecticut Legal Rights Project (CLRP)	March 2008	Completed
Obtain approval for policy statement from Attorney General's office and Department of Mental Health and Addiction Services' Office of the Commissioner	CLRP	December 2008	Revised
Draft procedures on documenting, tracking, and supporting the use of advance health care directives, including psychiatric advance directives, throughout Department of Mental Health and Addiction Services system	CLRP, Yale University Program for Recovery and Community Health (Yale PRCH)	June 2009	Completed
Train providers, persons in recovery, family members on advance health care directives, including psychiatric advance directives	CLRP, Yale PRCH	September 2009	Completed

Project Year 2007/2008 Progress: New legislation has been drafted into policy on the advance health care directive. Final forms have been created and have been sent to the Attorney General's office for approval. Once final approval is received, trainings on advanced care directives will begin.

Project Year 2008/2009 Progress: A policy and procedure on advance directives has been created. Retirements in the office of the Attorney General and the Commissioner of the Department of Mental Health and Addiction Services prevented the approval of a Commissioner's level policy on Advance Directives Policy during project year 4. Training on state statutes relating to advance health care directives, including psychiatric advance directives has been provided to 292 persons across the state.

ALL ACTION ITEMS ASSOCIATED WITH THIS OBJECTIVE HAVE BEEN COMPLETED

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Mental Health Care Is Consumer and Family Driven.

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: Currently many people (consumers, family, friends, neighbors, employers, employees, etc.) in Connecticut dealing with mental illness are not aware of their rights under the Americans with Disabilities Act (ADA), the concept of recovery, self directed care or the importance of advance directives for mental health care emergencies.

OBJECTIVE CYF 8: Ensure compliance with the American's with Disability Act within the Department of Mental Health and Addiction Services and contracted agencies.

Begin Date: October 2007
Impact: Improved service accountability and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2008/2009 1) Revise the Department of Mental Health and Addiction Services policies related to the American's with Disabilities Act by May 2008 (GPRA 1).

Action Item	Parties Responsible	Completion Date	Status
Revise the Department of Mental Health and Addiction Services policies related to the American's with Disabilities Act.	Senior Policy Analyst	April 2008	Completed

Project Year 2007/2008 Progress: By the end of March 2008, DMHAS policies related to the Disabilities Act had been revised and submitted to the State Attorney General's office for review.

ALL ACTION ITEMS ASSOCIATED WITH THIS OBJECTIVE HAVE BEEN COMPLETED

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Mental Health Care Is Consumer and Family Driven.

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.

- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: The Psychiatric Security Review Board (PSRB) is a state agency to which the Superior Court commits persons who are found not guilty of a crime by reason of mental disease or mental defect. These individuals are called "acquittees." The PSRB's responsibility is to review the status of acquittees through an administrative hearing process and order the level of supervision and treatment for the acquittee necessary to protect the public. The Board is governed by Connecticut General Statutes, Sections 17a-580 through 17a-603.

The PSRB, at the time of commitment, takes jurisdiction over the acquittee and decides which hospital an acquittee is to be confined and when and under what circumstances an acquittee can be released into the community.

OBJECTIVE CYF 9: Assess need to propose legislative changes governing the Psychiatric Security Review Board.

Begin Date: September 2007
Impact: Improved service accountability and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2007/2008 1) Report of legislative review for Psychiatric Security Review Board by October 2007 (Non-GPRA).

Action Item	Parties Responsible	Completion Date	Status
Review current legislation for Psychiatric Security Review Board	DMHAS	October 2007	Completed

Project Year 2007/2008 Progress: In October 2007, Legislation was reviewed for the Psychiatric Security Review Board. At this time, there are no proposed or anticipated changes to the statutes governing the Psychiatric Security Review Board.

ALL ACTION ITEMS ASSOCIATED WITH THIS OBJECTIVE HAVE BEEN COMPLETED

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Mental Health Care Is Consumer and Family Driven.

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: Persons receiving services in acute care settings experience issues unique to that treatment setting. It is important that patients in all acute care settings are aware of their rights

and of how to access them. Persons in recovery possess first-hand knowledge of this, making them uniquely qualified to translate patients' rights into language/words that are more readily understood.

OBJECTIVE CYF 10: Ensure that persons in recovery, particularly those in acute care settings have access to information and understand their rights.

Begin Date: September 2007
Impact: Improved service accountability and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2007/2008 1) Revise document outlining and explaining patients' rights based on feedback from persons in recovery by September 2007 (GPRA 1).

Action Item	Parties Responsible	Completion Date	Status
Persons in recovery will lead a process to rewrite the Patients Rights Booklet available at Connecticut Valley Hospital.	DMHAS	September 2007	Completed

Project Year 2007/2008 Progress: Patients at CT Valley Hospital completed the rewriting of the Patients' Rights Booklet according to the scheduled completion date.

ALL ACTION ITEMS ASSOCIATED WITH THIS OBJECTIVE HAVE BEEN COMPLETED

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Mental Health Care Is Consumer and Family Driven.

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: Consumer, youth, and family involvement must extend to evaluating system change. Participatory action research exemplifies a consumer-driven approach because individuals who are most affected by a situation (i.e., consumers and their relatives) engage in independent evaluation and research activities. Participatory action research embodies transformation because the emphasis is on change and improving situations rather than answering questions. As a result of this effort, a network of adults in recovery, youth, and families will be established to engage in participatory action research and evaluation activities.

OBJECTIVE CYF 11: Establish a network of consumer, youth, and family members who are skilled in conducting participatory action research.

Begin Date: October 2007
Impact: Increased accountability and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2008/2009

1) By September 2009, train 25 consumers, youth, and family members in research methods (GPRA 2).
 2) By September 2009, Establish the Consumer Research and Evaluation Network (GPRA 6).

Project Year 2009/2010

1) By September 2010, train an additional 15 consumers, youth, and family members in research methods (GPRA 2).
 2) By September 2010, 15 consumers, youth, and family members are employed to conduct research and evaluation (non-GPRA).

Action Item	Parties Responsible	Completion Date	Status
Provide training in research methods (e.g., qualitative interviewing, survey construction, data analysis) to 25 consumers, youth, and family members	Yale University Program for Recovery and Community Health (Yale PRCH)	September 2009	Completed
Collaborate with the MHT Consumer, Youth, and Family Advisory Council and other consumer and family groups on developing research/evaluation projects	Yale PRCH	September 2009	Completed
Provide ongoing technical assistance to various consumer, youth, and family groups in the creation, data analysis, and dissemination of research and evaluation results	Yale PRCH	September 2009	Completed
Continue to recruit, hire, and train consumers, youth, and family members to participate in research and evaluation projects	Yale PRCH	September 2010	On-target

Project Year 2007/2008 Progress: This project aims to increase consumer, youth, and family involvement in the transformation process. The results are anticipated to promote a more resilience and recovery-oriented approach.

- A total of 10 consumers were trained in qualitative interviewing techniques. They conducted 80 interviews of people in recovery to develop the “A Day in the Life” project which described how they spend their days, how they wish they could be spending their days, and how mental health services do or do not assist them in pursuing the kind of day they would like to be having.
- In June, a group of adults in recovery who were trained in qualitative research presented the preliminary findings of the A Day in the Life project, Over 70 people attended the

presentation including representatives from DMHAS, various Catchment Area Councils, and advocacy organizations.

- The group of 8 consumers are now concluding analysis of these interviews and will be presenting the results at a meeting with the Commissioner.
- An online survey was created with input from members of the Consumer, Youth, and Family Advisory Council. The survey which was disseminated to all of the individuals who have participated in the MHT grant process will help to identify strategies for increasing consumer, youth, and family-involvement in Transformation and the mental health service system in general as well. Analysis of the survey data is underway with the assistance of a group of consumers and family members who are helping with interpreting the results and formulating recommendations.
- A Consumer Research and Evaluation Network has been formed to train consumers, youth, and family members in quantitative and qualitative research methods to assist agencies with program evaluation and other research activities. This network will also play a role evaluating other MHT activities.

Project Year 2008/2009 Progress: The Consumer/Youth/Family Research and Evaluation Network (CREN) continued to hire and train persons in recovery to participate in a number of evaluation projects. Examples from the past year include:

- Nine persons in recovery were trained in qualitative research methods to assist with analyzing focus group results and writing a final report for a cultural disparities project. A draft report was submitted to the Commissioner and Director of the Office of Multicultural Affairs at the Department of Mental Health and Addiction Services (DMHAS).
- Thirteen persons in recovery were hired and trained to assist with the Quality Improvement Collaborative (QuIC), which included developing and piloting different training materials that were subsequently used by the Central Coordinating Council (CCC) of the QuIC.
- Three persons in recovery were hired and trained in qualitative approaches to analyzing data to help evaluate mini-grant initiatives.
- Thirty members of the CREN were trained in the administration of two surveys developed by the QuIC to assess consumer, youth, and family involvement in quality improvement efforts.
- The consumer research team responsible for the "A Day in the Life" project gave several performances for a variety of audiences around the state, both within and beyond the mental health system. The team submitted an application to the Foundation for Mental Health to fund the production of a DVD of the performance. The application was positively reviewed and initial indications are that it will be funded in the Fall of 2009. Finally, an article about the project was submitted to a peer-reviewed research journal and the consumer research team and their consultant are currently negotiating a book contract with New York University Press to describe the project and its findings.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

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- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: The Substance Abuse and Mental Health Services Administration (SAMHSA) considers the involvement of people in recovery and their families to be a critical ingredient of MHT. The purpose of the Connecticut Consumer, Youth, and Family Advisory Council is to provide input to all levels of MHT and enhance its decisions, processes and outcomes by amplifying the voice of consumers, youth and families. Various MHT representatives (e.g., leadership staff, evaluators, and consumer and family liaisons) attend the monthly Advisory Council meetings. The Advisory Council participates in a variety of activities that influence the development of policies affecting the design, delivery, and evaluation of mental health services.

Objective CYF 12: Strengthen and sustain the influence of the Consumer, Youth, and Family Advisory Council in transforming the mental health system through participation in decision-making, resource allocation, and policy development.

Begin Date: October 2007

Impact: Increased accountability and service effectiveness

Ease of completion: Average/Realistic Goal

Population: Across the lifespan

Performance Measurement:

- Project Year 2007/2008** 1) Establish the Consumer, Youth, and Family Advisory Council by September 2008 (GPRA 4, 6).
- Project Year 2008/2009** 1) Develop policies and procedures for the continuation of a consumer, youth, and family advisory council beyond the scope of the MHT grant by September 2010 (GPRA 1).
- Project Year 2009/2010** 1) Increase by 50% the number of Advisory Council members by September 2010 (GPRA 6).
2) Collaborate in the creation of the Transformation Toolkit by September 2010 (Non-GPRA).

Action Item	Parties Responsible	Completion Date	Status
Meet with the MHT Chairperson and leadership staff on a quarterly basis about ways to increase and sustain consumer, youth, and family involvement in the mental health system	Co-Chairs of the Consumer, Youth, and Family (C/Y/F) Advisory Council	September 2010	On-going

Draft the Roles and Functions of the Consumer, Youth and Family Advisory Council that defines and guides their work	C/Y/F Advisory Council	September 2008	Completed
Participate in quarterly meetings of the MHT Oversight Committee	Members of the C/Y/F Advisory Council	September 2010	On-going
Meet with project directors for the major MHT initiatives on a quarterly basis to provide input on ways to increase consumer, youth, and family involvement	C/Y/F Advisory Council	September 2010	On-going
Participate in the development of messages to be used in public awareness campaigns about mental health, stigma, and recovery	C/Y/F Advisory Council	January 2009	Completed
Expand the membership and diversity of the Advisory Council to broaden its influence on local systems of care	C/Y/F Advisory Council	April 2009	On-going
Develop participatory action research projects to enhance consumer, youth, and family involvement across the state	C/Y/F Advisory Council	September 2009	Completed
Collaborate in the development of a Transformation Toolkit about promoting a recovery- and resiliency-oriented, consumer and family-driven system	C/Y/F Advisory Council, Yale University Program for Recovery and Community Health	September 2010	On-target

Project Year 2007/2008 Progress: This is a new objective added to the CMHP during 2007-08. The Advisory Council met each month with much of its time during the past year devoted to discussions about what “consumer-driven” means in relation to the MHT grant and system change. These deliberations culminated in consulting the definition and principles of consumer-driven care that are proposed by the Substance Abuse and Mental Health Services Agency (SAMHSA) and meeting with individuals from Yale PRCH and MHT leadership to consider how the Advisory Council sees its role in Transformation. The Consumer, Youth and Family Advisory Council Roles and Functions document was drafted and accepted by the Oversight Committee in September 2008. Members of the Council also participated in the strategic planning meeting with the advertising consultants for the social marketing campaign as well as served on the review committees for the mini-grant process described at the end of this document.

Project Year 2008/2009 Progress: The Advisory Council continued to provide input at multiple levels in the MHT process over the past year. These include:

- Meeting with MHT leadership on a quarterly basis.
- Participating on conference calls with representatives of other Transformation states.
- Assisting with an evaluation project resulting in a report regarding meaningful involvement of consumers, youth, and families in MHT projects.
- Participating as voting members during decisions regarding possible budget changes and resource allocation.

Representatives from the Department of Correction and Judicial Branch, as well as specific MHT initiatives (e.g., the Quality Improvement Collaborative, QuIC) met with the Advisory Council to discuss consumer, youth, and family involvement. The Advisory Council has

reviewed various state-mandated boards and councils as they consider increasing membership, and look to potential linkages for sustainability.

The Advisory Council will work in collaboration with the Yale Program for Recovery and Community Health on developing a Consumer, Youth, and Family Transformation Toolkit. This Toolkit will document the transformation process to date, highlighting those interventions that have been the most effective in promoting a resiliency and recovery-oriented, consumer and family-driven system, and will provide various tools for the ongoing education and empowerment of other consumers, youth, and families around the state. Following completion of the Transformation grant, the Toolkit will be useful in educating other states around the country about Connecticut's experiences.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Mental Health Care Is Consumer and Family Driven.

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- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: The Connecticut Department of Mental Health and Addiction Services (DMHAS) has taken significant and important steps to address the needs of young adults, ages 18-25, with serious mental illnesses. Experience with and analysis of the young adult treatment and service systems continues to give us very useful information and direction regarding needed services, infrastructure, and process improvements. In October 2007, DMHAS successfully leveraged the federal Center for Mental Health Services (CMHS) **Alternative to Restraint and Seclusion State Incentive Grant (ARS SIG)** funds to conduct a strategic planning process to develop and implement a comprehensive strategy to reduce, and ultimately eliminate, use of restraint and seclusion among young adults, ages 18-25, with serious mental illnesses.

OBJECTIVE CYF 13: Reduce, and ultimately eliminate, the use of restraint and seclusion within DMHAS' two psychiatric hospitals: Connecticut Valley Hospital and Cedarcrest Hospital.

Begin Date: January 2008
Impact: Increased service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2008/2009

- 1) By September 2009, the reduction, and ultimate elimination, of seclusion and restraints will be incorporated into policies and procedures (GPRA 1).
- 2) By September 2009, train 300 people in the provision of trauma-informed care (GPRA 2).

Project Year 2009/2010

- 1) By September 2010, implement changes in policies and procedures that promote a recovery and trauma-informed environment (GPRA 4).
- 2) By September 2010, implement enhanced assessment and treatment practices that incorporate individualized sensory-modulation techniques (GPRA 7).
- 3) By September 2010, restraint and seclusion events will be reduced by 30% at CVH and Cedarcrest (GPRA 5, 7).
- 4) By September 2010, train an additional 300 people in the provision of trauma-informed care (GPRA 2).
- 5) By September 2010, permanent changes will be made to inpatient units to create more recovery-oriented and trauma-informed physical environment (GPRA 4).

Action Item	Parties Responsible	Completion Date	Status
Engage in a strategic planning process to develop a comprehensive strategy to reduce, and ultimately eliminate, the use of restraint and seclusion among young adults with serious mental illnesses served by DMHAS' two psychiatric hospitals	MHT Staff	July 2008	Completed
Conduct a high quality process evaluation to determine the stakeholders' level of satisfaction with the strategy development process and results	Project Evaluation Team	September 2010	On-going
Implement the comprehensive Strategic Plan across the two targeted psychiatric hospital intervention sites	MHT Staff	September 2010	On-going
Train staff in trauma-informed care	CVH and Cedarcrest	September 2010	On-going
Create "comfort rooms" within each unit	CVH and Cedarcrest	September 2010	On-going
Review and modify all formal and informal policies at CVH to make more recovery-orientated	CVH	September 2010	On-going
Implement the use of person-centered, sensory-modulation tools and techniques	CVH and Cedarcrest	September 2010	On-going

Project Year 2007/2008 Progress: Both Connecticut Valley Hospital (CVH) and Cedarcrest Hospital have been engaged in assessing their hospital's capacity for providing trauma informed services. This process involves specific focus on assessing each individual admitted for services for any history of trauma, staff knowledge and training in a trauma informed approach and redesign of the physical environment. The Alternative to Restraint and Seclusion Grant provides the framework in which to do this work. Using the Six Core Strategies, both hospitals have drafted a strategic plan that is currently undergoing revision based on the recommendations received in a consultation site visit by representatives from NASMHPD.

Project Year 2008/2009 Progress: Significant changes have occurred at both Connecticut Valley and Cedarcrest Hospitals over the past year. Highlights include:

- Creating a Committee, including consumer participation at each facility that specifically addresses the prevention of violence and adoption of a trauma informed approach to services.
- Internal marketing and staff recognition programs that reinforce positive behaviors and interactions and promote culture change.
- The design and implementation of comfort rooms and use of sensory tools to promote appropriate treatment approaches in the prevention of violence and use of seclusion and restraint.
- Approximately 30 staff from both units have received training from the National Education and Training Institute.
- CVH formal and informal policies have been reviewed and revised including the hospital mission statement.
- 248 supervisors and 1,040 direct care staff received training in trauma-informed approaches.
- 23 direct care staff at Cedarcrest Hospital received additional training in sensory modulation techniques.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Mental Health Care Is Consumer and Family Driven.

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: Recovery University is a 60-hour advanced training and certification program funded by the CT Department of Mental Health and Addiction Services for persons in recovery from psychiatric disabilities and co-occurring disorders. Upon successful completion of the course and the certification examination, graduates will be state certified as Recovery Support Specialists (RSS), Peer Delivered Services. There are two new Medicaid initiatives that offer employment opportunities for people who become certified RSS workers.

OBJECTIVE CYF 14: Develop the Recovery University to train and certify recovery support specialists and peer-delivered services.

Begin Date: April 2009
Impact: Increased service effectiveness
Ease of completion: Average/Realistic Goal
Population: Adults

Performance Measurement:

Project Year 2008/2009 1) By September 2009, 40 persons in recovery will be trained and certified (GPRA 2).
Project Year 2009/2010 1) By September 2010, an additional 50 persons in recovery will be trained and certified (GPRA 2).

Action Item	Parties Responsible	Completion Date	Status
Issue RFP for peer certification process	DMHAS	May 2008	Completed
Select contractor based on competitive bidding process	DMHAS	October 2008	Completed
Develop a curriculum to be used by Recovery University	Advocacy Unlimited	July 2009	Completed
Initiate session 1 training to persons in recovery interested in becoming certified peer specialists	Advocacy Unlimited	July 2009	Completed
Administer certification exam for students who completed session 1 classes	Advocacy Unlimited	September 2009	Completed
Begin session 2 classes	Advocacy Unlimited	November 2009	On-target
Administer certification exam for students who completed session 2 classes	Advocacy Unlimited	December 2009	On-target

Project Year 2008/2009 Progress: In 2009, DMHAS awarded Advocacy Unlimited a grant to develop a curriculum and exam to certify persons with psychiatric disabilities and co-occurring disorders as Recovery Support Specialists (RSS). The Recovery University is a free ten week, 60-hour training course created and taught by AU to prepare peers for the Certification Exam. Competency areas include:

- Effective, Empathetic Communication Skills
- Legal and Ethical Practice, Boundaries, Client Rights
- Introduction to Mental Health, Substance Abuse, and Co-Occurring Disorders
- Principles of Psychiatric Rehabilitation
- Medicaid Mental Health Waiver/Money Follows the Person
- Using Your Recovery Story, Role of Peer Supports on Teams, Recovery Culture
- Role Challenges, Conflict Resolution, Self Care
- Recovery Planning and Documentation
- Entitlements and Benefits Management
- Cultural Awareness

The first cohort of 42 Recovery University Graduates sat for the certification examination in September 2009.

There are two new Medicaid initiatives in CT that will offer employment opportunities for people who become certified RSS workers. These initiatives include:

- Mental Health Waiver (also called the WISE Program) – This DMHAS-operated program is designed to help divert and discharge people with serious mental illness from nursing homes. The initiative will need RSS staff to work in three (3) types of programs. The first two program types involve a team approach to supporting people in recovery -- these are Assertive Community Treatment (ACT) teams, and Community Support Program (CSP) teams. RSS staff would work alongside other team members. The third type of care that will require RSS workers in the WISE Program is called “Peer Support.” Peer Support will be provided as a “step-down” after a person is discharged from an ACT or CSP team. In each of these three (3) programs (i.e., ACT, CSP and Peer Support), RSS workers would receive supervision from a licensed clinician.

- Money Follows the Person (MFP) – this Medicaid program is operated by the Department of Social Services (DSS) and is also designed to help discharge people with mental illness from nursing homes. MFP will pay for the same types of services provided by RSS workers as the WISE Program.

The certification process is a critical step in moving toward consumer driven services in CT. DMHAS will continue to offer training classes using the curriculum initially developed by Advocacy Unlimited and revised based on feedback from the first cohort of Recovery University students. Advocacy Unlimited will retain the responsibility for administering the certification exam.

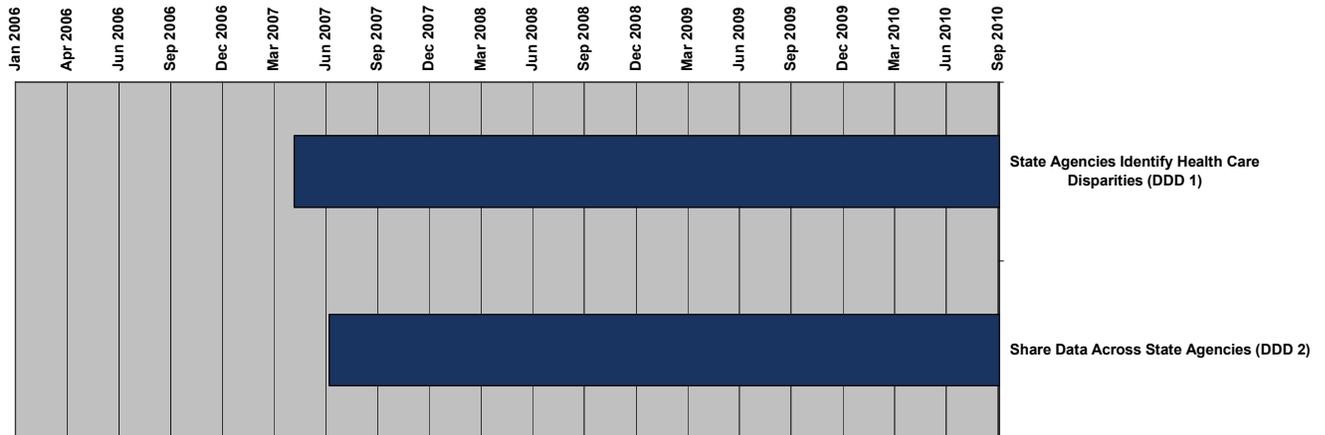
DATA-DRIVEN DECISIONS (DDD)

DESCRIPTION: Data driven decision making was highlighted in early transformation efforts by Workgroup # 3. As part of their process in identifying recommendations for change that would result in the elimination of mental health disparities, the group began to develop data variables related to diverse groups including ethnicity, age, gender and those impacted by trauma. They proposed investing in an infrastructure that would link state agencies, the judicial branch, providers and payers to allow for a variety of analyses to be conducted on client demographic, performance and outcome data.

Standardized collection of demographic data such as race and ethnicity, age, and gender, will increase the capacity to conduct analyses and track performance and outcome data for clients who have received services in multiple state systems. An additional benefit is that database users will be able to explore a wide range of questions related to disparities and will be able to explore more general questions related to client service utilization and outcome patterns.

SYSTEM TRANSFORMATION: Investing in an infrastructure that links state agencies, the judicial branch, providers and payers to allow for a variety of analyses to be conducted on client demographic, performance and outcome data will improve system accountability and effectiveness. Standardized collection of demographic data such as race and ethnicity, age, and gender, will increase the capacity to conduct analyses and track performance and outcome data for clients who have received services in multiple state systems.

Data Driven Decisions Timeline



NEW FREEDOM COMMISSION GOAL / END OUTCOME

Disparities in Mental Health Services are eliminated.

- 3.1 Improve access to quality care that is culturally competent.
- 3.2 Improve access to quality care in rural and geographically remote areas.

OVERVIEW: MHT staff, with representatives from the Department of Social Services' (DSS) Medicaid Infrastructure Grant (MIG), Connecticut Office of Workforce Competitiveness and the Governor's Early Childhood Education Cabinet have been meeting to address data interoperability issues. It is the intent of this group to identify and pool resources across agencies and initiatives to fund and further advance data sharing opportunities. Aggregate and individual-level data will enable analyses on key client demographics. Performance and outcome data within and across agencies and State systems, will provide a clearer understanding of: 1) the systemic correlates of behavioral health disparities; 2) the effectiveness of interventions in eliminating disparities and increasing systems cultural competence; and, 3) ways in which data can be used to inform policy development and cross-system, cross agency interventions to eliminate behavioral health disparities.

OBJECTIVE DDD 1: State agencies will identify health care disparities according to age, gender, and race/ethnicity.

Begin Date: May 2007
Impact: Improved accountability, service capacity, and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2008/2009

- 1) By September 2010, develop guidelines for the uniform collection of demographic variables (GPRA 1).
- 2) By September 2010, seven state departments collect and analyze demographic data to identify disparities in care (GPRA 5).

Action Item	Parties Responsible	Completion Date	Status
Establish the Data Interoperability work group	MHT Staff	August 2007	Completed
Meet with Commissioners from state agencies to establish the level of commitment to the data interoperability process	MHT Staff	January 2008	Completed
Identify data requirements and reports needed to determine where disparities exist	Data Interoperability WG	June 2008	Completed
Identify business requirements for information system	Data Interoperability WG	September 2010	Initiated

Implement a pilot to share employment related data amongst the DMHAS, Department of Social Services' Bureau of Rehabilitation Services (BRS) and the Department of Developmental Services	Data Interoperability WG	August 2008	Completed
Develop and distribute an inventory questionnaire to various state agencies to determine which demographic variables are currently collected and required	Data Interoperability WG	September 2008	Revised
Disseminate findings of the pilot data sharing with state agency Commissioners	Data Interoperability WG	October 2008	Completed
Hire a full-time project manager	Data Interoperability WG	July 2009	Completed
Review other state agency data sharing projects for possible collaboration	Data Interoperability WG	October 2009	Initiated
Identify additional members needed to participate in the Workgroup	Data Interoperability WG	October 2009	Initiated
Develop guidelines regarding uniform collection of demographic variables across state agencies	Data Interoperability WG	September 2010	Initiated

Project Year 2007/2008 Progress: CT is fortunate to have multiple inter-agency stakeholders that not only recognize the benefits of data interoperability, but support and are willing to share responsibility for carrying out data interoperability efforts. Many short term goals have been realized and steps toward achieving long term goals in place including:

- The Data Interoperability workgroup was created with members from the DSS Bureau of Rehabilitation Services (MIG staff), Office of Workforce Competitiveness, Early Childhood Education Cabinet, and MHT-SIG. The group met consistently throughout project year 2007-08.
- In March and again in August, the Data Interoperability work group hosted a meeting with Commissioners to present recommendations identified by the Public Consulting Group (PCG) and to elicit support and input for initiating next steps.
- The Department of Information Technology (DOIT), a member of CT's MHT-SIG Oversight Committee, completed and presented a plan to address four business questions through the sharing of data to work group members.
- Demographic variables were identified.

Project Year 2008/2009 Progress: The Departments of Mental Health and Addiction Services (DMHAS), Developmental Disabilities (DDS), Social Services (DSS), and the Bureau of Rehabilitation Services (BRS) signed a Memorandum of Agreement to participate in a data interoperability pilot study. In October 2008, the preliminary results from the data interoperability pilot study were presented to Commissioners of and/or representatives from approximately 10 state agencies. A request for additional analyses was made at the Commissioners' meeting to assist with future strategic planning regarding data interoperability. In depth review was conducted on a sample of records pertaining to individuals who received services from all three

agencies during a specified period. This review demonstrated the lack of coordination and communication between agencies ultimately resulting in a delay of needed services and in some cases a lack of engagement in services. In addition, the business questions were unable to be answered fully based on the limitations of our current data and data systems.

A full time Project Manager was hired using funds from the MHT Grant and the Medicaid Infrastructure Grant (MIG) who will oversee the ongoing implementation of this complex initiative. Since the inception of the data interoperability project, several other projects related to data sharing have begun or have continued their work. In the Fall of 2009, the Project Manager will gather information related to other data sharing initiatives to determine whether or not it is feasible and/or appropriate to collaborate.

Lastly, this project has received the full support of the Commissioner's of the Departments of Social Services and Mental Health and Addiction Services. In July of 2009, both of these individuals announced their intent to retire from State Government in the Fall of 2009. It is unclear at this time what if any impact this will have on the data interoperability project.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Technology is used to access mental health and information.

- 6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
- 6.2 Develop and implement integrated electronic health record and personal health information systems.

OBJECTIVE DDD 2: Data is shared across state agencies to identify needed system change.

Begin Date: July 2007
Impact: Improved accountability, service capacity, and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2007/2008 1) Of the 14 state departments and judicial branch, 3 will adopt new Memorandums of Agreement to share data with one another by September 2008 (GPRA 4).

Action Item	Parties Responsible	Completion Date	Status
Coordinate with other state agencies and initiatives also exploring data sharing options such as those associated with the Medicaid Infrastructure Grant	MHT Staff	September 2010	Revised
Explore federal and state laws and regulations that pose a barrier or limit opportunities for data sharing	Department of Social Services Medicaid Infrastructure Grant (MIG) staff	February 2008	Completed

Gather information about existence of current inter-agency Memorandum of Agreement regarding data sharing	MHT and MIG staff	March 2008	Completed
Adopt new Memorandum of Agreement regarding sharing of data	Data Interoperability WG with state agencies	September 2008	Completed

Project Year 2007/2008 Progress: After the project received consultation from the Public Consulting Group (PCG) and presented findings to the Commissioners, the focus of the Data Interoperability Workgroup was solidified to be the identification of Health Care Disparities and sharing of data across state agencies. To achieve this, a pilot program has been initiated to answer key questions about individuals who receive services from DMHAS, the Department of Developmental Services (DDS), and the Bureau of Rehabilitative Services (BRS). The analysis of 'population caseload overlap' will include information about the characteristics of individuals and the presence of possible disparities.

- PCG analyzed and made recommendations for CT's next steps toward data interoperability based on state and federal regulations re: data sharing in February 2008.
- In March 2008, PCG and the Data Interoperability work group completed an assessment of existing data sharing agreements between CT state agencies.
- An agreement was reached for three state agencies (the Departments of Developmental Services, BRS and DMHAS) to implement a pilot to develop data collection and sharing guidelines and to collect and share data relative to variables identified by the data interoperability workgroup.
- Preliminary plans have been made to begin holding quarterly meetings between Data Interoperability Group and Commissioners.
- Next steps include MHT staff continuing to work with the goal of signing Memorandums of Agreement (MOA) between the state agencies for which the anticipated completion date has changed from June to September.

Project Year 2008/2009 Progress: A Memorandum of Agreement between the Department of Social Services, Bureau of Rehabilitation Services, the Department of Development Services and the Department of Mental Health and Addiction Services was signed in September of 2008. The purpose of the MOA was to allow data to be shared for the purposes of conducting the data sharing pilot described above. Continued progress in this area will be tracked in DD1.

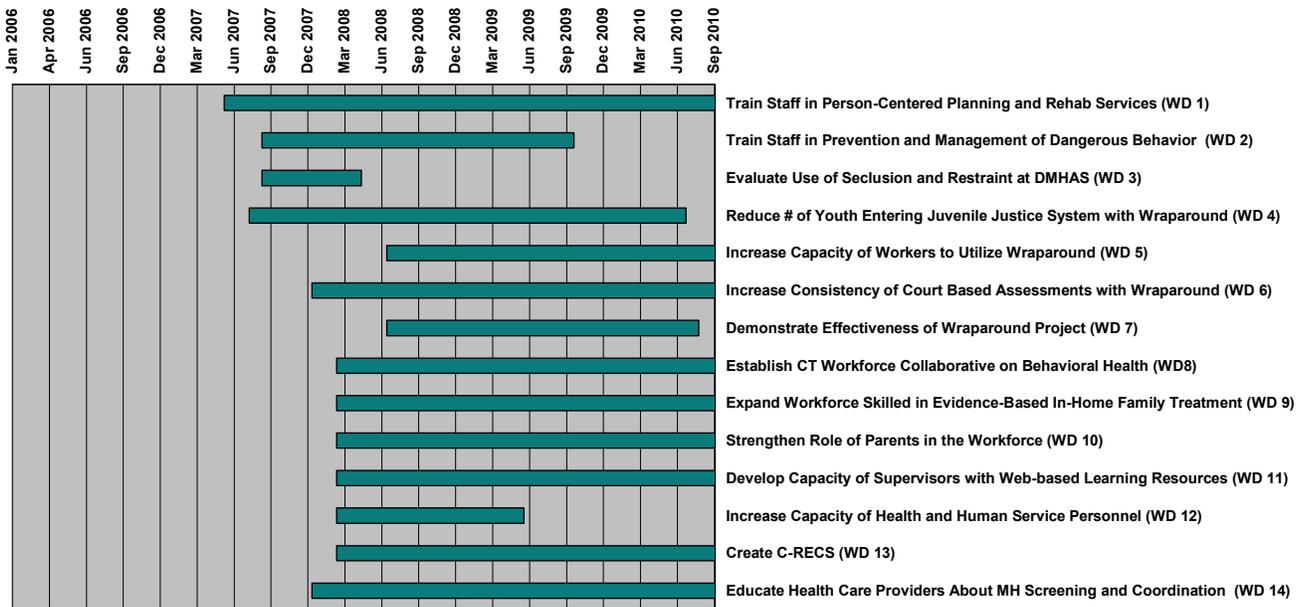
WORKFORCE DEVELOPMENT (WD)

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

SYSTEM TRANSFORMATION: In its final report, the New Freedom Commission identified workforce development as an essential element of sustainable reform and a critical vehicle for achieving the transformation of current systems of care. Connecticut's MHT-SIG Workforce efforts will address many of the crises described by the New Freedom Commission including:

- Recruitment and retention of qualified employees, particularly in the private, non-profit sector;
- The critical shortage of personnel trained and skilled in caring for special populations such as children and the elderly;
- Increased diversity and cultural competence of staff relative to service populations;
- Training behavioral health staff in recovery-oriented approaches to care.

Workforce Development Timeline



NEW FREEDOM COMMISSION GOAL / END OUTCOME

Mental Health Care Is Consumer and Family Driven.

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: Transforming the staffing structures, composition and proficiencies of the behavioral health workforce is fundamental to the greater task of transforming Connecticut's mental health system. A sustained effort to recruit, retain, train, supervise and support Connecticut's behavioral health workforce must be foremost among the state's priorities as it strives to improve access to compassionate and effective care.

OBJECTIVE WD 1: Enhance mental health services by training direct care staff and supervisors in person-centered planning and rehabilitative services.

Begin Date: June 2007
Impact: Improved service capacity and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2008/2009

- 1) By September 2009, train 500 direct care staff and 50 supervisors in person-centered planning, rehabilitative services, introduction to trauma-informed care, and other recovery-oriented practices (GPRA 2).
- 2) By September 2010, enhance the content and protocol of the electronic medical record (GPRA 1).

Project Year 2009/2010

- 1) By September 2010, train an additional 250 staff and 25 supervisors in person-centered planning and recovery-oriented practices (GPRA 2).
- 2) By September 2010, train 400 people in use of the Recovery Management System (GPRA 2).
- 3) By September 2010, 400 recovery plans will be implemented using the Recovery Management System (GPRA 4, 5, 7).

Action Item	Parties Responsible	Completion Date	Status
Select and refine training curriculum on person-centered planning and rehabilitative services to be offered to staff at Connecticut Valley Hospital	Connecticut Valley Hospital Leadership	October 2007	Completed
Provide training to direct care staff and supervisors at Connecticut Valley Hospital	Connecticut Valley Hospital Department of Education	December 2008	Completed

Enhance the content and protocol of the electronic medical record pilot currently underway to ensure maximum adherence to person-centered principles as outlined in the recently awarded CMS Real Choice System Change Person-Centered Planning Grant	DMHAS Director of Recovery and Community Affairs	June 2009	Completed
Train staff to use the Recovery Management System (RMS), including an electronic recovery plan	Connecticut Valley Hospital Department of Education	September 2010	Ongoing
Expand training to division-specific training focusing on an introduction to trauma informed care, alternatives to restraint and seclusion, and increasing the number of recovery-oriented groups	Connecticut Valley Hospital Department of Education	September 2010	Ongoing
Provide training in person-centered planning and recovery-oriented practices to direct care staff and supervisors across the mental health system	Connecticut Valley Hospital Department of Education and Yale Program for Recovery and Community Health	September 2010	On-going
Implement person-centered recovery treatment plans using the Recovery Management System	DMHAS facilities	September 2010	Initiated

Project Year 2007/2008 Progress: Efforts to enhance the provision of person centered and recovery-oriented care by training direct care staff at Ct Valley Hospital have been successful. In addition to the following accomplishments (which were completed ahead of schedule), the hospital has expanded plans to shift from a hospital-wide to a division-specific training process. Trainings will focus on trauma informed care and alternatives to restraint and seclusion. Efforts are also underway to increase the number of recovery-oriented groups that will take place during project year 2008-09.

- In October 2007, training curriculum in person centered planning was selected and refined.
- By May 2008, 1280 persons successfully completed the training, since then the cumulative number of people trained exceeds 1400.

In conjunction with the Person Centered Planning Grant and the Alternative to Restraint and Seclusion Grant, Connecticut Valley Hospital will begin a person-centered, recovery-planning process that is trauma informed and includes personal preferences and tools to prevent the use of restraint and seclusion. The goal is to support expansion of these efforts into the broader service system and provide consistency in approach throughout the continuum of care.

Project Year 2008/2009 Progress: Hospital-wide trainings in person centered and recovery-oriented approaches continued to be offered at Connecticut Valley Hospital. Between October 2008 and June 2009, a total of 304 supervisors and 1,250 direct care staff attended such trainings. Since these training opportunities were initiated in October 2007, the cumulative attendance has been 3,840 people. A range of recovery-oriented groups were also initiated, such as the "Sharing Our Strengths" series which included a range of topics such as art therapy,

qigong, developing resiliency, and panel discussions with patients. Collectively, these groups were attended by 138 patients and staff.

Training in person centered approaches was expanded to the service system to include outpatient Local Mental Health Authorities (LMHAs) throughout Connecticut. Between October 2008 and June 2009, a total of 1,041 individuals participated in the trainings. Individuals included diverse providers, administrators/supervisors, and persons in recovery. Similarly, staff training in an electronic person centered recovery plan (the Recovery Management System) began and was attended by 267 staff.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Mental Health Care Is Consumer and Family Driven.

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: Recently a group of staff employed at all levels, representing multiple DMHAS agencies have come together to explore current best practices related to the prevention and management of dangerous behavior.

OBJECTIVE WD 2: Provide training to direct care staff on effective prevention and management of dangerous behavior techniques.

Begin Date: September 2007
Impact: Improved service accountability and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2008/2009

- 1) Finalize curriculum to replace Behavioral Management System training by September 2009 (GPRA 1).
- 2) Train 150 direct care staff in prevention and management of dangerous behavior techniques by September 2009(GPRA 2).
- 3) Implement revised curriculum across the system by September 2009 (GPRA 7).

Action Item	Parties Responsible	Completion Date	Status
Explore prevention and management of dangerous behavior curriculums recognized as best practices to replace Behavioral Management System training	DMHAS	May 2008	Completed
Develop plan to implement new curriculum statewide	DMHAS	September 2008	Completed

Train direct care staff	DMHAS	September 2009	Completed
Implement revised curriculum across the system	DMHAS	September 2009	Completed

Project Year 2007/2008 Progress: CT issued a Request for Information seeking appropriate parties to train staff in approaches to prevent and respond therapeutically to aggressive behavior. Disappointingly, the effort yielded only one proposal, which did not address CT's desired goals. In lieu of this approach, focus groups were conducted with staff from inpatient settings to obtain input on curriculum revisions.

CT's MHT staff works closely with this committee to ensure that the curriculum is consistent with the principles discussed earlier in this report, specifically prevention, use of personal preferences and trauma informed approaches to care.

Project Year 2008/2009 Progress: The Collaborative Safety Strategies (CSS) Training Program was developed by the Division of Safety Services, Education and Training Unit and implemented in December 2008. Several important changes and enhancements were made to the content and course delivery to ensure the approach is consistent with prevention, the use of personal preferences and trauma informed care. Highlights of the content changes/enhancements include greater focus on:

- The therapeutic use of self, the therapeutic milieu and staff roles in preventing behavior from escalating;
- The use of therapeutic interventions with an enhanced philosophical model that shifts thinking to better align with recovery, thus reduce the need for restrictive measures;
- Interventions being matched to the person rather than the crisis phase they are in;
- Critical thinking and decision making related to preventing dangerous behavior; and,
- National data about the leading causes of deaths that have occurred while applying or caring for someone in restraints is enhanced.

In FY09, CSS Skill Training Sessions were formally implemented for staff that work in 24 hour settings throughout the DMHAS system. The majority of sessions focus on verbal intervention skills. The training model is learner driven (case scenario, questions, discussion, skill practice), with lecture/presentation provided only to reinforce knowledge. As of July 2009:

- 20 new employees have completed CSS New Employee Training Program. The number of new employees trained is reflective of the hiring freeze that has been in effect for over a year.
- 1,513 inpatient employees of the approximate 1,780 have completed the CSS Inpatient Review training.
- 879 outpatient employees of the approximate 1,200 have completed the CSS Outpatient Review training.

All remaining inpatient and outpatient employees will complete training by the end of September 2009 and annually thereafter.

ALL ACTION ITEMS ASSOCIATED WITH THIS OBJECTIVE HAVE BEEN COMPLETED

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Mental Health Care Is Consumer and Family Driven.

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: In 2003, after a Hartford Courant article brought to light the reality of using restraint for persons with psychiatric disorders, SAMHSA’s Administrator, Charles Curie, stated that: "Seclusion and restraint should no longer be recognized as a treatment option at all, but rather as a treatment failure." SAMHSA then set forth a vision and a plan to reduce and ultimately eliminate seclusion and restraint from treatment settings for mental and addictive disorders. Since that time, Connecticut along with the nation has examined its practices in the use of seclusion and restraint. Staff training and establishment of revised protocols has resulted in reduced application of seclusion and restraint. The Department of Mental Health and Addiction Services continues to strive toward the elimination of seclusion and restraint in acute care settings.

OBJECTIVE WD 3: Evaluate the use of seclusion and restraint throughout the Department of Mental Health and Addiction Service system.

- Begin Date:** Sept. 2007
- Impact:** Improved service accountability and service effectiveness
- Ease of completion:** Average/Realistic Goal
- Population:** Across the lifespan

Performance Measurement:

Project Year 2008/2009 1) By September 2009, report findings from evaluation of seclusion and restraint (Non-GPRA).

Action Item	Parties Responsible	Completion Date	Status
Request technical assistance from the Substance Abuse and Mental Health Services Administration’s National Technical Assistance Center	DMHAS	January 2008	Completed
Senior leadership from CVH and Cedarcrest Hospitals attend SAMHSA training on seclusion and restraint	DMHAS	April 2008	Completed

Project Year 2007/2008 Progress: In October 2007, DMHAS received the award to implement an Alternative to Restraint and Seclusion State Incentive Grant. This award has propelled DMHAS’ evolution to a restraint free environment. As such, we have significantly increased and coordinated efforts to eliminate the use of seclusion and restraints as a component of this CMHP as reflected by the addition of the second action item. Updates on accomplishments to obtain this objective include:

- In February 2008 requested technical assistance.
- Senior staff from CT Valley and Cedarcrest Hospitals attended SAMHSA training on seclusion and restraint.

See Objective CYF 13 to learn more.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Excellent Mental Health Care Is Delivered and Research Is Accelerated.

- 5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illness.
- 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
- 5.3 Improve and expand the workforce providing evidence-based mental health services and supports.
- 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

OVERVIEW: One task of transformation was to create a strategy to prevent youth from becoming involved in or having repeated involvement in the juvenile justice system through the use of evidence-based practices. This strategy aims to divert children and youth from involvement in the juvenile justice system through a focused implementation of Community Based Wraparound, a proven effective approach to addressing the needs of children and families. Wraparound is a truly transformative approach to delivering care that places the family at the center of decision making and shares the concepts and values of the adult Recovery Movement and other approaches that build upon the natural resilience of children, families, and communities. The entire project will be awarded to contractor/contractors through one or more competitive procurements. Procurements will be structured to encourage utilization of family members, advocacy organizations and other entities familiar with the target communities.

OBJECTIVE WD 4: Establish a system-level infrastructure for implementing Community - Based and Family Wraparound.

Begin Date: August 2007
Impact: Improved service accountability, service capacity, and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Children and Adolescents

Performance Measurement:

Project Year 2007/2008 1) Signed Memorandum of Agreement between Department of Mental Health and Addiction Services, Department of Children and Families (DCF) and the Court Support Services Division (CSSD) of the Judicial Branch by December 2007 (GPRA 1).

Project Year 2008/2009 1) MacArthur Foundation funding will be integrated with MHT funding to expand the Community Based and Family Wraparound Project by September 2009 (GPRA 3).

Action Item	Parties Responsible	Completion Date	Status
Establish Memorandum of Agreement between Department of Mental Health and Addiction Services, Department of Children and Families and the Court Support Services Division of the Judicial Branch	MHT staff with DCF and CSSD	November 2007	Completed
Issue Request for Proposals for Coordinating Center to provide leadership and management of the Connecticut Community and Family Wraparound Project	DCF	September 2007	Completed
Contract with awarded agency to serve as Coordinating Center	DCF	February 2008	Completed
Seek funding from MacArthur Foundation to expand Community based and Family Wraparound	CSSD	August 2008	Completed
Integrate MacArthur Foundation funding with MHT funding to expand the Community Based and Family Wraparound Project	CSSD	July 2009	Completed

Project Year 2007/2008 Progress: Progress has been made toward full implementation of Wraparound by building upon existing resources in two local communities, providing quality assurance, and establishing a workforce development infrastructure. Resources that have contributed to the successful implementation of the project include:

- Local community collaboratives;
- Local family support organizations;
- DCF funded care coordinators;
- DCF and CSSD flexible funding programs;
- Emily J. initiatives;
- Existing parole, probation, and protective services workers that deliver case-management services;
- Existing wrap-around training programs (DCF, Emily J. and community collaborative training initiatives);
- DCF and CSSD funded local mental health service providers and services;
- Local juvenile review boards;
- Family with Service Needs (FWSN) Support Centers;
- Court evaluation programs; and,
- Other complementary initiatives.

Progress to date has been guided by the goal of creating and sustaining (post-MHT-SIG) a parent-driven system of care. A significant step toward sustaining the initiative links the wraparound initiative with MacArthur Mental Health/Juvenile Justice Action Network School-based Diversion initiative that will divert children and youth to the mental health system and decrease school-based arrests for acting out behaviors driven by mental health issues. Achievements in project year 2007-08 include:

- MOA signed in November 2007;
- Connecticut Center for Effective Practice (CCEP) of the Child Health and Development Institute (CHDI) awarded contract;

- Updated agency leadership on status of project implementation; and,
- Braiding funding from the MacArthur foundation. These dollars will provide expanded training and coaching opportunities for school personnel and school resource officers.

Project Year 2008/2009 Project: Funding from the MacArthur Foundation was secured and has been used to expand the project to include school personnel and school resource officers.

ALL ACTION ITEMS ASSOCIATED WITH THIS OBJECTIVE HAVE BEEN COMPLETED

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Excellent Mental Health Care Is Delivered and Research Is Accelerated.

- 5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illness.
- 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
- 5.3 Improve and expand the workforce providing evidence-based mental health services and supports.
- 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

OVERVIEW: Previous efforts to implement Wraparound relied primarily on training to change the way that the system served families. The State’s extensive experience with multiple models of evidence-based practice has demonstrated that for programs to be effective, training must be supported by coaching in the field. Quality assurance processes are necessary to insure that service is being delivered as designed. Training is most effective when hands-on coaching in the field follows it. In this model, expert trainers provide coaching by providing feedback regarding the implementation of child and family specific teams, crisis planning, service coordination, etc., as Wraparound is delivered.

OBJECTIVE WD 5: Increase the capacity of communities to effectively implement and utilize the Wraparound process by building local community infrastructure and leadership capacity to support wraparound.

Begin Date: July 2008
Impact: Improved service accountability, service capacity, and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Children and Adolescents

Performance Measurement:

- Project Year 2007/2008**
- 1) An agreement will be created with two community collaboratives to participate in the Wraparound project by September 2008 (GPRA 4).
 - 2) Establish a shared uniform curriculum for Wraparound services by July 2008 (GPRA 1).
- Project Year 2008/2009**
- 1) Train 330 stakeholders in Wraparound services by September 2010 (GPRA 2)
 - 2) Implement a system of ongoing in vivo coaching regarding Wraparound by September 2009 (GPRA 7).
- Project Year 2009/2010**
- 1) Six service systems receive technical assistance from the Coordinating Center by September 2010 (GPRA 7).

Action Item	Parties Responsible	Completion Date	Status
Establish a shared uniform curriculum	Coordinating Center	June 2008	Completed
Issue Request for Qualifications to select two community collaboratives to participate	Coordinating Center	July 2008	Completed
Enter into Agreement with the two selected community collaboratives to participate	Coordinating Center	September 2008	Completed
Create by-laws, sub-committee structure, policies, procedures, goals, and objectives to build local community collaborative infrastructure	Coordinating Center	February 2009	Completed
Hire two part-time youth coordinators	Coordinating Center	December 2009	Revised
Hire local coaches to work with training/coaching consultants and begin local in-vivo coaching	Coordinating Center	July 2009	Completed
Design and implement a system of ongoing in vivo coaching and technical support to care coordinating agencies, to participants in systems of care in selected communities	Coordinating Center	September 2010	Initiated
Initiate local in-vivo coaching	Local Coaches	September 2009	Completed
Deliver training curriculum to multiple system stakeholders in selected communities	Coordinating Center	December 2009	On-target

Project Year 2007/2008 Progress: The contracted Coordinating Center provided assistance in the selection of the pilot communities, coordination of advisory bodies, training, in-vivo coaching, fidelity assessment, administrative supports, clinical quality reviews, and quality assurance activities. The Coordinating Center worked with the DCF and Court Support Services Division of the Judicial branch (CSSD) to develop and issue a Request for Qualifications (RFQ) that forms the basis of the methodology for selecting the target communities. The Coordinating Center also worked jointly with CSSD and DCF staff assigned to the contract to convene local advisory/steering committees in each pilot community and a statewide body composed of representatives from the local bodies.

Trainers have been identified and will implement training consisting of an overview of the Wraparound approach for all stakeholders and a series of smaller sessions to instruct project participants in the core competencies of wraparound practice. Expert coaches will provide coaching as Wraparound is being delivered. Coaches will provide feedback regarding the implementation of child and family specific teams, crisis planning, service coordination, etc.

The Coordinating Center has also hired one part-time youth coordinator through FAVOR for each selected site to help youth participation in the Wraparound process once communities have been selected. Recruitment efforts are again underway to fill this youth coordinator position. In addition to orientation and assessment, the Coordinating Center will work with each community to identify data collection personnel, technical assistance needs, and administrative support needs and begin to coordinate implementation of these services.

Other action steps identified above were revised as follows:

- The shared, uniform curriculum was developed according to schedule.
- Two communities were selected and local systems engaged in the project.
- Communities were notified of their selection and site assessments were scheduled.
- Court evaluators have been engaged in the project.
- The Wraparound Fidelity Index (WFI) assessment tool has been selected and the data collection system designed.
- Wraparound trainers have been identified, in-vivo coaching program designed, and family advocacy organization engaged.
- The timeline for the delivery of the curriculum is anticipated to be completed in October 2008.
- The implementation of in vivo coaching has been delayed until October 2008.

Project year 2008/2009 Progress: The Coordinating Center conducted a resource inventory and needs assessment in both of the pilot communities via a standardized inventory of community supports for Wraparound. A number of strategic planning meetings were held with both communities to discuss school engagement, training, and linkage to community resources as well as participation in the MacArthur School-Diversion initiative.

A second youth coordinator was hired in the fall of 2008 to promote youth involvement and advocacy during Wraparound implementation. Both coordinators attended a two-day conference devoted to youth coordination. One of the youth coordinators recently graduated with a Master's in Social Work and found a full-time job elsewhere, thus a search for a replacement is currently underway. Other steps to enhance family and youth engagement included meetings with providers and family advocates and the formation of a sub-committee specifically for this task.

Both communities began implementing their own trainings with consultation from the Coordinating Center. Over 400 stakeholders were trained in Wraparound curriculum, parent leadership, and/or in-vivo coaching. The delivery of the Wraparound curriculum began in March 2009 and is expected to be completed in December 2009. The implementation of in vivo coaching began in July 2009. To facilitate communication and collaboration, an online community resource web page was used so that the two communities could announce training opportunities, access project resources, and post questions or comments. Furthermore, collaboration was established between one of the community collaboratives and the parent leadership initiative (see objective WD 10) to provide parent leadership training to community collaborative members.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Excellent Mental Health Care Is Delivered and Research Is Accelerated.

- 5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illness.
- 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
- 5.3 Improve and expand the workforce providing evidence-based mental health services and supports.
- 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

OVERVIEW: When implemented with high fidelity, Wraparound has been shown to improve child behavior, reduce social problems, improve school attendance, decrease functional impairment, and reduce delinquency (Burchard et al., 2002). Coaches, Trainers, and the Training Coordinator will utilize existing instruments to measure fidelity to the wraparound process and provide corrective feedback. Existing measures will be modified to assess the quality of existing court based assessment processes and to reinforce assessment processes that are consistent with the Wraparound approach.

OBJECTIVE WD 6: Organizations and courts will demonstrate fidelity to the Wraparound model.

Begin Date: January 2008
Impact: Improved service accountability, service capacity, and service effectiveness
Ease of completion: Average/Realistic Goal
Population: Children and Adolescents

Performance Measurement:

Project Year 2007/2008 1) Develop policies and procedures regarding court evaluations to promote fidelity and the use of Wraparound principles and services (GPRA 1).
Project Year 2009/2010 1) Six service systems will collect data to assure Wraparound fidelity by September 2010 (GPRA 4, 5).
 2) Train 40 court evaluators in Wraparound services by May 2010 (GPRA 2).

Action Item	Parties Responsible	Completion Date	Status
Design and implement a system of review of court evaluation reports, including revising a wraparound fidelity tool for application in court evaluations	DCF, CSSD, Coordinating Center	July 2009	On-going
Establish project advisory board	Coordinating Center	October 2008	Completed
Develop project communication plan	Coordinating Center	October 2008	Completed
Site assessments of selected communities	Coordinating Center	October 2008	Completed
Inventory of community administrative needs	Coordinating Center	November 2008	Completed
Make infrastructure support funds available to selected communities	Coordinating Center	November 2008	Completed
Finalize training plan	Coordinating Center	November 2008	Completed
Complete site assessments	Coordinating Center	October 2008	Completed
Train court evaluators in wraparound, incorporate wraparound into evaluation policy and practice, and conduct review of application of wraparound in sample of court evaluations	Coordinating Center	May 2010	Revised

Conduct a fidelity assessment of wraparound process	Coordinating Center	September 2010	On-target
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Project Year 2007/2008 Progress: The Coordinating Center has initiated work with DCF and CSSD to evaluate the quality of current court evaluations and provide feedback on their fidelity to the principles and practices of wraparound. A quality assurance data system will be established to link with the Department's reporting system.

The target date for designing and implementing a system of clinical review of court evaluation reports has been changed to November 2008 due to delays in identifying target communities. A previously identified action item regarding families as evaluators and trainers has been removed as it inaccurately reflected the intention of this objective. Key quality assurance and utilization data will be collected periodically throughout the project and used in conjunction with fidelity measures to inform practice. Accomplishments include:

- CT Center for Effective Practice (CCEP) was awarded the contract to provide project coordination.
- Two communities representing both urban and suburban areas (Greater Bridgeport and Bristol/Farmington Valley) have been selected.
- Agency leadership was updated on the status of project implementation.

It should also be noted that this initiative serves as the reference for the Child Recovery/Resiliency Measure that is to be evaluated in the cross site evaluation or proof of concept study.

Project Year 2008/2009 Progress: The target date for designing and implementing a system of clinical review of court evaluation reports was changed to July 2009 due to delays in identifying target communities. However, preparatory steps continued, such as the creation of a second advisory board to help with the court-based assessment process. Additional progress includes:

- The Center for Effective Practice (CCEP), the State of Connecticut Department of Children and Families (DCF), the Judicial Branch Court Support Services Division (CSSD), and the University of Connecticut Health Center (UCHC) representatives from the Coordinating Center developed an audit tool to evaluate whether evaluations ordered by the court are consistent with wraparound principles. The tool, titled Adherence to Wraparound Principles Rating Scale for the Audit of Court Evaluations, has seven sections: 1) Methods of Data Collection; 2) Family Involvement & Voice; 3) Child/Youth Perspective & Voice; 4) Strengths-based Qualities; 5) Cultural and Linguistic Competence; 6) Recommendations; and 7) Basic Quality Indicators. Auditors evaluate the presence or absence of items or qualities that correspond to the core principles of wraparound in the written report of evaluation. At the end of each section, the auditors also rated the quality of the written evaluations adherence to wraparound principles across the domain described by the section.
- In September 2009, the Court Evaluation Team consisting of representatives from CCEP, DCF, CSSD, Riverview Psychiatric Hospital, and UCHC conducted an audit of six randomly selected court-ordered evaluations. These evaluations were conducted by consultants hired through CSSD. The audit's findings strongly support the need to train consultants hired to conduct court-ordered evaluations on the use of wraparound principles when conducting evaluations.

Collect data to show impact of wraparound initiative to support future funding	Coordinating Center	August 2009	On-going
Collect baseline data in pilot and control sites, including court evaluators statewide	Coordinating Center, Yale PRCH, UCHC	September 2009	On-target
Develop report cards for each system of care and court evaluator	Coordinating Center	July 2010	On-target
Refine data collection system at local level, collect fidelity assessment data and provide ongoing feedback to selected communities	Coordinating Center	September 2010	On-going

Project Year 2007/2008 Progress: Identification of key outcome measures as well as identification of an evaluation design have been completed on schedule. Collection of baseline data is anticipated to be completed as proposed. Coordination of the evaluation with the Emily J Project has been delayed until September 2008. The MacArthur funds are being processed through CSSD's accounting department and are anticipated to be available in October 2008.

Project Year 2008/2009 Progress: As part of the quality assurance and evaluation processes that are part of the Wraparound initiative, the Coordinating Center: 1) Met with the identified quality assurance/data collection liaisons at each site; 2) Conducted a data collection needs assessment with each site; and 3) Hired an additional research assistant for the quality assurance/evaluation component.

The assessment tool for the court evaluators is being finalized and will be used to collect baseline data in September 2009, while training in data collection and the use of the Wraparound Fidelity Index (WFI) is currently underway and will be used in September 2009 to collect initial Wraparound process data. In addition, the Community Supports for Wraparound Inventory was collected in November 2008 to assess the capacity of each community to implement Wraparound and will serve as one measure of each community's knowledge and capacity for Wraparound prior to the beginning of training. The MacArthur funds were processed through CSSD's accounting department and the Connecticut Community and Family Wraparound Project and the MacArthur Mental Health/Juvenile Justice Action Network School-based Diversion Initiative were effectively merged in January 2009.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Excellent Mental Health Care Is Delivered and Research Is Accelerated.

- 5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illness.
- 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
- 5.3 Improve and expand the workforce providing evidence-based mental health services and supports.
- 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

OVERVIEW: MHT-SIG funds can address only a portion of the many workforce challenges facing the state of Connecticut. Therefore, a critical element of the State's effort to transform its workforce must be to ensure that a permanent infrastructure is established that can link and leverage existing resources to address the many workforce issues that call for attention. The

proposed strategy is to create the Connecticut Workforce Collaborative on Behavioral Health Workforce Collaborative, drawing on related initiatives in California and Alaska. The mission of the Collaborative will be to proactively recruit, develop, support, and retain Connecticut's mental health workforce through coordinated planning and action involving public and private organizations in partnership with persons in recovery, youth, and family members.

OBJECTIVE WD 8: Establish the Connecticut Workforce Collaborative on Behavioral Health as a permanent body charged with planning, coordinating, and implementing interventions to strengthen the workforce.

Begin Date: March 2008
Impact: Improved service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2007/2008

- 1) Establish the Connecticut Behavioral Health Workforce Collaborative and convene 20 meetings of its Councils by September 2008 (non-GPRA).
- 2) Identify best practices in at least three areas of workforce development by September 2008 (non-GPRA).
- 3) Convene the Collaborative and its Councils at least semi-annually to plan and oversee projects to strengthen the workforce by September 2009 (non-GPRA).

Project Year 2008/2009

- 1) Execute a state interagency Memorandum of Agreement (MOA) involving at least five state agencies to guide and sustain the Collaborative by May 2009 (GPRA 1, 4).

Project Year 2009/2010

- 1) Develop and implement sustainability plans for the Collaborative and selected workforce projects by September 2010 (non-GPRA).
- 2) Convene the Collaborative and its Councils at least semi-annually to plan and oversee projects to strengthen the workforce by September 2010 (non-GPRA).

Action Item	Parties Responsible	Completion Date	Status
Governor issues an Executive Order to establish the Connecticut Mental Health Workforce Collaborative	MHT-SIG managers and Convener of Workforce Transformation Workgroup (WTW)	March 2008	Revised
Establish and convene the Executive Committee of the Collaborative	WTW staff	April 2008	Completed
Establish and convene the General Membership of the Collaborative	WTW staff	May 2008	Completed
Establish and convene the Standing Councils of the Collaborative	WTW staff	May 2008	Completed

Develop a series of working papers on promising practices in workforce development	Work Force Development Workgroup	September 2008	Completed
Execute a Memorandum of Agreement between state agencies to guide and sustain the Collaborative	WTW staff	May 2009	Completed
Develop and implement sustainability plans for the Collaborative and key workforce projects	WTW staff	September 2010	On-target
Conduct workforce planning and project oversight by convening the Collaborative and its Councils	WTW staff	September 2010	Ongoing

Project Year 2007/2008 Progress: The Collaborative met twice, in May and September 2008, with a primary focus being recruiting and supporting diverse membership. Meetings included convening all of the Workforce Councils as well as facilitated discussions about community colleges and the behavioral health workforce, youth leadership in the behavioral health workforce, and training and workforce development guidelines.

- 1) A report focusing on community colleges and the behavioral workforce needs was completed and members of the Workforce Collaborative met with the Community Colleges Chief Academic Officer.
- 2) Outcome measures have been established and work with each individual Collaborative project around collection of initial data has begun.
- 3) In September 2008, Youth Leadership stakeholders held a second meeting with increased representation of men and women from diverse ethnic and cultural backgrounds. These members bring valuable perspectives including youth development and gang prevention at the grassroots level throughout Connecticut.
- 4) One major change to the CMHP was the revision to reflect a modification to the establishment of a Governor's Executive Order. Upon pursuing this with the Governor's office it was determined that this activity did not meet the criteria for an Executive Order. As a result, efforts will concentrate on identified Council priorities and implementation plans, including completion of an interagency Memorandum of Agreement and development of a sustainability plan.
- 5) Efforts will continue to assure that a majority of Collaborative members are persons in recovery, youth and family members, and that membership is representative of ethnic and cultural diversity.

Project Year 2008/2009 Progress: Seven state departments signed a Memorandum of Agreement (MOA) to collaborate in planning for the sustainability of the Collaborative. The seven departments are as follows:

- 1) Department of Mental Health and Addiction Services (DMHAS),
- 2) Department of Children and Families (DCF),
- 3) Department of Administrative Services (DAS),
- 4) Department of Labor (DOL),
- 5) Court Support Services Division of the Judicial Branch (CSSD),
- 6) Office of Workforce Competitiveness, and
- 7) Department of Higher Education.

After working closely with the Multicultural Institute, the action planning group that emerged from the September 2008 Collaborative meeting circulated its strategic plan for the recruitment and meaningful participation of culturally/ethnically diverse individuals at the May 2009 Collaborative

meeting. Each of the Workforce Councils convened at this statewide meeting, which included the Council on Consumers, Youth, and Families in the Workforce facilitating a discussion and role-plays on “Achieving Authentic Participation.” Other highlights from the year included the following:

- The Council on Consumers, Youth, and Families in the Workforce (CYFW) had a speaker come to present about efforts to reduce hiring discrimination towards persons with a history of criminal justice system involvement. Members of the Council also attended a training offered by the Consumer Leadership Academy from the West Virginia CONTAC program.
- The Collaborative launched its web site (www.cwcbh.org), where visitors can find a range of behavioral health workforce resources.
- The Collaborative partnered with the Connecticut Association on Infant Mental Health to develop competencies in Early Infant Mental Health. The Collaborative also worked with other interested partners in developing best practices in youth workforce development.
- In its efforts regarding youth leadership development, the Collaborative also formed a partnership with various groups to establish a Youth and Young Adult Consortium. Participating groups include: Families United, North Central Regional Mental Health Board, the Connecticut Chapter of the National Alliance on Mental Illness (NAMI-CT), the Department of Children and Families (DCF), a consultant (Cliff Davis), and the Yale Center for Workforce Development.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Excellent Mental Health Care Is Delivered and Research Is Accelerated.

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- 5.3 Improve and expand the workforce providing evidence-based mental health services and supports.
- 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

OVERVIEW: The Department of Children and Families (DCF), at the direction of Governor Rell and with the support of the legislature, has continued to prioritize the delivery of intensive home-based services as an alternative to psychiatric hospitalization, residential treatment, and detention. In home services for adolescents have also been established as a priority by the Court Support Services Division of the Judicial Branch. A barrier to the successful implementation of these treatments is the limited availability of staff entering the workforce with the requisite training and skills to effectively deliver such services, exemplified by vacancy rates in such positions of approximately 20%. The proposed strategy will engage university faculty members in fellowships to learn these treatment approaches. Subsequently, the faculty will implement courses for students on intensive, home-based services and assist in placing these students in internships where they can gain practical experience. University and mental health systems will coordinate recruitment and job placement efforts to engage these students in the workforce after graduation.

OBJECTIVE WD 9: Expand the workforce skilled in providing evidence-based intensive in-home family treatment through coordinated curriculum development, faculty development, university-based course work, experiential learning through internships, and recruitment of graduate students.

Begin Date: March 2008
Impact: Improved service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2007/2008

1) By April 2008, finalize graduate training curriculum in evidence-based intensive in-home family treatment models (GPRA 1).
 2) By September 2008, five university professors from distinct graduate programs will participate in a faculty development seminar to train graduate students in evidence-based in-home family treatment (GPRA 2).

Project Year 2008/2009

1) By December 2008, faculty will complete the implementation of the course within their respective departments (Non-GPRA).
 4) By September 2009, 35 graduate students will be trained to provide intensive in-home family services (GPRA 2).

Project Year 2009/2010

1) By October 2009, four additional faculty members from newly participating colleges and universities will be trained in providing the curriculum (GPRA 2).
 3) By September 2010, train four additional faculty members from colleges and universities that participated in 2008/2009 (GPRA 2).
 4) By September 2010, an additional 35 graduate students will be trained to provide intensive in-home family services (GPRA 2).

Action Item	Parties Responsible	Completion Date	Status
PHASE I			
Finalize a graduate training curriculum in evidence-based intensive in-home family treatment models.	Selected contractor	April 2008	Completed
Initiate training seminar to selected faculty fellows for Phase I (5 Faculty Members, each from a distinct Graduate Training Program)	Wheeler Clinic Staff	September 2008	Completed
Initiate student recruitment events and identification of internship resources at each participating university for Phase I	Wheeler Clinic Staff	September 2008	Completed
Complete Participation Agreements for Phase I	Wheeler Clinic Staff	September 2008	Completed

Recruit and coordinate model-specific provider representatives to assist in Faculty Fellows Training, Student Recruitment, and Guest Lecturing in the student course for Phase I	Wheeler Clinic Staff	November 2008	Completed
Ensure compliance with university agreements to deliver a course at each site during Phase I (minimum of 35 students total across all sites)	Wheeler Clinic Staff	February 2008	Completed
Deliver consultation, coaching, and group feedback sessions to Faculty Fellows from Phase I	Wheeler Clinic Staff	January 2008	Completed
Develop and implement Phase I system for connecting students with internship and employment opportunities involving In-Home Services	Wheeler Clinic Staff	March 2008	Completed
Assist in identifying key process and outcome variables and measurement strategies to assess this intervention	Wheeler Clinic Staff	September 2009	On-going
Elicit and analyze Phase I Course Evaluation Feedback from guest lecturers and student participants	Wheeler Clinic Staff	June 2008	Completed
PHASE II			
Deliver consultation, coaching, and group feedback to Faculty Fellows from Phase I	Wheeler Clinic Staff	June 2009	Completed
Provide information regarding Fellowship to all Graduate Training Programs in Connecticut and local surrounding area and elicit university participation in the program	Wheeler Clinic Staff	August 2009	Completed
Utilize feedback from instructors, students, family members, and providers to revise curriculum	Wheeler Clinic Staff	September 2009	On-target
Identify key process and outcome variables and measurement strategies to assess this project	Wheeler Clinic Staff	September 2009	On-target
Initiate training for a second group of four faculty members from newly participating graduate programs	Wheeler Clinic Staff	September 2009	On-target
Phase III			
Recruit family and provider guest lecturers for training	Wheeler Clinic Staff	June 2010	On-target
Ensure compliance with university agreements to deliver a course at each site during Phase I (minimum of 35 students total across all sites)	Wheeler Clinic Staff	September 2010	On-going
Obtain and analyze Phase II course evaluation feedback	Wheeler Clinic Staff	September 2010	On-target
Deliver consultation, coaching, and group feedback sessions to Faculty Fellows	Wheeler Clinic Staff	September 2010	On-target

Project Year 2007/2008 Progress: Wheeler Clinic was selected as the contractor for the intensive in-home family treatment training effort. The graduate school programs that will partake in this initiative include:

- (1) University of Connecticut (Social Work and Marriage and Family Therapy),
- (2) University of Hartford (Psychology),
- (3) Southern Connecticut State University (Social Work and Marriage and Family Therapy),
- (4) Central Connecticut State University (Marriage and Family Therapy).

Project Year 2008/2009 Progress: Wheeler Clinic, the selected subcontractor, collaborated with model developers to create a 14-week graduate curriculum and instructor toolkit to teach the course “Current Trends in Family Intervention: Evidence-based and Promising Practice Models of In-Home Treatment in Connecticut.” Participating faculty members received 24 hours of fellowship training and an instructor toolkit with resources for course implementation, including an instructor’s manual, PowerPoint presentations, reading lists and materials, in-class activities, suggested assignments, and exam questions.

Of the six participating graduate school programs, two of the Marriage and Family Therapy programs have made the curriculum part of the required coursework. Discussions are in process with the remaining four programs and at least three of these four are likely to offer the course annually. The fourth is undergoing change of leadership, and negotiations are deferred until the leadership transition is complete.

A total of 75 students received a certificate of course completion. The course increased student awareness of the nine empirically-driven models of practice in Connecticut. Training, supervision and rigorous skill development inherent within each model is emphasized. Students were exposed to the experiences of guest lecturers who are families having received these treatment models and providers having delivered the models.

A total of 28 providers representing one of the models made guest presentations at one or more of the graduate programs offering the course. Providers offered perspectives on what the work is like, and their presentation of case examples provided vivid images of the models being delivered in actual practice.

Nine families who had received one or more of the models made one or more presentations to the graduate students enrolled in the class. They were encouraged to see this as their opportunity to provide feedback to therapists in training about what families find helpful and what they liked about the particular model they received. Additional family members participated in the planning process and have opportunities to be involved as guest presenters in the future.

Feedback has been collected from all stakeholders about their experience with the course (professors, students, and the provider and family presenters). Student reports indicate the critical importance of family involvement. There is unanimous enthusiasm about the innovation of the guest presenter component of the course. There is also increased awareness of the creativity and individualization of treatment that exists within evidence-based practice.

In terms of curriculum revision, a request was disseminated to model developers for ideas, references and contributions to tweak the curriculum including: video clips that illustrate the key model concepts; direct and explicit reference to the cultural competency of each of the models. Feedback is being incorporated from multiple sources (e.g. faculty, students, and guest lecturers) to enhance the curriculum.

Recruitment of new universities is in process. Fordham University, St. Joseph’s University and Springfield College have made commitments to participate by enrolling a total of five faculty in the Phase II fellowship program. Outreach to Fairfield University continues.

Universities participating in Phase I that are committed to training new faculty presently include Southern Social Work program and Central CT State University Counseling Program, with other universities in the process of determining their involvement in Phase II.

A system is being set up to track how many students are employed after course completion in positions within settings that offer one of the intensive in-home service models.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Mental Health Care Is Consumer and Family Driven.

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: A training curriculum on leadership skills will be selected, refined, and offered repeatedly throughout the state to the parents of children with emotional/behavioral difficulties. This initiative will: (1) facilitate parents' increased participation and influence in their child's treatment team; (2) increase parents' competency in skills necessary for paid and volunteer family advocate roles on behalf of other families and their children; and (3) assist parents in developing skills to shape state policy, thereby moving Connecticut closer to a family-driven system of care.

OBJECTIVE WD 10: Strengthen the role of parents in the behavioral health workforce and their ability to advocate for (a) their own children, (b) other families, and (c) systems level change.

Begin Date: March 2008
Impact: Improved service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2008/2009

- 1) By March 2009, 120 parents will receive leadership training (GPRA 2).
- 2) By September 2009, an additional 50 parents will receive leadership training (GPRA 2).
- 3) By September 2009, develop a network of at least five regional peer support groups across the state for parent alumni of the leadership training as a structure for continuing opportunities for involvement, support, learning, and advocacy (GPRA 6).

2) By September 2009, 50 parents, at least half of whom will be training alumni, will receive specialized training in Peer Mentor Certification Program (GPRA 2).

Project Year 2009/2010

- 1) By May 2010, an additional 50 parents will receive leadership training (GPRA 2).

2) By May 2010, an additional 50 parents, at least half of whom will be training alumni, will receive specialized training in Peer Mentor Certification Program (GPRA 2).

Action Item	Parties Responsible	Completion Date	Status
Select an organization(s) to implement this initiative	Yale University	March 2008	Completed
Select and finalize a training curriculum on leadership skills to be offered to parents	Families United Staff	June 2008	Completed
Initiate training statewide to parents using the selected curriculum	Families United Staff	August 2008	Completed
Link trained parents with opportunities for involvement in advocacy	Families United Staff	September 2008	Completed
PHASE I			
Coordinate with model developer of approved curriculum to make any needed Connecticut-specific modifications	Families United Staff	September 2008	Completed
Recruit parents to participate in Phase I train-the-trainer group	Families United Staff	September 2008	Completed
Deliver Phase I training to trainers	Families United Staff	October 2008	Completed
Recruit parents to receive Phase I training	Families United Staff	October 2008	Completed
Deliver Phase I training to parents	Families United Staff	March 2009	Completed
Link Phase I trained parents with opportunities for involvement in advocacy	Families United Staff	March 2009	Completed
PHASE II			
Analyze course evaluation from training participants and revise curriculum based on their feedback	Families United Staff	June 2008	Completed
Deliver Phase II training to 50 parents	Families United Staff	September 2009	On-target
Recruit and train at least nine graduate family leaders, three of whom will be bilingual (English/Spanish) to help to lead and coordinate regional support groups	Families United Staff	September 2009	On-target
Establish and convene at least five regional support groups of alumni	Families United Staff	September 2009	On-target
Provide Peer Mentor Certification Training to at least 50 pre-screened parents, at least half of whom are graduates	Families United Staff	September 2009	On-target
PHASE III			
Deliver Phase II training to 50 additional parents	Families United Staff	May 2010	On-target
Maintain and support at least five regional support groups of alumni	Families United Staff	September 2010	On-target
Analyze Peer Mentor course evaluation feedback from Phase II parent participants and revise curriculum based on feedback	Families United Staff	December 2009	On-target

Complete delivery of Peer Mentor Certification Training to a minimum of 50 additional pre-screened parents, at least half of whom are graduates	Families United Staff	May 2010	On-target
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Project Year 2007/2008 Progress: Families United is the selected contractor for this initiative. Families United has braided funding from a MHT-SIG mini grant and other SAMHSA funding to increase the scope of this initiative. In August 2008, Families United invited stakeholders to participate in a campaign Kick-off event. The focus of the campaign is to increase public awareness and promote knowledge development opportunities for all children, youth and young adults with emotional, behavioral, and mental challenges. In addition, the campaign will provide families leadership training and access to effective family and youth driven services and supports within a system that responds to each family's culture, unique strengths, and needs as they develop. The Kick-off event was an opportunity for stakeholders to learn more about the Campaign for transformation and determine how to work in partnership to promote the mission.

Additional progress toward the objective includes:

- The Agents of Transformation (AOT) curriculum was selected and tailored to Connecticut's needs.
- The first group of parents (n=71) attended a leadership skills class. Also, parents are being linked to advocacy activities through the Behavioral Health Partnership Advisory Council, such as participating in committees and oversight councils.
- Next steps include beginning the first of ten series of Advanced Leadership classes with every third series being offered in Spanish.

Project Year 2008/2009 Progress: The Agents of Transformation (AOT) curriculum is an 18-hour, six-module parent leadership training program that was written and developed by the Parent Support Network of Rhode Island and adapted for Connecticut. Key training topics of the training include: 1) defining family driven care; 2) the roles of families in the workforce; 3) family advocacy and peer support; 4) communication and facilitation; and 5) wraparound care planning.

Families United provided training and support to a total of 232 parents across the state. Formal AOT training in English and Spanish was completed by 169 parents and 63 parents attended an introductory orientation to the class. Of the parents who received AOT training, approximately one-third of them were trained in Spanish and one-third of them were African-American. The Spanish-version of the AOT curriculum was developed in collaboration with a group of Spanish-speaking parents from a variety of Latino/Hispanic backgrounds to enhance the curriculum's relevance for Latino/Hispanic subgroups (e.g., Dominican, Puerto Rican, Mexican, etc.). Other accomplishments included connecting parents with opportunities for advocacy and membership on boards, committees, etc., that help shape state policy on behavioral health.

Parents interested in pursuing additional training will be offered the opportunity to participate in Peer Mentor Certification Training (PMCT). This six-module training program focuses on the following topics: 1) Peer mentor overview; 2) Rights and protections of the families; 3) Family engagement and advocacy; 4) Handling crisis and emergency needs; 5) Identification of formal and informal resources; and 6) Becoming an active peer mentor. In addition to the training classes, parents will receive ongoing coaching and support by telephone and in-person as they complete Peer Mentor Certification.

Other accomplishments include incorporating parent feedback into a revised AOT Training curriculum and finalizing the PMCT curriculum with parent input. Recruitment of additional parents to participate in Phase II training included collaboration with local systems of care and another MHT initiative (i.e., the Family and Community Wraparound Initiative). Finally, local regional support groups for AOT alumni were initiated to provide ongoing training, support, and opportunities for parent-involvement in systems of care, advisory councils, and other advocacy-related activities.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Technology is used to access mental health and information.

- 6.1 Use health technology and tele-health to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
- 6.2 Develop and implement integrated electronic health record and personal health information systems.

OVERVIEW: There is an urgent need to provide substantive support to staff serving people with psychiatric disabilities and to ensure the provision of competent and supportive supervision. To this end, the Supervision Competency Development Initiative (SCDI) is focusing on enhancing competencies of supervisors in three primary areas: (1) Managing supervisory relationships; (2) Managing job performance of supervisees; and (3) Promoting professional development among supervisees. The content of the trainings has centered on four core components to the supervisory process: (a) preliminary/tuning in; (b) contracting; (c) middle/work phase; and (d) ending/transitions. Complementing the trainings is the development of Supervision Standards focused on the nature and frequency of supervision to be provided in participating agencies. To date, eight agencies have been trained, six private non-profit and two state operated facilities. All participating agencies are receiving ongoing training, mentoring, and consultation focused on sustaining the core supervisory skills and integrating formal supervision standards into Agency policy. E-learning modules are also being provided and have been made accessible to supervisors and their direct care staff.

OBJECTIVE WD 11: Develop the capacity of supervisors to train, manage, and mentor direct care staff with the support of Web-based learning resources.

Begin Date: March 2008
Impact: Improved service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

- Project Year 2007/2008**
- 1) Develop and disseminate supervision standards to contracted agencies by July 2009 (GPRA 1).
 - 2) Train 15 supervisors in a functional, competency-based model of supervision by September 2008 (GPRA 2).
- Project Year 2008/2009**
- 1) Train an additional 15 supervisors in a functional, competency-based model of supervision by September 2009 (GPRA 2).
 - 2) Two organizations will adopt supervision standards by September 2009 (GPRA 4).

Project Year 2009/2010

- 1) Train an additional 15 supervisors in a functional, competency-based model of supervision September 2010 (GPRA 2).
 2) Two organizations will adopt supervision standards by September 2010 (GPRA 4).

Action Item	Parties Responsible	Completion Date	Status
Phase I			
Select participating organizations	Yale University	March 2008	Completed
Finalize training model/curriculum for supervisors	Yale University	May 2008	Completed
Initiate training of supervisors	Yale University	May 2008	Completed
Begin development of standards for supervision standards regarding supervision	Yale University and Council on Adults in the Workforce	June 2008	Completed
Make e-learning available to participating staff	Yale University	June 2008	Completed
Train supervisors and staff in supervision competencies	Yale University	December 2008	Completed
Phase II			
Select a second group of participating organizations	Yale University	January 2009	Completed
Make e-learning training resources available to participating staff from second group of organizations	Yale University	March 2009	Completed
Train supervisors and staff in supervision competencies from second group of organizations	Yale University	May 2009	Completed
Select a third group of participating agencies	Yale University	May 2009	Completed
Finalize standards for supervision	Yale University	June 2009	Completed
Work with participating agencies from Phase I and Phase II to implement supervision standards	Yale University	September 2009	On-Target
Complete formal evaluation of supervision initiative	WTW staff and Yale Consultation Center	September 2009	Completed
Phase III			
Finalize participating organizations (pre-selected in Phase II)	Yale University	September 2009	On-Target
Train supervisors and staff in supervision competencies from third group of organizations	Yale University	March 2010	On-Target

Work with Phase III participating agencies to implement supervision standards	Yale University	September 2010	On-Target
Develop continuing education network to sustain supervisory competencies	Yale University	September 2010	On-Target
Develop one-hour continuing education module focused on bringing knowledge about person centered, recovery-oriented care into the supervisory process.	Yale University and Council on Adults in the Workforce	September 2010	On-Target

Project Year 2007/2008 Progress: The Supervisory Competency Development Initiative (SCDI) has been working with Dr. Lawrence Shulman, the project's primary consultant, to implement the project and to plan for ongoing sustainability. The SCDI has also focused on the development of an e-learning component. The e-learning modules will be available through the Yale portal. Trilogy, the company responsible for the development of the Network of Care, will be sending two representatives to the September 2008 SCDI Supervisor trainings.

Work has also begun on developing supervisor standards, a draft of which has been presented to the Adult Council on Workforce Development. As part of the discussion, it was decided a sub-group should be established to help ensure that consumer-based ideas/language and philosophy are infused into the standards. This subgroup met in July 2008. In September 2008, the Adult Council presented a draft form of the Standards to the larger Collaborative.

Supervisor trainings have begun with 97 supervisors trained as of June 2008, far exceeding the proposed target number of 15.

Project Year 2008/2009 Progress: Work that was commenced through the Council on the Workforce for Adults included a thorough review of the literature, where supervisory competencies and best practices were identified and agreed upon with the core trainer and consultant, Dr. Lawrence Shulman. As noted above, a sub-group was established to help ensure that consumer-based ideas/language and philosophy were infused into the standards. The intent of the standards is to help promote the delivery of supervision in mental health and addiction programs and services throughout Connecticut. Their adoption is considered a key step for provider organizations and service systems in developing a *culture of supervision* that promotes safe and effective care, improved client outcomes, and a healthy and supportive work environment for staff members.

As with Phase I, a Request for Qualifications (RFQ) was issued and a review group was formed with over 51% consumer representation. A second group of four additional organizations were chosen, three private non-profits and one state agency. Between the eight participating agencies, a total of 189 supervisors and 269 direct care staff received training in the supervisory model. Supervisors also received training on how to mentor direct care staff with the support of the web-based learning resource provided by Trilogy. Participants in both Phase I and Phase II of the trainings completed surveys developed specifically for this initiative. Initial results from Phase I (Phase II results are pending) suggest the following:

- The majority of supervisors rated the trainers' teaching ability as excellent or outstanding.
- Supervisors who attended the trainings reported increased ability in management of supervisory relationships (i.e., developing supervisory contracts and session specific agendas), management of job performance (i.e., conveying clear expectations, conducting effective evaluations, and achieving compliance with requirements and

adherence to standards), and promotion of professional development (i.e., supporting staff development plans).

The Council on the Workforce for Adults reviewed and approved the supervision standards. Yale also worked closely with each of the participating agencies throughout Phase II in integrating these standards into Agency policy. To date, all eight participating agencies (Phase I and Phase II) are on target to adopt supervision standards by September 30, 2009. As part of an overarching sustainability plan, Yale also assisted agencies with the following: (a) developing an agency-wide plan for supervision; (b) integrating e-learning modules into agency professional development plans for supervisees; (c) reviewing supervisor job descriptions to assure that they thoroughly and accurately reflect the supervisor's role and responsibilities; and (d) creating learning communities designed to help supervisors be increasingly responsible for their own learning, mentor junior supervisors in the agency and increase camaraderie and collegial support among supervisors agency-wide.

Another RFQ was recently issued and a review group with 70% consumer/family representation was convened to select a third group of participating organizations for Phase III, which included the Department of Correction, one state-operated agency, and two private non-profits. Finally, a logic model was developed to provide a general framework for the activities, products, and results of the SCDI. The Logic Model was disseminated at the Connecticut Workforce Collaborative on Behavioral Health (CWCBH) General Meeting in May 2009.

NEW FREEDOM COMMISSION GOAL/ END OUTCOME

Technology is used to access mental health and information.

- 6.1 Use health technology and tele-health to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
- 6.2 Develop and implement integrated electronic health record and personal health information systems.

OVERVIEW: A large number of health and human service personnel who are not part of the specialty behavioral health workforce, routinely respond to the needs of persons with a variety of psychiatric disabilities, and co-occurring addictive disorders. Similarly, members of the community, who have no formal service role, also play a "first responder role" to persons with mental health conditions. This initiative will provide training to these individuals and groups, covering information about with the nature of mental illness, treatment options, and practical strategies for assisting individuals in distress.

OBJECTIVE WD 12: Through the provision of training, increase the capacity of health and human service personnel and members of the community to assist persons with mental health conditions.

Begin Date: March 2008
Impact: Improved service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2007/2008 1) By September 2008, train 30 health and human service personnel in skills for working with and assisting persons in recovery (GPRA 2).

Project Year 2008/2009

1) By September 2009, train an additional 45 health and human service personnel and community members in skills for working with and assisting persons with mental health conditions (GPRA 2).

Project Year 2009/2010

1) By May 2010, train an additional 45 health and human service personnel and community members in skills working with and assisting persons with mental health conditions (GPRA 2).

Action Item	Parties Responsible	Completion Date	Status
Identify training needs and available curriculum for health and human service personnel selected	Yale University	April 2008	Completed
Select and finalize curriculum for training health and human service personnel	Yale University	September 2008	Completed
Initiate training of health and human service personnel	Yale University	September 2008	Completed
Establish procedures for health and human service organizations to access consultation	Yale University	September 2008	Completed
Provide email refreshers and access to web-based resource on behavioral health services to participating staff	Yale University	July 2009	On-target
Select and finalize curriculum for training health and human service personnel and community members.	Yale University	January 2009	Completed
Attend the train-the-trainer program for Mental Health First Aid Curriculum	Yale University	February 2009	Completed
Identify participating agencies and community members to participate in training program	Yale University	August 2009	Completed
Complete delivery of training to at least 45 health and human service personnel and community members	Yale University	September 2009	On-target
Identify participating agencies and community members to participate in training program	Yale University	December 2009	On-target
Complete delivery of training to at least 45 health and human service personnel and community members	Yale University	May 2010	On-target

Project 2007/2008 Progress: The first action step has been completed while the completion dates for the other action steps have been changed to September 2008. The Yale Workforce team has developed in partnership with NAMI-CT a curriculum to train persons in the workforce who are not mental health professionals. Initial trainings were provided to Department of Labor staff in September. Curriculum highlights include:

General Introduction

- a) Introduction to NAMI
- b) Who are people with Mental Illness?

- c) Language
- d) Myths about Mental Illness
- e) Truth about Mental Illness
- f) Vulnerable populations

Introduction to Mental Illness

- a) General Brain Biology
- b) Neurotransmitters and Serious Mental Illness
- c) Substance Abuse Disorders

Specific Disorders

- d) Depression/Major Depression
- e) Bipolar Disorders
- f) Anxiety Disorders
- g) Thought Disorders
- h) Stigma
- i) Verbal/Non-verbal de-escalation techniques

Understanding how the symptoms affect functioning

- a) Effects of Anxiety Disorders on Work Functioning
- b) Effects of Depressive Disorders on Work Functioning
- c) Effects of Bipolar Disorders on Work Functioning
- d) Effects of Schizophrenia on Work Functioning
- e) Effects of Chronic Alcohol/Drug Use on Work Functioning
- f) Common Medication Side Effects that can Impact Work
- g) Disclosure

Community Resources and Employment Strategies

- a) Starting with a Recovery Model
- b) Disclosure
- c) Learning Assessment Strategy
- d) ADA/Reasonable Accommodations
- e) Common Functional Limitations
- f) Customized Employment
- g) SSI / SSDI

Network of Care Presentation

Project Year 2008/2009 Progress: In September 2008, a total of 67 staff persons were trained at two sites for the Department of Labor (DOL). Job positions that were represented among the training participants included Career Development Specialists, Veterans Employment Outreach Workers, Community Services Representatives, and Program and Services Coordinators. Initial plans were to offer a second round of trainings for DOL staff. The training curriculum was revised to enhance its content regarding recovery-orientation, competency-based skills in working with persons with mental illnesses. In addition, the training coordinator from the Multicultural Leadership Institute was consulted about making the curriculum more culturally competency. The Department of Labor staff is currently unavailable for additional training due to the increased demands placed upon them as a result of the large number of employees who have recently retired from that agency and the high unemployment rates in CT. Training will be resumed, if possible, later in project year 5.

Project Year 2009-2010 of this initiative is scheduled for completion by May 2010. In addition to health and human service personnel, this initiative has grown to include community members as part of the non-specialty behavioral health workforce. Yale staff has attended the train-the-trainer program for the Mental Health First Aid Curriculum, which has been selected as the curriculum to be provided this year. The training curriculum includes a 12-hour training course designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis.

Three complete 12-hour trainings were held at two centralized sites in Hartford and the New Haven areas, and offer certification to members once they have completed the training program. In total, 53 individuals were certified using the Mental Health First Aid curriculum.

Additional areas of focus within this initiative include: (1) Finalizing a logic model associated with the initiative; and (2) Development of a sustainability plan.

NEW FREEDOM COMMISSION GOAL / END OUTCOME

Mental Health Care Is Consumer and Family Driven.

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

OVERVIEW: An effective infrastructure is required to promote and sustain persons in recovery from diverse cultural backgrounds in the workforce through paid employment and volunteer roles. The Connecticut Recovery Employment Consultation Service (C-RECS) will be established through contract to a private, non-profit, organization and staffed by persons in recovery. It will manage a recruitment and placement service that includes an on-line job bank, provide training and support to persons in recovery to facilitate and sustain their role in the workforce, and provide consultation and technical assistance to mental health provider agencies in integrating persons in recovery into their workforce.

OBJECTIVE WD 13: Promote the recruitment and retention of persons in recovery in the mental health workforce by creating the Connecticut Recovery Employment Consultation Service (C-RECS).

Begin Date: March 2008
Impact: Improved service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2007/2008

- 1) By September 2008, create and launch the consumer-run Connecticut Recovery Employment Consultation Service (C-RECS) (GPRA 6).
- 2) By September 2008, provide employment training to 30 adults in recovery (GPRA 2).

Project Year 2008/2009

- 1) By September 2009, provide employment training to an additional 30 persons in recovery (GPRA 2).
- 2) By September 2009, 20 provider agency supervisors and staff persons will receive training/technical assistance in strategies for supporting and sustaining persons in recovery in the workforce (GPRA 2).
- 3) By September 2009, at least 10 persons in recovery will obtain employment (non-GPRA).

Project Year 2009/2010

- 1) By February 2010, at least three agencies will implement plans outlining ways in which employment of persons in recovery will be sustained (GPRA 4).
- 2) By September 2010, an additional 30 persons in recovery will receive pre-employment training (GPRA 2).
- 3) By September 2010, at least 20 provider agency supervisors and staff persons will receive training on legal and personnel issues in employing persons in recovery (GPRA 2).
- 3) By September 2010, an additional 10 persons in recovery will obtain employment (non-GPRA).
- 4) By September 2010, technical assistance on employment of persons in recovery will be provided to at least three agencies (GPRA 2).

Action Item	Parties Responsible	Completion Date	Status
Phase I			
Select an organization(s) to develop and manage C-RECS	Yale University	March 2008	Completed
Establish and manage a recruitment and placement service	Focus on Recovery United (FOR-U)	August 2008	Completed
Identify number, percentage, roles, and geographic distribution of self-identified persons in recovery in CT DMHAS-funded workforce	FOR-U, Employment Consultant; Workforce management staff Advocacy Unlimited	August 2008	Completed
Develop a working paper on promising emerging practices for engaging youth in the work force	Work Force Development Workgroup	September 2008	Completed
Convene a youth work force development initiative statewide stakeholders' meeting	Work Force Development Workgroup	September 2008	Completed
Develop and initiate the provision of training plus support to persons in recovery to facilitate their entry, retention, and job satisfaction within the workforce	FOR-U, educators and coaches with consultants	September 2008	Completed
Develop and initiate the provision of technical assistance and consultation services to provider agencies to enhance receptivity and capacity to integrate persons in recovery into their workforce	FOR-U, educators and coaches with consultants	September 2008	Completed
Assist persons in recovery in obtaining employment	FOR-U, educators and coaches with consultants	October 2008	Completed

Complete a survey of all state-run and state-funded mental health service providers regarding currently filled and currently available positions for persons in recovery	FOR-U, Employment Consultant; Workforce management staff Advocacy Unlimited	October 2008	Completed
Create and update at least quarterly a recruitment data-base including online job-bank of persons in recovery seeking employment in the mental health workforce and of providers seeking to employ persons in recovery	FOR-U, educators and coaches with consultants	November 2008	On-going
Assist in identifying key process and outcome variables and measurement strategies to assess C-RECS performance	Project Director with Workforce Team	November 2008	Completed
Provide post-hire training and employment support for persons in recovery employed in the mental health workforce	FOR-U, educators and coaches with consultants	January 2009	Completed
Conduct focus groups on current retention needs and initiatives, including provider needs for training, consultation and technical assistance related to sustaining individuals in recovery in their workforce	FOR-U, educators and coaches with consultants	March 2009	Completed
Develop technical assistance brief on legal and personnel issues involved in creating, posting, and hiring persons in recovery	FOR-U, educators and coaches, consultants	April 2009	Completed
Train and provide technical assistance to agencies employing persons in recovery	FOR-U, educators and coaches, consultants	April 2009	Completed
Phase II			
Offer training to agency staff based on completed Technical Assistance Brief on legal and personnel issues involved in creating, posting, and hiring persons in recovery	FOR-U, educators and coaches, consultants	September 2010	On-target
Continue to provide training and support to new and continuing C-RECS participants to facilitate their entry, retention, and job satisfaction within the workforce	FOR-U, educators and coaches with consultants	September 2010	On-target
Continue to assist C-RECS participants in obtaining employment	FOR-U, educators and coaches with consultants	September 2010	On-target
Continue to provide training, technical assistance and consultation services to provider agencies to enhance receptivity and capacity to integrate persons in recovery into their workforce	FOR-U, educators and coaches, consultants	September 2010	On-target

Project Year 2007/2008 Progress: Focus on Recovery United (FOR-U) was selected as the consumer-run organization to develop and manage C-RECS. C-RECS has been established and recruitment is underway. Training of persons in recovery is scheduled to begin in September and technical assistance in October 2008. The action items related to youth work

force development were added as additional action steps and are anticipated to be completed on time. An online job bank and database for wait-list participants has been developed and recruitment of adults in recovery for employment in behavioral health is underway. Two part-time positions have been filled for maintaining the database and advocacy.

C-RECS implementation is proceeding on schedule, with draft resources for pre-employment (and post-employment) training submitted.

Project Year 2008/2009 Progress: As part of the creation of C-RECS, adults in recovery were hired and trained as peer employment coaches. 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 and four found jobs within the first month.

During Phase I, a total of 436 individual coaching sessions were held for 82 individuals, with 24 additional individuals on the waiting list. Fifteen adults in recovery obtained employment in behavioral health jobs, 6 full-time and 9 part-time in positions including peer mentor, counselor, peer support specialist, drug and alcohol counselor, office manager IT assistant, recreation aide, recovery coach, dietary/health aide and driver. A state-wide conference for human resource staff and agency administrators in January 2009 addressed ways to encourage and continue employment of persons in recovery. Weekly peer employment support groups were initiated in February 2009. An online job bank and database for employers and participants was developed and is used on an ongoing basis. Consultation and technical assistance was provided to three agencies.

During Phase II, C-RECS continued to meet its goals in providing coaching to active participants, with an average of 34 individual participants per month and an average of over 60 coaching sessions offered per month. To date, nearly 600 individual coaching sessions have been provided to adults in recovery. Six C-RECS participants obtained employment, although the current poor economic climate has increased the challenges in participants obtaining employment and agencies' receptivity to and availability for training and technical assistance. The weekly peer employment support groups continue for employed participants, with two new groups starting, and attendance ranging from 6 to 18 individuals. The on-line job bank and recruitment website continues to receive active use. Since the job bank was created in September 2008, the number of positions has increased from 4 positions to 303 positions. Similarly, the C-RECS web site (www.creecs.org) has been receiving more unique visitors each month.

NEW FREEDOM COMMISSION GOAL / END OUTCOME:

Early mental health screening, assessment, and referral to services are common practice.

- 4.1 Promote the health of young children.
- 4.2 Improve and expand school mental health programs.
- 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
- 4.4 Screen for mental disorders in primary health care, across the lifespan, and connect to treatment and supports.

OVERVIEW: Public Act 06-188 Sec. 31 requires the Commissioner of Mental Health and Addiction Services, in consultation with the Community Mental Health Strategy Board, to establish and implement a pilot program for general pediatric, family medicine and geriatric health care professionals to improve their ability to identify, diagnose, refer and treat patients with mental illness and evaluate the program. A report of the findings and recommendations are

to be presented to the joint standing committee of the General Assembly having cognizance of matters relating to public health in January 2009.

OBJECTIVE WD 14: Educate pediatric, family medicine and geriatric health care professionals about mental health screening and coordination with behavioral health providers.

Begin Date: January 2008
Impact: Increased service effectiveness
Ease of completion: Average/Realistic Goal
Population: Across the lifespan

Performance Measurement:

Project Year 2008/2009 Implement a pilot program to educate health care providers to facilitate early identification, referral and treatment of mental illness (GPRA 2, 3).

Action Item	Parties Responsible	Completion Date	Status
Issue Request for Proposals to establish a pilot program to educate pediatric, family medicine and geriatric health care professionals	MHT Staff	February 2008	Completed
Select applicant and begin contract negotiations	MHT Staff	April 2008	Completed
Implement pilot programs	Selected Contractors	August 2009	Initiated
Develop/select curriculum to include: <ul style="list-style-type: none"> • Appropriate age, culture and gender specific developmental information • Appropriate age, culture and gender specific screening tools • Treatment of mental health issues within the primary care setting • Recognition of the need and appropriate time to refer to a behavioral health specialist • Comprehensive resource list of behavioral health services, programs, and providers available within the local pilot site 	Selected Contractors	September 2008	Completed
Implement and conduct training for general pediatric, family medicine and geriatric health care professionals	Selected Contractors	June 2009	Initiated

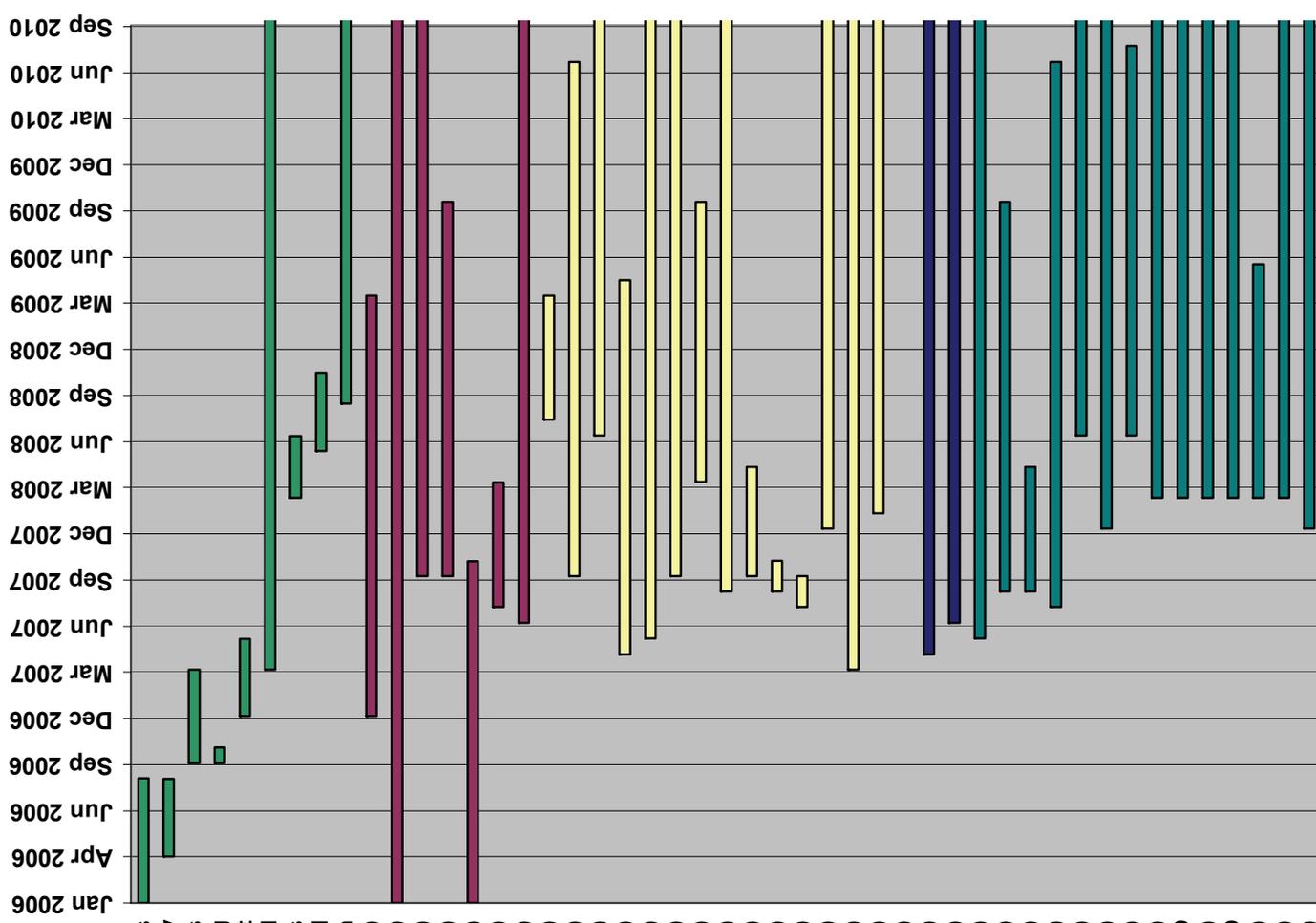
Project Year 2007/2008 Progress: In the spring of 2008, DMHAS on behalf of the MHT-SIG released a Request for Proposals (RFP) seeking qualified applicants to develop and implement a program to educate pediatric, family medicine and geriatric health care professionals in mental health with the goal of improving their ability to identify, diagnose, refer and treat patients with

mental illness. In June 2008, two applicants were identified to implement the pilot program: one to target medical providers serving children and adolescents and one, serving adults.

Project Year 2008/2009 Progress: Both selected contractors, Wheeler Clinic and Fair Haven Community Health Center identified curriculums to be used in their initial proposal. Contract negotiations were significantly delayed due to restrictions on new purchased service agreements at the state level. As a result, contracts were not executed until September 2009.

Summary

In this section of CT's CMHP 2008-09, readers will find a GANNT chart that illustrates all major MHT-SIG activities that have occurred in Connecticut since the inception of the project, an in-depth section providing detail about CT-specific Government Performance Results Act measures (GPRA's), and the conclusion.



Workgroups Identify CT MHT-SIG Recommendations

Complete Needs Assessment and Resource Inventory

Workgroups Identify Strategies for Identifies Recommendations

First Statewide Electronic Town Hall Meeting

Sub-Committees Meet

C/Y/F Advisory Council Established

MHT RFP Releases \$1.3 Million to 35 Projects

MHT Projects Implemented

Cross Site Evaluation

Anti-Stigma Media Campaign (CE 1)

Transformation Presentations (CE 2)

School Mental Health Education (CE 3)

Expand MH in SBHC (CE 4)

Launch NoC (CE 5)

NoC Oversight (CE 6)

Increase Awareness of NoC (CE 7)

Youth Guided Change to NoC (CE 8)

Establish a C/Y/F Evaluation Collaborative (CYF 1)

C/Y/F Evaluation Process (CYF 2)

Implement Home & Community Based Waiver (CYF 3)

Integrate Recovery-Oriented Care Guidelines (CYF 4)

Employ Persons in Recovery (CYF 5)

Train C/Y/F as Recovery Supporters (CYF 6)

Advance Health Care Directive Procedures (CYF 7)

ADA Compliance (CYF 8)

Legislative Changes to PSRB (CYF 9)

Educate Persons in Recovery on Their Rights (CYF 10)

Increase the # of C/Y/F Conducting Research (CYF 11)

C/Y/F Advisory Council (CYF 12)

Alternative to Seclusion and Restraint (CYF 13)

Peer Specialist Certification (CYF 14)

State Agencies Identify Health Care Disparities (DDD 1)

Share Data Across State Agencies (DDD 2)

Train Staff in Person-Centered Planning and Rehab Services (WD 1)

Evaluate Use of Seclusion and Restraint at DMHAS (WD 2)

Reduce # of Youth Entering Juvenile Justice System with Wraparound (WD 3)

Increase Capacity of Workers to Utilize Wraparound (WD 4)

Increase Consistency of Court Based Assessments with Wraparound (WD 5)

Demonstrate Effectiveness of Wraparound Project (WD 6)

Establish CT Workforce Collaborative on Behavioral Health (WD8)

Expand Workforce Skilled in Evidence-Based In-Home Family Treatment (WD 9)

Strengthen Role of Parents in the Workforce (WD 10)

Develop Capacity of Supervisors with Web-based Learning Resources (WD 11)

Increase Capacity of Health and Human Service Personnel (WD 12)

Create C-RECS (WD 13)

Educate Health Care Providers About MH Screening & Coordination (WD 14)

Progress toward the Achievement of Government Performance Results Act (GPRA) Measures

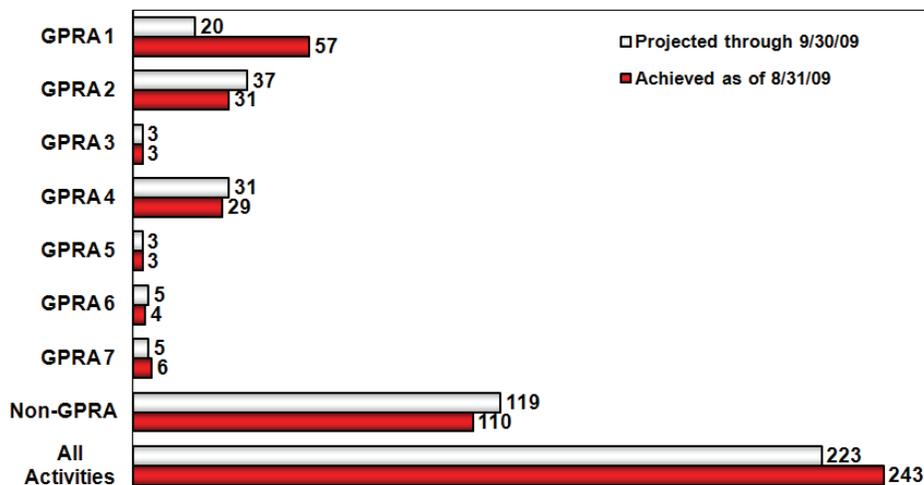
Connecticut's MHT-SIG collects data and evaluates progress toward achievement of the seven GPRA indicators provided by SAMHSA on a quarterly basis. The quarterly reports track Connecticut's success in achieving goals related to the following seven infrastructure changes:

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

In addition, Connecticut's MHT-SIG tracks activities and outcomes that do not directly result in infrastructure changes, even if they are necessary processes or action steps for such changes to occur. These action steps and outcomes are classified as Non-GPRA activities. For example, identifying a vendor, creating a curriculum, and recruiting participants are prerequisites to training individuals in service improvements (GPRA 2) but do not directly result in such infrastructure enhancement, as defined by the seven GPRAs, thus are categorized as Non-GPRA data.

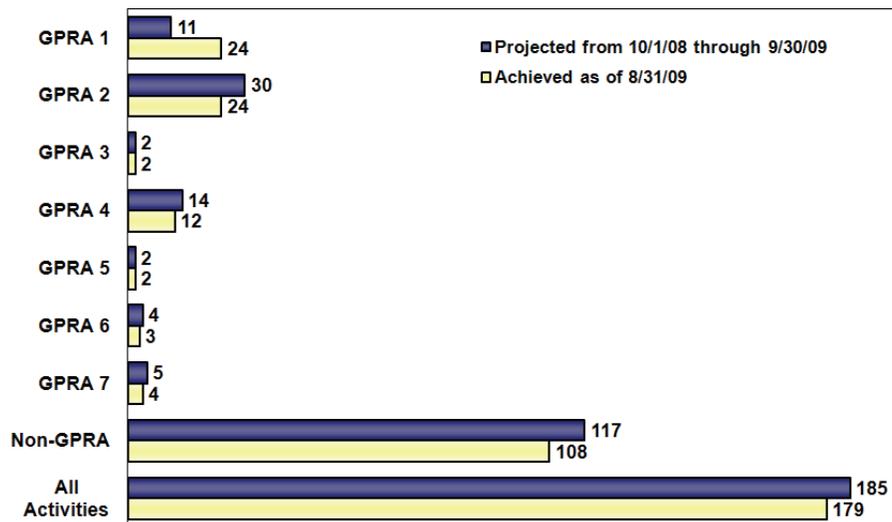
An assessment of Connecticut's overall progress to date reveals a high degree of success towards transforming the mental health system through infrastructure enhancements. Whereas 104 GPRA changes were projected to be completed by the end of September 2009 in the 2007/2008 and 2008/2009 plans, as of August 31, 2009, this goal was already surpassed by 28% by achieving 133 infrastructure changes. As can be seen in the figure below depicting Connecticut's cumulative progress to date, this is largely due to a greater than expected number of policy changes (GPRA 1).

Figure 1: Cumulative MHT-SIG Progress



Connecticut is also on target for achieving most of its performance indicators that were projected to be achieved during 2008/2009 (see figure below).

Figure 2: Previous Year MHT-SIG Progress



GPRA 1: Increase % of policy changes completed as a consequence of the CMHP

GPRA 1 activities achieved over the past year include the passage of 16 pieces of legislation that bring our system of care closer to the one outlined in the President’s New Freedom Commission report, including an act directing the adoption of recovery-oriented language in the statutes regarding persons with psychiatric disabilities and substance use disorders to reflect the respect and dignity due to these individuals. A number of other bills were passed that relate to older adults, data sharing between state departments, and increasing access to medical and behavioral health care to people across the lifespan. Eight additional activities resulted in policy changes during federal fiscal year 2008/2009, including:

- 1) Approving performance measures to be used to assess continuous quality improvement throughout the mental health system;
- 2) Establishing an electronic medical record protocol to ensure adherence to person-centered principles;
- 3) Finalizing the curriculum to replace the Behavioral Management System training throughout the system;
- 4) Establishing a Memorandum of Agreement between DMHAS, DCF, and CSSD for the implementation of the Wraparound initiative;
- 5) Creating by-laws, policies, and procedures to build local community collaborative infrastructure for the Wraparound initiative;
- 6) Executing a Memorandum of Agreement between state agencies to guide and sustain the Collaborative on Workforce Development;
- 7) Creating standards for supervision;
- 8) Incorporating goals to reduce and eliminate seclusion and restraints into policies and procedures at Connecticut’s two state psychiatric hospitals (Connecticut Valley Hospital and Cedarcrest Hospital).

Two GPRA 1 activities pertaining to advance directives were revised due to a change in the scope of the project. The remaining GPRA 1 activity, “approving standards for consumer, youth, and family involvement in continuous quality improvement throughout the system,” is expected to be achieved early in the federal fiscal year 2009/2010.

GPRA 2: Increase in number of persons in the mental health care and related workforce who have been trained in service improvements recommended by the CMHP.

Twenty-three training initiatives representing 30 CMHP action items resulted in the training of over 11,000 individuals in Connecticut (some training initiatives involve multiple action items). Specific GPRA 2 activities, and their respective cumulative attendance since training began, included the following:

- 1) Mental health documentaries (n = 152,000 viewers);
- 2) Transformation presentations and Network of Care demonstrations (n = 2,758);
- 3) Continuous quality improvement and survey administration training for consumers, youth, and family members as part of the Quality Improvement Collaborative (n = 450);
- 4) Recovery supporter training for persons in recovery (n = 67);
- 5) Advance directives to persons in recovery and staff (n = 292);
- 6) Research and evaluation training for consumers, youth, and family members as part of the Consumer/Youth/Family Research and Evaluation Network (n = 73);
- 7) Certified peer specialist training (n = 42);
- 8) Trauma-informed care training and alternatives to restraint and seclusion to staff at Connecticut Valley Hospital and Cedarcrest Hospital (n = 1,288);
- 9) Sensory modulation techniques (n = 23);
- 10) Person-centered planning for staff at Connecticut Valley Hospital (n = 3,840);
- 11) Person-centered treatment plans using the Recovery Management System (n = 267);
- 12) Collaborative Safety Strategies to Department of Mental Health and Addiction Services staff (n = 2,412);
- 13) Basic Wraparound training to diverse stakeholders (n = 324);
- 14) Wraparound in vivo coaching (n = 21);
- 15) Evidence-based in-home family treatment to faculty members (n = 5);
- 16) Evidence-based in-home family treatment to graduate students (n = 75);
- 17) Leadership training to parents (n = 232);
- 18) Leadership to stakeholders in association with the Wraparound project (n = 92);
- 19) Supervisor competency and standards for supervisors and direct care staff (n = 458) (two action items);
- 20) Mental Health First Aid training (n = 53);
- 21) Employment training for consumers as part of the Connecticut Recovery Employment Consultation Service (n = 150);
- 22) Health and human service personnel to work with persons in recovery (n = 67);
- 23) Person-centered planning training for community-based providers (n = 1,041);

The following training activities are expected to be completed or initiated by the end of federal fiscal year 2008/2009 as initially projected: 1) training a second group of faculty members from participating graduate programs in evidence-based in-home family treatment {WD 9}; 2) Phase II training of parents in parent leadership {WD 10}; 3) training parent leadership graduates to help lead regional support groups {WD 10}; and 4) peer mentor certification training to graduates of parent leadership training {WD 10}. One training activity was not completed according to schedule: educating health care providers about mental health screening and coordination with behavioral health providers {WD 14}.

GPRA 3: Increase percent of financing policy changes completed as a consequence of the CMHP

The two financing policy changes that were implemented were: 1) The Medicaid - Home and Community Based Waiver, known as the WISE (Working for Integration, Support, and Empowerment) Program; and 2) The braiding of funding from the MacArthur Foundation to

enable expanded training and technical assistance through the Wraparound Infrastructure project.

GPRA Indicator 4: Increase percent of organizational changes completed as a consequence of the CMHP

Connecticut achieved 12 of the 14 projected GPRA 4 activities as of August 31, 2009 for this fiscal year. These activities included:

- 1) Working with Medicaid Infrastructure Grant (MIG) partners to leverage Connect-Ability marketing specific to the mission of state agencies;
- 2) Increasing the number of agencies that post links to the Network of Care website;
- 3) Increasing the number of services and resources listed by programs on the Network of Care website;
- 4) Establishing the Central Coordinating Council of the Quality Improvement Collaborative;
- 5) Implementing the Home and Community Based Waiver program;
- 6) Implementing the WISE program;
- 7) Establishing the Consumer Research and Evaluation Network;
- 8) Hiring a full-time project manager for the data interoperability project;
- 9) Implementing a system of review of court evaluation reports;
- 10) Executing a Memorandum of Agreement between state agencies to guide and sustain the Workforce Collaborative;
- 11) Implementing strategic plans for the reduction of seclusion and restraint in Connecticut's state hospitals;
- 12) Adopting supervision standards at two agencies.

The following organizational changes are expected to be completed or initiated by the end of federal fiscal year 2008/2009 as initially projected: 1) Dissemination of revised, integrated recovery-oriented care guidelines with letter from the DMHAS Commissioner {CYF 4}; and 2) Establishing at least five regional support groups for alumni of the parent leadership training {WD 10}.

GPRA Indicator 5: Increase the number of organizations that regularly obtain and analyze data relevant to the goals of the CMHP

Connecticut is on target with the achievement of GPRA 5 activities. First, a survey was completed of all state-run and state-funded mental health service providers regarding currently filled and available positions for persons in recovery as part of the Connecticut Recovery Employment Consultation Service (C-RECS). This data will continue to be collected periodically in the future. Second, C-RECS also created a recruitment database which includes an online job-bank of persons in recovery seeking employment in the mental health system that is reviewed and updated quarterly.

GPRA Indicator 6: Increase the number of consumers and family members that are members of statewide consumer- and family-run networks

Connecticut is also on target with the achievement of GPRA 6 activities. New members joined three newly established networks: 1) The Central Coordinating Council; 2) The Consumer Research and Evaluation Network; and 3) The Consumer, Youth, and Family Advisory Council. The final GPRA 6 action item is on-target for completion this year—the establishment and recruitment of members for statewide, regional support groups for alumni of the parent leadership project.

GPRA Indicator 7: Increase the number of programs implementing practices consistent with the CMHP

Four of the five GPRA 7 activities projected for this year were accomplished. First, the Home and Community Based Waiver Program was implemented in Connecticut {CYF 3}. Second, the WISE program was implemented across the system {CYF 3}. Third, the anti-stigma media campaign was disseminated in print and radio formats across Connecticut {CE 1}. And finally, a revised training curriculum in the prevention of dangerous behavior was delivered to staff across the system {WD 2}. The creation of a system for ongoing in vivo coaching in Wraparound was postponed until early 2009/2010.

Non-GPRA Activities

Connecticut is on target with completing the majority of activities that are critical to achieving the remaining GPRA activities for this year. As described previously, many of these activities are preliminary steps and thus do not directly result in infrastructure changes as defined by the GPRAs, however they are steps that are essential to the process.

Proof-of-Concept Study

Connecticut's Proof-of-Concept study involves an in-depth outcome evaluation of 300 participants (150 youth and 150 adults), family members, and providers of services involved in two MHT initiatives -- one adult and one youth. The Wraparound initiative (Objectives WD 4 – WD 7) serves as the project for the youth “resiliency” study and the person-centered planning training initiative is the project for the adult “recovery” study (WD1). In federal fiscal year 2008/2009, preparations were completed for both projects, including finalizing the design of the studies, forming partnerships with service agencies, and obtaining IRB approval from multiple institutions to carry out the studies. As of August 2009, baseline data collection was completed for the adult study. The youth study is still undergoing one final IRB review through the Court Support Services Division. Data collection for the youth study is expected to begin during the first quarter of 2009/2010 fiscal year. Follow-up data will be collected on all study participants in the final quarter of 2009/2010 fiscal year.

CONCLUSION

Connecticut's Mental Health Transformation efforts as reflected by this, our fourth Comprehensive Mental Health Plan (CMHP), continue to evolve. In project years 1 and 2, over 200 consumers, family members, non-profit providers and state agency representatives participated in seven workgroups designed to identify recommendations related to each of the New Freedom Commission goals and Connecticut's seventh goal, workforce development. From this process, over 48 recommendations were identified.

In project year 2006-07, workgroups developed a strategy for implementation of prioritized recommendations. Workgroups presented their strategies to a group comprised of newly formed Consumer, Youth and Family Advisory Council members and members of four Oversight Committee sub-committees.

In year three (2007-08), Connecticut's Transformation Initiative made its largest strides towards system change in two areas: Cross agency coordination and Consumer, Youth and Family involvement. First we capitalized on opportunities for change by pursuing like-minded initiatives, partnering with state agency colleagues who understand and accept the vision of change, and most importantly, listening to the voices of those who have first hand experience with what changes should be expected- the consumers, youth and families who have used the system. In matters related to involving consumers, youth and family members, we made steady and consistent progress toward identifying how best to engage consumers in the process.

The 2007-2008 CMHP marked a significant structural change within CT's MHT-SIG. Based on strategic planning and technical assistance facilitated by Martin Cohen, consensus was met among Connecticut's Transformation governing structure (the Oversight Committee and Consumer, Youth and Family Advisory Council) to move forward organizing efforts by focusing on four domains:

- 1) Increasing consumer and family involvement;
- 2) Using data to evaluate effectiveness and inform practice;
- 3) Educating the community about mental health and Transformation; and,
- 4) Training the workforce.

The 2008-09 CMHP moved CT transformation activities to a new level, one of implementation and outlined changes that were made along the way.

While Connecticut's MHT efforts remain stalwartly headed toward the promotion of resilience, recovery, and inclusion in community life, this past year has been filled with challenges. Despite these challenges, this year's CMHP (2009-2010) describes CT's current progress toward achieving the vision of transformation and the steps underway to sustain that vision.