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**Connecticut Department of Mental Health
And Addiction Services**

***Aligning for Recovery:
Towards A Strategic Systems Blueprint
To Promote a Recovery-Oriented
Mental Health System in Connecticut***

**Consultant Report
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Under Contract to:

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Part I: Background and Format of Consultation

In April of 2002, the State of Connecticut Department of Mental Health and Addiction Services (DMHAS) requested technical assistance related to the design and implementation of a recovery-oriented system of care from the National Technical Assistance Center (NTAC) of the National Association of Mental Health Program Directors, (NASMHPD).

The Connecticut request included specific targeted deliverable as part of this technical assistance request. These included:

- Define what services and supports should be included in a recovery-oriented system of care
- Specify strategies for internal organizational development that would lead to changing attitudes and adopting a recovery culture
- Identify providers' resource and training needs to fully integrate Connecticut's Recovery Core Values into all of its services
- Describe a comprehensive training program for clinicians, staff and consumers, and provide appropriate training materials
- Provide a plan for promoting recovery through the media and for developing other communication and public relations products on recovery

NASMHPD responded favorably to the DMHAS technical assistance request. Recognizing that the scope of the Connecticut activities related to moving towards a recovery-oriented system of care would probably cover a period of years, the goals for a preliminary technical assistance consultation were refined and narrowed. Through correspondence, emails and conference calls, an initial technical assistance agenda was developed that included the following specific objectives and work products:

Objectives for Initial NASMHPD Consultation/Site Visit

- Introduce selected NASMHPD consultant to key system stakeholders involved with the Connecticut recovery initiative
- Provide information to consultant related to perspectives on the recovery initiative of key system stakeholders at levels of the state, consumer, family member and providers
- Identify cross-system dimensions to statewide recovery initiative
- Identify range of policy and treatment issues involved in shifting to a recovery orientation
- Identify range of administrative and outcome-related issues involved in shifting to a recovery orientation

Specific work products to emerge from the site visit:

- A framework for a survey to collect information on recovery-oriented initiatives in other jurisdictions
- An outline of core components of a strategic plan/blueprint for a Connecticut State recovery initiative
- A description of key elements of the strategic plan/blueprint for a recovery initiative

David M. Wertheimer, M.S.W., M.Div. was selected by NASMHPD and approved by DMHAS as the consultant for this initial set of consultation activities. Mr. Wertheimer is Principal Consultant with Kelly Point Partners, a Seattle-based consulting firm that works with states, counties and municipalities around the nation on issues related to the configuration of publicly-funded human service systems.¹

NASMHPD contracted with Mr. Wertheimer for a two-day site visit to Connecticut that could provide the information needed to complete the objectives and work products identified as part of this initial consultation. October 21-22, 2002, were selected as the dates for this site visit. A series of 10 meetings with key stakeholder groups were scheduled for these two days. A complete agenda for the site visit can be found in ***Attachment #1*** to this report.

More than 75 individuals were part of these meetings, including state-level system stakeholders, members of the state Board of Mental Health and Addiction Services, consumers and self-advocates, family members and advocates, mental health service providers and representatives from allied systems. A list of participants in the meetings with key stakeholders is included in ***Attachment #2*** to this report.

¹ For additional information about Mr. Wertheimer and Kelly Point Partners, visit the agency's web site at www.kellypointpartners.com.

Part II: Key Stakeholder Perspectives

State DMHAS Perspectives

The State of Connecticut has clearly articulated a vision to promote the concept of recovery as the overarching goal of the service system operated by DMHAS. The State defines recovery as “*a process of restoring or developing a positive and meaningful sense of identity apart from one’s condition and then rebuilding one’s life despite, or within the limitations imposed by that condition.*”² DMHAS considers that recovery is a person-centered approach and may vary from individual to individual within the mental health and addictions communities. Examples of recovery include:

- Returning to a healthy state evidenced by improving one’s mood and outlook on life following an episode of depression
- Managing one’s illness such that the person can live independently and have meaningful employment and healthy social relationships
- Reducing the painful effects of trauma through a process of healing
- Attaining or restoring a desired state such as achieving sustained sobriety
- Building on personal strengths to offset the adverse effects of a disability

Members of the DMHAS core staff are enthusiastic supporters of this vision of recovery. State staff have endorsed a systems approach and are committed to the process of moving the mental health system towards an underlying change in philosophy that can drive: How people struggling with mental illness are approached; a configuration of services that promotes recovery; and, system goals and outcomes that are clearly defined and measured. Because of the belief that the shift towards a recovery paradigm must be systemic, DMHAS seeks to move the system as a whole towards implementation of this vision, rather than working to develop experimental recovery-oriented programs in pilot sites around the state.

State-level staff view moving towards the recovery paradigm as a staged process. The basic steps in this process include:

1. Engaging system stakeholders in a discussion about what recovery actually is and developing a vision of a recovery-oriented system of care
2. Articulating to the field with specificity what is meant by a recovery-oriented system in terms of skills and services, policies, procedures, training, etc.
3. Implementing recovery-oriented models of care, identifying core outcomes and evaluating the effectiveness of support and treatment interventions.

² See Commissioner’s Policy Statement #83, “Promoting a Recovery-Oriented Service System, September 10, 2002

A significant amount of activity is already underway in the first two stages of this change process. Some of these activities include:

- Convening a Governor's Blue Ribbon Commission on Mental Health
- Conducting and compiling the results of a Recovery Self-Assessment targeting consumers/self-advocates, family members and provider agency staff
- Mobilizing a three-stage, statewide Recovery Institute to train people in recovery, providers and stakeholders about the concepts central to a recovery-oriented system of care
- Developing and enhancing the vocational system and employment services for persons in recovery
- Addressing the usefulness of Advance Directives as a component of effective care with the Connecticut Legal Rights Project
- Ensuring the delivery of culturally competent services within a recovery framework
- Identifying evidence-based preferred practices appropriate to a recovery-oriented system of care
- Convening a variety of work groups to promote and implement the recovery vision, including the Recovery Policy Work Group, the Commissioners Advisory Group and the Policy Advisory Work Group

In summarizing the meetings held with the DMHAS stakeholders, the level of interest and excitement among state staff about implementing a statewide, recovery-oriented system of care is particularly noteworthy. The current national economic climate, and the associated cuts to state human service budgets have had a devastating impact on mental health treatment and community support services throughout the United States. In many parts of the country, state mental health staff present as a demoralized group of beleaguered bureaucrats, doing their best to hang on to the hard won gains of the past several decades in the face of seemingly overwhelming odds. The level of enthusiasm about and commitment to a recovery-oriented system of care that is present among state staff in Connecticut is a stark and refreshing contrast to the gloom that is present in so many other states. DMHAS should take note of how embracing a new vision for the system of care has boosted staff morale, and celebrate with staff that there are alternatives to silent acquiescence in economic hard times.

State Board of Mental Health and Addiction Services Perspectives

Members of the State Board are also highly enthusiastic about the recovery initiative. They have a particular interest in helping persons recovering from serious and persistent mental illness access the types and range of services that were not available in the past that can help individuals to gain confidence in their ability to fully participate in society – e.g., maintaining a job, a home and meaningful relationships.

The Board has appreciated all of the planning opportunities that have been made available under the auspices of DMHAS, including the convening of meetings in each of the five state regions to identify the needs that are specific to each of regions. The Board

also noted and congratulated DMHAS on a very clear recovery policy statement from the Commissioner.

The Board believes that it is logical to talk about recovery if you are a consumer or family member, but winning the confidence and participation of the existing provider network may prove somewhat more challenging. Providers can be resistant to change and do not necessarily seem as comfortable or familiar with recovery concepts. For example, some providers are not yet grasping what it means to truly involve clients in the treatment planning process; consumer participation must be more than a signature on a standardized treatment planning document. It will also be essential to link the recovery orientations in both mental health and chemical dependency services, but there may also be resistance to this activity among providers in both arenas.

Concerns and suggestions raised by the Board members included:

- *Increase public awareness of mental illness and addictions:* Addressing stigma about mental illness and addiction disorders is essential to move legislators beyond their hesitancy to provide adequate funding of treatment and support needs, and to stop them from taking money away from essential services. Efforts must include demonstrating that investment in the DMHAS system of care is necessary to save money and lives.
- *Increase system capacity:* Many community mental health agencies have long waiting lists for basic services. Other providers are swamped with individuals needing crisis intervention and short-term services. With limited system capacity, many providers may perceive that they don't have the time, staff or resources to address recovery issues as "the next new thing."
- *Create information clearinghouse:* The system does not yet offer a coordinated clearinghouse of recovery-oriented activities that are ongoing and organizations/programs that are being established. This conveys a non-strategic approach to systems change – that things are happening on a "one-shot" basis rather than in a coordinated, building-block approach to systems change. The range of recovery-oriented activities must be linked to each other via a mechanism that promotes a coordinated campaign to change the system, measure what is happening and provide insight into the change process. (The United Way community "thermometer" approach was cited as an example of this type of mechanism.) A regular "systems change report card" that is oriented towards recovery would be helpful.
- *Address self-doubt of persons in recovery:* Stigma has an impact both on the public as well as on persons with mental illnesses. Many consumers don't believe that recovery is within reach, in part because of what they have been told/taught by their providers. A large number of clients have never had or have lost their hope in the vision of recovery.

- *Provide training for providers on recovery issues:* Many providers do not know or believe that recovery from mental illness is possible – this includes doctors, clinicians, case managers, etc. The system must instill sense of HOPE that recovery is possible among consumers and providers alike, or the initiative itself will be jeopardized. Training must be focused on front-line workers – the lowest paid individuals who have the most direct client contact. Understanding the goals, principles and practices of recovery-oriented care might help to increase job satisfaction and decrease burnout and turnover among line staff.
- *Increase prevention activities:* Prevention efforts are an essential component of a recovery-oriented model. For example, many in both the legislature and the community do not yet realize that community-based services cost a fraction of institutionalized services, and are better for individual clients.
- *Address heterogeneous needs of the population:* Although legislators and politicians may be sympathetic to the issues, the complexity of the target populations makes the issues and the problems complex. Generalizations about “what works” are neither helpful nor accurate. Although legislators may respond to those persons with mental illness who are labeled “most dangerous and/or most critically ill,” this often means that services provided in the community (rather than in institutional settings) that can facilitate recovery get lost in the shuffle. It is also essential to ensure that services provided address the broad range of cultural populations that can be found throughout the state.
- *Promote employment:* Jobs that pay livable wages should be a top priority of a recovery-oriented model. If individuals with mental illnesses cannot move away from poverty, recovery will be intermittent and incomplete over time. Training and education is critical to helping providers and consumers to pursue recovery in more “normal” ways (e.g., work, housing, etc.) and not just in providing treatment and medications.
- *Increase credibility of consumer providers:* Providers who are also consumers have not yet won the respect and support of more traditionally “credentialed” providers. Part of moving to a recovery model will require that the system employ more consumers as providers and ensure that they receive the same level of respect that is shown to other providers.
- *Promote voter registration:* Part of recovery involves participation in society, and persons with mental illness have among the lowest levels of voter registration. Efforts to register voters and interest them in the electoral process must be a focus of activity in mental health agencies and other treatment settings.

In summary, the Board members believe that DMHAS is moving the system in extremely healthy, important and encouraging directions. The DMHAS posture on recovery-oriented services the right one. The system is listening to people in recovery to

understand and address their needs. The Board is fully supportive of moving the mental health system in the direction of recovery-oriented care.

Consumer/Self-Advocate Perspectives

The consumer/self-advocates who met with the consultant also expressed complete and enthusiastic support for the recovery-oriented processes that DMHAS has put in place. There is hope that the initiative will be implemented in a logical fashion, with mechanisms for monitoring compliance in place. Recovery must be something that is both “talked” and “walked,” rather than a vague notion “out there” that no one is really implementing. Providers must be held accountable for implementing a recovery model.

Consumers/self-advocates perceive employment as one of the most a critical components of a recovery model. Employment returns self-respect to individuals, based on participation in meaningful work that is adequately compensated. A job provides a sense of being wanted and a feeling of belonging.

Assertive vocational programs must be part of the process of preparing people for employment. Many existing programs are too “timid” and appear to be more concerned with maintaining relationships with employers than with building effective skills and relationships with employees. Counselors often put too many limits on consumers seeking work, recommending only certain jobs or types of work. This attitude and practice discourages a client’s sense of hope and belief in the possibility of recovery.

Often, consumers must seek employment “in the closet” -- i.e., not disclosing the nature of their mental illnesses to prospective bosses. Consumers, providers, the community and employers need education about mental illness and the reality that recovery is possible. It also is important to create an environment that promotes paid employment while preserving individual client health benefits. There is currently a perverse incentive that prevents many consumers from job and wage advancement; in order to preserve eligibility for benefits, the more money you earn the fewer hours you are able to work.

Consumers/self-advocates believe that part of a moving towards a recovery orientation means that DMHAS must create opportunities for success for clients with psychiatric diagnoses. Success must be measured not only in terms of jobs, but also in relation to housing and community/family support systems. Rather than suggesting clients limit their visions of recovery, the system should encourage clients to define and pursue their own visions of success. Success often happens when you pursue it yourself rather than have someone else try to make it occur for you. However, the system and provider agencies also must learn system how to facilitate this type of client-generated success. Promoting supportive rather than patronizing services is an essential first step.

Consumers need services and supports that are appropriate to their specific illness and the stage and level of recovery they are in. This means a range of services targeting people at different points in their recovery process. “The curse of the high functioning” must be addressed as part of this continuum of care; currently, it is assumed that if an individual is

relatively well functioning at a given point in time and can do most things for him/herself, he/she doesn't need (and never gets) the help needed when it is required to sustain the level of recovery that has already been achieved.

The consumer/self-advocate group stated that implementation of a recovery-oriented system requires obtaining regular and meaningful input into system design and evaluation from people in recovery and their family members. Accountability measures that move the system where it needs to go must be built into contracts. These measures should be related to program configuration, staff competencies, desired outcomes, etc. DMHAS should develop a process for competency-based staff certification and agency accreditation and licensing around recovery issues and service delivery. Client satisfaction surveys should be focused at the individual client level rather than the agency level.

Other issues addressed by the consumer/self-advocate group included:

- *Address system gridlock:* Currently, consumer/self-advocates report that there is a minimum wait of 6 weeks for an intake appointment, and waiting 2-3 months is not unusual, even when the individual is Medicaid-eligible. It is extremely difficult to get into services, easy to get discharged from care for “non-compliance.”
- *Provide adequate treatment for mental health services, including consumer provider programs:* Often, it seems that the state constantly tries to get providers to provide more services with less money. This is also true in area of consumer provider programs. Although the recovery model promotes paying consumers market fair wages for their work, there is no money to adequately pay people for the work they do.
- *Increase linkages to the Department of Corrections:* Consumers currently come out of DOC with only a two-week supply of medication and no clear service linkages. They are told they must find someone who will maintain their medication and treatment, but this is virtually impossible to do because of the systems gridlock in psychiatric referrals and evaluations. Many of these individuals end up in hospital emergency rooms and are forced to say they are at risk of harming themselves or someone else in order to get assistance and medication.
- *Improve access to dental care:* Many consumers have high levels of dental problems and needs that have gone untreated for years. Almost no dentists are available that will accept Medicaid payments.
- *End paternalistic provider attitudes:* The recovery model and paternalism are incompatible. The attitude of “I will take care of you, I know what you need” must be discouraged and replaced with a more recovery-oriented perspective.

Consumer/self-advocates refer to this as the “Fairfield Hills/Norwich Hospital Syndrome -- Control, maintain and govern.”

- *Provide adequate staff training:* Newly hired staff who perceive that they are coming into agency settings to promote recovery-oriented services are quitting their jobs because they cannot tolerate the traditional and patronizing environment sustained at many of the provider agencies. Both new and existing agency staff must receive training and ongoing supervision and support that are specific to recovery-oriented treatment.
- *Promote a strategic system response:* Given the backlog of individuals waiting for treatment and support services, recovery can be seen as a valuable and strategic mechanism for promoting wellness and increasing system capacity. The approach must be strategic. Providers who are unable and unwilling to adopt a recovery orientation should no longer receive contracts for services to publicly funded clients.
- *Ensure longevity of recovery-oriented initiative:* System stakeholders, including providers and consumers must be convinced by DMHAS that the recovery paradigm is not just the “flavor of the month” or the latest fad. The state can begin to do this by starting at home; hiring more “out” and visible consumers as staff at DMHAS will help to demonstrate that the state is serious and will begin the processes of institutionalizing the paradigm shift to a recovery model.

In summary, the consumer/self-advocate representatives who met with the consultant presented a highly articulate and highly supportive voice in support of the DMHAS recovery initiative. They demonstrated the power and potential that is unleashed when individuals with serious mental illnesses are fully connected to the belief and hope that recovery is possible. This group represents an extremely strong ally in the system change process, and the resources that they offer to the recovery initiative have only begun to be tapped and put to constructive uses.

Family Member/Advocate Perspectives

Family members/advocates are also extremely supportive of the DMHAS recovery-oriented initiative. The primary concern expressed by this stakeholder group was the issue of how the initiative will be “fleshed out” and made real. Particular concern was voiced about the providers with whom the state contracts for community-based mental health treatment. The group encouraged the placement of strong language related to recovery in all agency contracts; there is a sense among family members that agencies can more or less do as they please without risking loss of public funding from one contract to the next. Agencies that do not measure up to the goals, objectives and outcomes of recovery should not receive renewal contracts. Even the larger mental health agencies that have enormous catchment areas should be evaluated on a program-by-program basis, and programs that fail to meet recovery-oriented standards should be altered or eliminated.

The family member/advocate stakeholder group was also concerned about the services that are provided by state-run and staffed agencies. Mechanisms that ensure effective evaluation of these agencies in relation to recovery principles must also be in place. Agencies must be effectively monitored and corrective actions, where needed, must be articulated. Regional mental health boards might be in the best position to undertake this monitoring activity. This would help to guarantee an independent evaluation process at the regional levels.

The results of evaluation activities should be used to inform decision-making about funding levels at different agencies. The five regional mental health authorities should understand and use the authority they are given in statute to monitor services. The evaluation process itself can be used a tool to move the system in the directions it needs to go, particularly in relation to recovery.

The family member/advocate expressed concern about the number of different planning groups that have been addressing system development and improvement over time. Planning has been ongoing for many years, without clearly discernable results. The stakeholder group strongly encouraged that the planning, evaluation and financing systems for mental health services to both adults and children/youth be woven together into a single fabric that creates a single strategic approach that defines what agencies should be funded to provide various services as well as the levels of funding allocated. This strategic approach should allow for local variations in the types of services funded based on input of the five regional mental health authorities in order to recognize local issues and needs that vary throughout the state.

This stakeholder group also discussed what it considered to be the critical outcomes that DMHAS should be measuring and monitoring as the recovery-oriented initiative moves forward. Outcomes should include specific client-level measures such as:

- The presence of a section on promoting recovery in every client treatment plan, whether hospital or community-based. Ideally, the concept of treatment plans should be replaced by “recovery plans,” and clients should be identified as leaders of the recovery team.
- Documentation of whether and how the life of the individual consumer has improved
- Increasing levels of competitive-wage employment
- Stable, decent, safe and affordable housing

Consumer providers would be particularly effective at conducting recovery-oriented consumer surveys that could collect this outcome data. The family member/advocate stakeholder group also identified a number of system-level data elements and measures that should be incorporated into the evaluation of the recovery initiatives. These include:

- Reduction in rates of arrest and jail recidivism
- Reduction in nursing home placements of mental health consumers

- Reduction in inpatient placements and hospital gridlock
- Reduction in homelessness
- Access to employment in non-traditional jobs (not “food, filth and flowers”)
- Access to supported education

Outcomes related to community education and prevention were also identified by the family member/advocate group. These include:

- Successful community education to reduce stigma
- School-based wellness programs, including those targeting youth depression, anger management, etc.
- Access to school curricula in local school districts, town by town (as is the case with substance abuse issues)
- Training of professionals working with youth in mental illness prevention strategies

The Family Member/Advocate stakeholder group identified a number of significant “next steps” that could be undertaken at a systems level that would create significant recovery-oriented impacts without substantial additional cost. These include:

- Creation of a NAMI-sponsored “Recovery College” to provide training to consumers, providers and planners about recovery issues and recovery-oriented care.
- Increased access to peer counseling and peer supports; for people with major mental illnesses, seeing and being involved with someone with a similar illness who is succeed can be life transforming.
- Increased hiring of people in recovery at state and agency levels and the creation of and environments that welcomes and include consumers as peers without stigma.
- Promotion of access to “real” employment at competitive salaries.
- Recognition and inclusion of families in the recovery process by DMHAS and provider agencies, treating them as more than just “invisible pillars.”
- Enhancement of supported/assisted living opportunities. In a recovery-oriented system, there should be talk of “homes” instead of “beds.” Individuals who provide assisted living should be paid appropriately to open their homes to persons with mental illness, (as is done in the MR/DD system).
- Strengthening of community psychiatry that moves the locus of psychiatric services away from inpatient services towards the community. This should include a DMHAS mandate for improved linkage between community and hospital based services.

Mental Health Provider Perspectives

The mental health provider stakeholders who met with the consultant fully endorse the concept of a recovery-oriented system of care, but also articulated a broad range of

questions and concerns related to how such a system will be planned, structured, mobilized, funded and monitored.

It is clear to the providers that change is and will be happening around recovery issues throughout the mental health system. From the perspective of the providers, this is first time the mental health authority has put in place a new philosophy that the recipients of service are strongly and collectively supporting. The provider stakeholders support it as well, and appreciate that all corners of the system are being presented with opportunities to offer extensive input before and during change process. The system is right to be moving forward cautiously.

Some of the providers view the move to a recovery model as more “evolutionary” than “revolutionary.” Intolerance for those who are not yet fully comfortable “buying into” the model should be eliminated. It is unfortunate when providers are told or made to feel that they way they used to conduct business or how services were provided in the past were “wrong” and that they must be reprogrammed to adopt a “new” way of being in the system.

Although there have been extensive planning processes, providers perceive that there is still limited information available about what a recovery-oriented system of care will look like at the level of direct services to individual clients. There is a perception/concern that “the devil is in the detail” and that insufficient consideration has been given to date to the concrete, service-level issues related to implementing such a significant system paradigm shift. The recovery model is not supported by many of the current structures, policies and processes that providers must work with on a day-to-day basis. The system may be at a point at which it is good to wind down the lengthy process discussion of the vision and to dive into the specific issues that must be addressed to actually implement a new system of care.

Issues and concerns raised by the providers included:

- *Defining relapse and recovery:* Overlaying the recovery paradigm from the chemical dependency treatment system will not work for persons with mental illnesses. It is unclear in the mental health arena what “relapse” actually means; it may not be an event, but a gradual progression or slide towards instability. Recovery is also more of a continuum of wellness than a discrete goal such as sobriety.
- *Balancing choice and risk:* The notion of taking responsibility for oneself is a core principle of recovery. The mental health system, however, remains somewhat parentified and patronizing. The ways in which the system is overseen and managed by DMHAS may itself need to change. For example, in a recovery model, what happens when something bad happens to or is done by a system client? Who is held accountable and by whom? Currently, the agencies perceive that they are held accountable and sometimes punished accordingly. The providers wonder if this is compatible with a recovery model. Giving clients

responsibility for themselves and offering choices requires developing the ability to tolerate increasing levels of risk. The state, provider agencies, consumers and other stakeholders will need to work collectively to balance the difficult line between the right to choice for clients and the goal of ensuring public safety.

- *Adjusting resource allocation procedures:* The providers are prepared to move towards a model that prioritizes care continuums and service configurations that support recovery. This may include cutting funding to programs that are no longer needed or do not fit the paradigm. However, concern was expressed about the way in which resource limitations get addressed at the state and federal levels; often, as funding gets tight, the systems cuts the services that consumers/self-advocates and others perceive as the most important recovery-oriented services, (e.g. vocational assistance, housing, etc.). Additionally, because Medicaid will not cover the full range and cost of recovery services, DMHAS must make up at least some of the difference; when state funding is reduced, the providers worry that these services will be among the first to be cut.
- *Addressing eligibility and reimbursement methodologies:* A number of external constraints must be changed or removed if the system is to move to a true recovery model. Holistic services cannot be provided until holistic services are acknowledged, accepted and embraced by the systems that plan, fund and monitor care. Existing reimbursement methodologies that are linked to specific funding streams may not be compatible with the treatment goals, modalities and processes inherent in a recovery-oriented system of care. A recovery orientation encourages shifting away from the diagnosis of “disability” to the diagnosis of “ability” – but this is not the way the system is structured or funded. Moving towards a truly strengths-based model must be balanced against the continuing requirements of documenting need and disability in order to obtain reimbursements. There is concern that the language of medical necessity is not being changed by policymakers at the system level to reflect a recovery orientation. As long as the system of care remains focused on individuals with more disruptive levels of illness that validate more intensive levels of care, a recovery model may have great difficulty matching eligibility and reimbursement procedures. This issue must be addressed at both the state and federal levels. There is a “systems disconnect” between what Medicaid and Medicare will pay for and what the system is seeking to purchase in a recovery framework. “Treatment plans” will still be required in order for provider to be paid for services provided, and the structure and content of a treatment plan is different from a “recovery plan.” Creating another layer of paperwork to document recovery plans will be too costly to administer and too time consuming for agencies that rely on reimbursement from third party payers.
- *Addressing licensing requirements:* Existing licensure requirements may not be compatible in all respects with a recovery model. DMHAS and providers will need to clarify the nature of the credentials required to obtain and keep licensing

among agencies providing recovery-oriented services as well as the types of staff credentials that are necessary to sustain agency licensure.

- *Defining the place and role of more assertive/potentially coercive treatment:* There are concerns about how the recovery model accommodates the needs of those individuals who will benefit most from more intensive types of services, such as Assertive Community Treatment (ACT), as well as individuals who require involuntary commitment and treatment. How will the system determine which service modalities and programs are compatible with a recovery orientation?
- *Developing recovery-oriented outcome measures:* Outcome measures that support a recovery orientation are essential. This means establishing outcome measures that are rooted in what the individual seeking services identifies as their individual goals and objectives, and not basing outcomes on service information such as the number of hours of care being provided in a given month. If recovery is a process, outcomes should also be process driven, and should be related to individual consumer satisfaction and their degree of involvement in the process of recovery. This means that outcome measurement needs to be highly individualized and consumer-centered with the capacity to measure consumer judgments about whether or not they are receiving the services they need in order to progress in an acceptable fashion. These types of outcomes are difficult to establish and monitor; the providers are concerned that when this outcome measurement becomes too difficult, the system will revert to counting service hours, client contacts, AMA discharge rates and other “widgets” related to care.
- *Creating effective cross-system relationships:* A recovery-oriented system of care will require that the mental health system and providers develop and sustain relationships with other systems that are not under the jurisdiction of DMHAS. This includes effective working relationships with state and local housing and employment agencies, state and local criminal justice systems, etc. Formal working agreements may provide one mechanism to ensure the presence of these linkages across existing system boundaries.

In summary, the provider stakeholders are very enthusiastic about the recovery-oriented system model, nevertheless many providers feel like they are functioning within a system that is calling for a paradigm shift in philosophy without the mechanisms and structures and tools and resources to implement the change. To date, many of the people who are going to carry responsibilities for implementing the model at the direct service levels have not been the people who have been included in practical discussions of how the model should be implemented. Some providers do not yet feel the “ownership” that is necessary for successful implementation.

Providers uniformly hope that resource management decisions do not drive the move to a recovery model; rather, the implementation of the model should be driven by what makes for the best possible recovery-oriented behavioral health system. The providers hope that

all upcoming short, intermediate and long-term planning activities involve stakeholders at all levels of the system. The providers would like the opportunity to meet as a group to develop recommendations to DMHAS related to implementation steps for a recovery model. It was recommended that the Provider Council and/or the local mental health authorities be used for this purpose. The fear among provider stakeholders is that without these dialogues, decisions will be made that do not primarily benefit people in recovery or the behavioral health system, but will reflect unrealistic DMHAS goals of saving both time and money.

Part III: Cross System Issues

Stakeholders from all parts of the mental health system identified the importance of effective cross system relationships to the successful implementation of a recovery-oriented system of care. Cross system linkages will be critical to creating a holistic environment in which the full spectrum of recovery issues can be effectively addressed. DMHAS staff are already actively involved in forging many important cross system relationships and programs. Areas identified during meetings with DMHAS staff and other stakeholders included:

Forensic Services: Forensic programs are working to incorporate recovery themes into all areas of their activities. Forensic services are highly structured to promote risk management and public safety; the recovery goal of making people more independent while they remain dependent, (e.g., on an inpatient unit) is difficult. It is challenging to help individuals become increasingly responsible for themselves when the system has powerful mechanisms in place to control and limit independence if they do anything wrong. The state is working to create a transitional program that allows clients to spend one day each week in the community. Current required staff-to-client ratios (1:2) for field visits make this somewhat problematic. Promoting recovery for the forensic clients sometimes involves small, incremental steps such as getting clients off the unit for group meetings, field trips, etc. to promote greater independence and move clients towards more responsibility for themselves. Transitioning from the forensic hospital setting to the community requires enormous time and patience, and good cross system linkages.

Jail Diversion: Many systems in Connecticut are accepting of the jail diversion concept and process. Because there are very few state-level, coercion-oriented statutes, jail diversion is highly compatible with a recovery model. Approximately 20 courts around the state are currently engaged in some level of diversion activities. Misdemeanor courts can request that a client comply with the treatment recommendations of a provider agency, based on client needs and what agency can deliver. Treatment agencies then report back to court are about engagement and treatment issues. Judges are unlikely to get involved in what the treatment entails. Clinic employees at the court level serve as liaisons, clinicians and case managers.

Treatment for Co-Occurring Substance Use Disorders (COD): Connecticut is implementing the Dartmouth/New Hampshire Dual Disorder Intervention and Treatment Program (DDIT), with the participation of Bob Drake. This model has raised some concerns on alcohol and drug side about the appropriateness of the model for services to people without severe MI. In addition, state and agency staff are working to ensure that the model is applied in a culturally appropriate fashion for the diverse population of Connecticut residents with co-occurring illnesses.

Housing: There is not currently a mechanism to ensure systemic inclusion of housing plans and strategies in all client treatment plans. This has proven to be one of the most troublesome components of mobilizing a recovery model. Many stakeholders are not yet

talking about housing as an essential component of recovery; basic treatment issues are still dominating most discussions. For many providers the medical model continues to dominate care and housing is often considered an ancillary or secondary service. Despite this problem, DMHAS plays a central role in the state's Continuum of Care planning process, and through this involvement DMHAS has created more new housing than any other state agency. But safe, decent and affordable housing is still in short supply. DMHAS is beginning to partner with housing authorities to combine housing supports with Project Based Section 8's. This works in cities like New Haven where there is housing capacity, but it is a problem in areas such as Danbury where there is no affordable housing stock available for housing authorities to rent.

Vocational Activities: Job related goals and activities are an extremely high priority for consumer/self-advocate stakeholders, but are also not yet consistently present in all treatment plans. Employment often remains an afterthought and is considered another ancillary or secondary service to think about when the client "gets better." Those jobs that are available are often low-wage and low-prestige jobs that do not promote client independence, self-esteem and well-being. For those clients who do advance in employment, increasing levels of income are perceived as posing a threat to continued eligibility for entitlements.

Transportation: Transportation linkages that can help consumers move to and from home, employment, treatment services and other community supports is relatively poor throughout the state. This issue is critical to DMHAS efforts to promote increased consumer independence and must be addressed as part of a recovery-oriented system.

Issues Related to Poverty, Race, Heterosexism and Class: Ultimately, many individuals struggling with mental illnesses find themselves "disabled into poverty." Issues of race and class also make basic survival, as well as recovery, more challenging activities. Traditional mental health services are often not organized or configured to maximize their accessibility to clients from diverse cultural and ethnic groups. This results in underutilization of core services by the African-American, Asian-American, Native American and Latino populations as well as the Gay, Lesbian, Bisexual and Transgender communities. DMHAS has clearly recognized these issues, and has invested significant time, energy and resources into the cultivation of culturally competent services. These efforts will, over time, increase access to services for groups that have been historically underserved or poorly served. However, the recovery process and the efforts of DMHAS cannot, by themselves, solve the larger problems of poverty, race, heterosexism and class. It will be essential for DMHAS and all system stakeholders to clearly identify what can be done to address these issues at the state level, what can be accomplished in collaboration with inter-governmental partners and community-based stakeholders, and what problems may lie outside of the capacity of our collective efforts to address at all.

Part IV: Identification of Recovery-Oriented Initiatives in Other Jurisdictions

Stakeholders in the Connecticut system are interested in learning from the experiences of other jurisdictions that are seeking to implement recovery-oriented systems of care. In many respects, Connecticut is a national leader on this front; although some local programs and jurisdictions have developed or are in the process of mobilizing recovery-based services, there are almost no other states (with the exception of South Carolina) in which a paradigm shift towards a recovery model is being actively contemplated or has been implemented. While this puts the Connecticut efforts at the forefront of what may well become an extremely important issue throughout the country, it means that there are relatively few other efforts that can offer lessons to Connecticut from the cauldron of practical experience.

In researching this topic prior to the site visit, the NASMHPD consultant identified the following state and regional initiatives that have the potential to be instructive in relation to Connecticut's statewide effort:

South Carolina: "Making Recovery Real"³

The South Carolina Department of Mental Health, Division of Healthcare Reform, has initiated a recovery-oriented initiative that it anticipates will transform their traditional mental health system into a culture that is consumer centered and in which each consumer drives his/her own treatment process. The mission of the Department is "*to support the recovery of people with mental illnesses.*" The Division of Health Care Reform has gathered definitions of recovery offered by consumers, families and professionals and has begun the work of clarifying the different stages of the recovery process. The state has defined:

- Basic assumptions of recovery
- Recovery values
- Guiding principles
- An action plan for "making recovery real in South Carolina"

Values that will drive the system will include: Hope, trusting relationships, respect, empowerment, partnering, collaboration, involvement, choices and rights and safety. The integration process will incorporate four core organizational functions:

- Policymaking
- Management
- Supervision
- Service Delivery

³ See "Making Recovery Real in South Carolina: The Implementation of Recovery," published by the South Carolina Department of Mental Health, Division of Healthcare Reform, 2002.

The Division of Health Care Reform plans on testing and promoting the recovery initiative in nine pilot sites; eight will involve community mental health centers and one will be focused on an inpatient setting. A Statewide Recovery Coalition Committee will be developed to assist the pilot sites with planning and implementing change. This committee will also be designated as the group responsible for developing:

- A unified definition of recovery
- Recovery values
- Changes in concepts, words and language required to support a recovery philosophy
- Policies and procedures that promote recovery
- A uniform recovery plan
- Employee and consumer recovery training curricula.

Ohio: Recovery Process Model and Emerging Best Practices⁴

The Ohio Department of Mental Health, Office of Consumer Services, has developed “Recovery Process Model and Emerging Best Practices” to “define and enhance the quality of mental health services in Ohio.” In the Ohio system, recovery is defined as “*a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence.*”

Individuals recovering from mental illness are seen as moving from a state of dependency to interdependency. The goals for individuals in the recovery process are to reach optimal functioning and to use and/or provide support to entities outside the mental health system. Four stages of the Recovery Process Model are identified:

- Dependent/Unaware
- Dependent/Aware
- Independent/Aware
- Interdependent/Aware

The Office of Consumer Services has defined nine essential components for the provision of effective, recovery-oriented community services and support:

- Clinical Care
- Family Support
- Peer Support & Relationships
- Work/Meaningful Activity
- Power & Control
- Stigma
- Community Involvement
- Access to Resources

⁴ For additional information see <http://www.mhrecovery.com/overview.htm>

- Education

In addition, 12 emerging best practice principles have been described:

1. The consumer directs the recovery process; therefore, consumer input is essential throughout the process.
2. The Mental Health System must be aware of its tendency to enable and encourage consumer dependency.
3. Consumers recover more quickly when hope is encouraged, work and meaningful activities are accessible, spirituality is considered, culture is understood, educational needs are identified and socialization needs are addressed.
4. Individual differences are considered and valued across the life span.
5. Recovery from mental illness is most effective when a holistic approach is considered.
6. In order to reflect current “best practices,” there is a need to merge all intervention models, including Medical, Psychological, Social and Recovery.
7. The clinicians’ initial emphasis on “hope” and the ability to develop trusting relationships influences the consumer’s recovery.
8. Clinicians operate from a strengths/assets model.
9. Clinicians and consumers collaboratively develop a recovery management plan. This plan focuses on the interventions that will facilitate recovery and the resources that will support the recovery process.
10. Family involvement may enhance the recovery process. The consumer defines his/her family unit.
11. Mental health services are most effective when delivery is within the context of the consumer’s community.
12. Community involvement as defined by the consumer is important to the recovery process.

Alaska: Recovery by Choice⁵

The Alaska Recovery by Choice initiative seeks to provide new levels of intensity and flexibility in community-based mental health services in the State of Alaska. Recovery by Choice is a limited intervention that is seeking to mitigate the impact of mental illness for the 80-100 highest users of acute care in the state. The initiative will seek to work with these clients to reduce reliance on hospitalization to more effective delivery of individualized services in the community while maximizing flexibility and choice for consumers.

The model will place the consumer at the center of the service planning process, moving the system towards consumer-directed services and a range of client supports that are available 24 hours a day, 7 days a week. The array of services available will include:

⁵ For additional information, contact the CMH/ARP at 2900 Providence Drive, Anchorage, Alaska 99508, (phone: 907-269-7108)

- Peer supports
- Assistance with daily living
- Skills training, education and employment assistance
- Alcohol and drug use management supports
- Medication assessment and management
- Primary health care
- Assistance in developing natural social supports
- Help with problem solving

Illinois: Recovery Vision: Overcoming the Catastrophic Consequences of Mental Illness⁶

The Illinois Recovery Vision is a program of the Illinois Department of Human Services (DHS), Office of Mental Health Services, Consumer Affairs and Development Section. The DHS recovery vision is “*to help people with mental illness reach their individual potential and maximize productive community living.*”

Recovery Vision promotes the understanding that recovery is possible, with the right sets of help and support. Recovery is viewed as a process and way of life that involves rising above the catastrophic consequences of mental illness, including both stigma and discrimination. The essential values of the recovery model include:

- Hope
- Respect
- Dignity
- Healing from within
- Empowerment
- Spirituality.

Recovery Vision identifies the core principles of recovery as:

- Self-Help
- Peer Support
- Coping Strategies
- Self-Responsibility
- Self-Esteem
- Self-Worth
- Meaningful Activity/Work
- Life Choices
- A Reason to Live
- Involvement in Treatment

⁶ For additional information, see <http://www.state.il.us/agency/dhs/4470r700np.html>
State of Connecticut
Department of Mental Health and Addiction Services
NASMHPD/NTAC Recovery Consultation Report, November 2002

Spokane (WA): The Spokane Recovery Coalition⁷

The Spokane County Recovery Coalition is a planning committee comprised of mental health services consumers from the Spokane region of Washington State and staff from the Spokane Falls Community College, the Spokane County Regional Support Network, United Behavioral Health, the Washington Institute for Mental Illness Research and Training, the Washington State Division of Vocational Rehabilitation, mental health provider agencies in the Spokane area and Desautel Hege Communications. Tom Budziack of San Diego and Joe Marrone of Portland (OR), facilitate the activities of the coalition. Mr. Marrone is affiliated with the Institute of Community Inclusion in Boston.

The Coalition has developed a web-based tutorial on “Understanding Recovery” which guides consumers, family members, providers and others through a process that includes:

- Developing an understanding of what recovery means
- Identifying the goals of recovery
- Describing recovery-based mental health systems
- Indicating how families, friends, health care and rehabilitation professionals and the Spokane community can participate in and support a recovery-oriented system

Central Islip (NY): Hands Across Long Island⁸

Hands Across Long Island (HALI) is an example of a grassroots, mental health self-help organization created by and for people affected by mental illness. The organization is rooted in the belief in the capacity of persons with mental illnesses to direct the course of their own lives; this direction is seen as the essential motivating component of all change and accomplishment. The goal of HALI is to be “*a consistent catalyst of hope to all those who pass through our doors that they may discover knowledge within themselves; and so emerge from fear and shame as strong, forward-moving people, adding their gifts and their contributions to the world.*” HALI is the largest consumer-run multi-service mental health organization in New York State, and facilitates the activities of 30 self-help groups throughout Suffolk County. In addition to the self-help groups, HALI programs include:

- Facilitator Training
- Double Trouble Groups
- In-Patient Advocacy Services
- Community Advocacy Services
- Pre-Arrest Program
- Consumers with Conviction Project
- Transportation Assistance

⁷ For additional information and access to the Recovery Tutorial, see <http://www.recoveryspokane.org/recoveryinspokane.htm>

⁸ For additional information, contact Hands Across Long Island, 159 Brightside Avenue, P.O. Box 1179, Central Islip, NY 11722, (telephone: 631-234-1925)

- Information and Referral Services
- Dances and Holiday Celebrations
- Band and DJ Services
- Food Co-op Project
- Music Program
- Supported Housing
- Self-Directed Rehabilitation
- Bi-County Consumer Conference
- Walk for Mental Health
- Community Kitchen

Over time, more than 60% of the people participating in HALI programs have reduced or eliminated the receipt of public benefits.

NASMHPD and the consultant recommended that DMHAS conduct a modest survey of state-level mental health authorities throughout the United States in order to gather any additional information on recovery-oriented initiatives that are being contemplated or implemented in other jurisdictions. A sample survey instrument developed by the consultant is included as *Attachment #3* to this report.

Part V: Moving Towards a Systems Change Blueprint

DMHAS staff and the NASMHPD consultant spent a significant amount of time during the second day of the on-site consultation addressing strategies and tactics for moving the publicly funded mental health services towards a recovery-oriented system of care. Central to this activity and the goals associated with it are the tasks of promoting a *consistent understanding of and approach to a recovery model* and *cross-system organizational alignment that supports recovery goals*.

Three key areas of alignment were identified:

1. Conceptual/Philosophical Alignment

Consistency and agreement is needed across the multiple systems and stakeholders engaged in the recovery initiative to describe *where the system needs to go and what it wants to accomplish*. Although all the key system stakeholder groups expressed enthusiasm about the move towards a recovery-oriented model, there is not yet a comprehensive understanding of or agreement about precisely what recovery means to each stakeholder constituency and what concrete services and activities will actually look like when they are embedded in the recovery philosophy.

This philosophical alignment must be cultivated manifested in each core mental health stakeholder group and within each component of the mental health system. Further articulation of the specific and concrete details of how recovery is defined and what it looks like at the “nuts and bolts” level is necessary among stakeholder groups, including:

- DMHAS staff
- State staff from other systems that partner with DMHAS
- Members of the State Board of Mental Health and Addiction Services
- Consumers and Self-Advocates
- Family Members and Advocates
- Mental Health Service Providers
- Co-Occurring Disorder Service Providers

In addition, discussion of what the practical and concrete implications of the philosophical paradigm shift towards a recovery orientation means within different, existing components of the mental health care system will be essential. Components of the system of care to include in this discussion are:

- Crisis Intervention and Stabilization
- Acute Care
- Involuntary Treatment
- Inpatient Services
- Forensic Services
- Housing Services and Supports

- Educational and Vocational Services
- Community-Based Services
- Consumer-Run Services
- Family and Advocacy Services
- Natural Community Support Systems and Services

Discussion will need to address balancing of individual rights with individual responsibility, mediation of potential conflicts between system components based on philosophical issues and understanding, development of working relationships among system components that can facilitate and promote recovery, etc.

2. Service/Skills/Competencies Alignment

Alignment is needed among the entities that purchase services and supports, the agencies that mobilize and deliver care and the organizations that monitor service effectiveness and track system and client specific outcomes. Collectively, system stakeholders must move towards agreement on what the state (and other funders) seek to purchase, how limited resources are allocated among different programs and service modalities, how services and supports address the need for culturally competent and regionally appropriate care and how outcomes and indicators of success are determined, measured and collected.

This will not necessarily be a linear process. There are multiple system and agency-specific components to the development and mobilization of the requisite services, skills and competencies that must be present in a recovery-oriented system of care. The system of care will be building, implementing and evaluating many new programs and infrastructures simultaneously. The existing array of stakeholders – especially those engaged in providing direct services – will need to be meshed and integrated with the spectrum of services that are identified as essential and the different modalities of care that are desired.

Some activities, such as dissemination of information on recovery issues and training about how to implement the recovery model, will take place on a system or statewide basis. Other activities, such as testing and piloting new concepts and services may be developed, tested and piloted on local or regional scales. Culturally and regionally specific programs may be tested and evaluated on a limited basis before they are adjusted and replicated in other parts of the state.

This wealth of simultaneous activities will require cultivating a larger environment in which all stakeholder systems are actively engaged in the collaborative process of planning, implementing and evaluating systems change. Specific hallmarks of this environment should include:

- **Activity Oriented Partnerships:** Ensuring that stakeholders are involved in specific, concrete actions as well as more general planning and process-related tasks.

- ***Building of Consensus:*** Leadership must be inclusive and respectful of the full spectrum of opinions that exist related to recovery issues, and move the system towards change without excluding key stakeholders or suggesting that what participants have done or accomplished in the past was “wrong.”
- ***Practical and Reality Based Activities:*** Stakeholders must identify and agree on what can be changed, (e.g., system guiding philosophy, service modalities, culturally competent services, etc.) and what cannot be changed or is beyond the scope of the system of care to impact, (e.g., global issues of poverty, class, race).
- ***Modeling of Recovery Philosophy:*** All interactions with and among stakeholders should be rooted in and consistent with recovery-oriented philosophy. This means challenging and changing patronizing behaviors that promote dependency, focusing on the balancing of rights and responsibilities, discouraging “sugar coating” of issues or concerns and prioritizing decisions and actions that have the practical potential to make recovery real.

3. Fiscal and Administrative Policies Alignment

The mechanisms created to pay for services must be consistent with the recovery-oriented care configurations and modalities. These mechanisms include billing and reimbursement methodologies, information systems configuration and procedures for measuring system, agency and client progress towards identified goals. Fiscal and administrative policies and procedures must simultaneously be aligned with the recovery model as well as the infrastructure of the Behavioral Health Partnership and the activities of the ASO that will be selected to manage the system of care. Access to funding sources such as Medicaid and TANF must be structured in a fashion that creates compatibility between existing federal-level requirements and the recovery orientation as it continues to emerge at the state-level.

Existing and potential revenue streams, (i.e., *the resources that are available*) will need to be matched precisely with the articulated array of services that the system seeks to fund, (i.e., *what will be purchased*). One immediate and highly significant example of this issue involves effective integration of the recovery-oriented system with the newly emerging Connecticut Behavioral Health Partnership (BHP).

The Behavioral Health Partnership (BHP) represents a collective activity of the Department of Children and Families (DCF), the Department of Social Services (DSS) and DMHAS. The purpose of the partnership is to plan and implement an integrated public behavioral health service system for adults, children and families. The primary goal of the BHP is to provide enhanced access to and coordination of a more complete and effective system of community-based behavioral health services and supports and to improve individual outcomes. Secondary goals include better management of state resources and increased financial participation in the funding of behavioral health services.

A Request for Proposals⁹ (RFP) has been issued by the BHP to select an Administrative Services Organization (ASO) to serve as the primary vehicle for organizing and integrating the clinical management processes and payer streams and mechanisms across the multiple systems that are participating in the BHP. The ASO will be expected to enhance communication and collaboration within the behavioral health delivery system, assess network adequacy on an ongoing basis, and improve the overall delivery system by working with the BHP to recruit and retain both traditional and non-traditional providers.

Extensive efforts have been made to incorporate recovery-oriented language into the RFP, and to ensure that the ASO will be familiar and comfortable with a mental health system rooted in the principles of recovery. However, DMHAS staff, mental health providers and the consultant all noted that there is a significant level tension between the recovery language used in the RFP to describe the program models to be implemented by the BHP and the traditional medical model language also used in the RFP to describe funding and reimbursement methodologies. It will be necessary to ensure that the fiscal activities of the ASO and the programmatic configuration sought by DMHAS are designed and implemented in a compatible fashion. If traditional funding and payment methodologies (e.g., Medicaid fee-for-service reimbursements) are utilized by a behavioral health managed care ASO operating the BHP, it will become increasingly difficult to mobilize and pay for a truly recovery-oriented system of care.

Funding streams that must be aligned with the emerging recovery model will need to include:

- Mental Health Block Grant
- Addictions Block Grant
- Medicaid
- Medicare
- Federal Discretionary Grants (e.g., CSAT, CMHS, DOJ, etc.)
- General Assistance
- State General Fund
- Private Insurance

The partnership for management of resources under the jurisdiction of the BHP must put DMHAS on an equal footing with its partners at DCF and DSS. For example, although DSS may retain jurisdiction over Medicaid dollars, in DMHAS' role as clinical manager for adult services as administered by the ASO, there will need to be a clear DMHAS voice in securing Medicaid management procedures that accommodate movement towards the recovery model.

⁹ See State of Connecticut, Behavioral Health Partnership, Administrative Services Organization Request for Proposals, 2002

A strategic approach to fiscal resource management that embraces the full spectrum of recovery-oriented activities suggests the need for the development of a matrix that matches existing and projected revenue streams with the array of services that the system seeks to support. Specific responsibilities for planning funding and service alignment will need to be assigned based on the revenue and service arrays identified in the matrix. Brief discussion with DMHAS staff during the consultation resulted in this initial list of assignments:

1. Medicaid resources and what they can fund: *Adult Implementation Team*
2. Services not funded by Medicaid and how they will be funded: *Systems Alignment Team*
3. Translation of dollars and services into a consistent system of care: *Ken Marcus*
4. Marketing and communication of new models to contractors and the ASO: *Paul DiLeo*
5. Implementation and evaluation of emerging system of care: *Ken Marcus and Paul DiLeo*

** ** **

Implementation of the recovery model will require simultaneous strategic systems change in all three of the areas discussed above. This will make for a challenging and potentially confusing change environment; altering and adjusting so many core variables simultaneously and within a limited time frame will make it difficult to identify the impact of each specific change activity and may at times result in a system that appears or feels somewhat out of control.

Part VI: Getting Strategic: Next Steps and Tasks

In order to create and sustain both a strategic focus and the momentum required to promote systems change over time, DMHAS staff and the consultant worked to identify a methodology to prioritize the tasks associated with implementing a recovery-oriented system of care. This methodology incorporates the identification of goals and associated activities along three different timelines:

1. **Short Term Goals:** Areas that are ripe for change at the present time and offer immediate opportunities to witness the impact of a recovery model. (Less than one year.)
2. **Mid-Term Goals:** Topics and issues that need to be addressed in the intermediate term in order to ensure the longer-term success of the recovery initiative. (One to two years.)
3. **Long Term Goals:** Tasks and activities that require more substantial, sustained attention over time. (Two to five years)

1. Short Term Goals: Areas Ripe for Change at the Present Time (< 1 year)

Directing attention and energy towards “low hanging fruit” that could stimulate a number of early, quick victories associated with the paradigm shift to a recovery philosophy could become important sources of positive energy and concrete outcomes that fuel the initiative over time. These are areas and activities that could be successfully undertaken within the next 6-12 months. Some of the areas identified by DMHAS staff that fall into this category include:

- *Modeling Respect for Clients:* All system stakeholders appear ready to take on the language, attitudes and roles related to respect for consumers and consumer choices that lie at the core of a recovery-oriented system of care.
- *Mobilizing Person-Centered Planning:* With only a modest amount of additional training and preparation, mental health providers may be ready to begin the process of shifting control over treatment planning from the provider to the client. Contract language and training activities could help to promote and stabilize this shift. This would incorporate moving towards a strengths-based model for assessment of client needs and development of treatment and recovery plans, (e.g., identifying what the client wants/what strengths the client has versus defining what the client needs based on what’s “wrong” with the client.)
- *Increasing Culturally Competent Care:* Because the state and provider agencies have already begun to focus significant attention on the development and provision of culturally competent services, it may be possible to begin in the short term to focus contract language, the development of culturally specific programming, cultural competency plans and standards, technical assistance and training, etc., through the lens of the recovery paradigm.

- *Developing Provider Consensus:* Providers of mental health services appear ready and interested in entering into discussions with the state about the application of a recovery-oriented philosophy to the concrete, day-to-day activities of service delivery and treatment. Building on the principles of respect for clients and person-centered planning, the state could enter into a dialogue with providers about the management of risk in a recovery-based system of care, regionally-specific issues related to mobilizing recovery services (e.g., urban vs. rural issues, culturally competent programming), mobilization of acute and community based services rooted in hope and rehabilitation as opposed to maintenance and dependency, etc.
- *Developing “Recovery Kits:”* Working together with other key system stakeholders, DMHAS could develop Recovery Kits that serve as tools for consumers, providers, family members, etc. These kits would provide information to help stakeholders from different arenas to understand the concept and process of recovery, what recovery services look like and how recovery can be supported and promoted. Recovery kits could be specifically designed for DMHAS staff, mental health service providers, consumer/self-advocates and family member/advocates. Consumers, consumer providers and family member/advocates should play a lead role in developing these kits, with the assistance of DMHAS and provider agency staff.

2. Intermediate Range Goals (1-2 years)

Intermediate range goals include specific and concrete activities that could be more clearly defined and mobilized within the next two years. These include:

- *Alignment of BHP, ASO and Recovery Model:* Although this activity should begin immediately and should be part of the process of selecting an ASO and clarifying of the ASO role, the complexities of this task suggest that it may take many months or several years to fully resolve the integration of the BHP and the recovery model. Significant effort will be required to promote consistency between the recovery model and BHP/ASO processes, including the definitions of medical necessity, the mechanisms created to provide reimbursement for services, and the integration of funding streams such as Medicaid and TANF into a recovery-oriented system of care.
- *Completing the conceptual shift from “treatment plans” to “recovery plans:”* Because of current requirements related to licensure and reimbursement, the ways in which mental health services are defined and documented are not yet fully compatible with a recovery model of care. Asking providers to maintain two separate sets of consumer-specific plans (one to justify reimbursement and the second to promote recovery) in the present environment represents an unreasonable paperwork burden on individual care coordinators. Moving towards “recovery plans” that have required treatment plan components embedded in them that will satisfy the current range of funders and can be easily extracted from

system databases will require a significant amount of discussion and planning that has not yet been initiated.

- *Developing Recovery-Oriented Performance Indicators:* The desired outcomes and associated measures affiliated with a recovery-oriented system of care may differ significantly from the measures and indicators currently collected and analyzed to determine system effectiveness. It will be important to identify desired indicators of recovery and translate those indicators into quantifiable and reportable measures. Some of these measures may be available from existing data sources; others may need to be added over time. This will most certainly be an iterative process, with progressive changes made to the information system and data collection procedures over time that enable the collection of recovery-oriented measures. Performance indicators will need to reflect where each client “is” in their recovery process and what consumers identify as the most important indicators of success. For example, consumer-centered, recovery-oriented measures/indicators may include:
 - If and how people stand by me when I need or want them to
 - How I was treated when I was not doing well
 - If I have a job
 - If I like where I live
 - If I have good family/community/indigenous social supports
 - If I am treated with dignity and respect
- *Replacing Consumer Satisfaction Surveys with Consumer Recovery Surveys:* Existing mechanisms for calculating consumer satisfaction are neither terribly accurate nor reflective of the shift to a recovery-oriented system of care. Replacing existing instruments with a set of questions that are focused on how clients perceive their level of recovery and how available services support recovery activities have been could help to increase the information available to the system about how effectively it is moving towards a true recovery model.
- *Defining recovery across the continuum:* As the planning and mobilization of recovery-oriented services proceeds, it will become essential to pause periodically to assess what services are available and how they are provided as well as what services are still missing and need to be added to the continuum of care. This systems-level self-evaluation and feedback process can be rooted in the principles of continuous quality improvement (CQI) and can be utilized to insure that mechanisms for “mid-course corrections” are in place.

3. Long Range Goals (3-5 years)

Although some long-range goals can be identified at the outset, most long-range goals will come clearly into focus as the initiative moves forward and short and intermediate range goals are pursued. Some of the long-range goals that have already been clarified include:

- *Development of a System Level Report Card:* It will be extremely important to develop a mechanism for communicating to key system stakeholders and the larger public a sense of how the system is doing in relation to mobilization of a recovery model. Services and activities will need to be analyzed and critiqued through the lens of recovery, identifying what fits, what works and what doesn't. A report card could provide a regular, (perhaps annual) tool for reporting on progress at no fewer than three different levels of the system: Client-specific outcomes, agency/service level outcomes and system-level outcomes. When effectively designed and implemented, a report card becomes not a tool for berating and criticizing providers, but for examining progress towards the recovery model, interpreting what has happened, understanding why it has occurred and identifying what could be done differently to produce more desirable outcomes.
- *Alignment of multiple systems involved with the change process:* The relationships across the multiple systems (other than the mental health system) that all must become part of a recovery-oriented initiative will take many years to effectively cultivate and align. Some of these relationships will be cultivated at the state level; others it will be necessary to develop at local or regional levels. The involved systems will include:
 - Educational and vocational services
 - Employment services
 - Income maintenance services
 - Law enforcement and criminal justice agencies
 - Housing developers and local housing authorities
 - Transportation services
 - Childcare and parenting services
 - Primary care systems and services
 - Alcohol and other drug addiction services
 - Faith-based communities
 - Indigenous community support systems

Each of these systems has an important role to play in relation to promoting recovery among persons with mental illnesses. Bringing these systems to the table, communicating the philosophy and principles of recovery and aligning their activities with the recovery initiative is an essential activity towards creating a truly holistic and comprehensive system of care.

- *Stabilization of change and sustaining of momentum:* As change occurs, it will be essential to maintain a stable *enough* system to continue to support ongoing change processes as well as strategies to sustain the momentum for systems change over time. Invariably, energy levels will wax and wane, and specific interventions may become necessary to ensure that the change process will be

supported as system and agency leadership change, economic variables fluctuate and public interests and priorities shift.

- *Marketing recovery-oriented system change strategies:* There is no question that Connecticut is at the forefront nationally of efforts to promote systems-level movement towards recovery-oriented models for the delivery of publicly funded mental health services. It will be important for Connecticut to help set the national agenda and pace for system change initiatives of this type. The State's experiences in this arena, (both positive and negative) will be highly instructive, and state officials and other key system stakeholders would be well advised to create and promote a replicable model for implementation of recovery-oriented services that can be implemented in other jurisdictions.

Part VII: Conclusion

Connecticut's efforts to move the publicly funded mental health system towards a recovery-oriented model of care place DMHAS and the Connecticut stakeholders at the forefront of the mental health recovery movement nationally. Although some other state and regional jurisdictions are engaged in the mobilization of recovery-based services, Connecticut is virtually unique in promoting a statewide change process on the broadest possible systems-level scale. The state's recovery vision is bold in this regard; articulating a change process that embeds the principles of recovery in every dimension of the publicly funded mental health system reflects conviction in the wisdom of a recovery philosophy and determination to shape a system that embodies recovery as an overarching and guiding concept.

It is doubtful that this recovery philosophy will turn into yet one more version of the "flavor of the month" in mental health service delivery. The momentum that is being created behind recovery principles by mental health consumers/self-advocates and family member/advocates is rapidly becoming a powerful voice at the local, state and federal levels. The assertiveness and determination of these advocates suggests that recovery-oriented mental health services will increasingly become the standard by which publicly funded mental health care is funded, organized and evaluated. This is a good thing; only through developing a legitimate sense of power and hope will the mental health community effectively be able to combat the stigma and marginalization that have for centuries prevented mental health consumers from achieving the goals of recovery in their own lives.

The level of interest and excitement that recovery discussions and planning have generated among all stakeholder groups confirms that Connecticut is truly in the process of breaking new ground. This has both disadvantages and advantages associated with it. On the down side, there are few road maps to follow in creating a state-level system that is rooted in a recovery philosophy. There may well be some significant missteps on the road to change; as these occur, they should be viewed as opportunities for mid-course corrections rather than fatal setbacks.

On the up side, the amount of stakeholder support for this initiative is truly remarkable, and the energy and determination manifested by key players from the levels of individual consumer/self-advocates through to the senior levels of the DMHAS administration will take the system a long way towards the goals it is seeking to achieve. Furthermore, Connecticut's timing with this initiative will place the state at the forefront of what is likely to become a national trend: Mobilizing recovery-oriented systems of mental health care. By putting itself ahead of the wave, Connecticut has the potential to serve as a national leader in this arena, providing guidance and assistance based on its own experiences to other jurisdictions that begin to move in similar directions. It will be critically important to document the process in Connecticut as it unfolds in order to create a model that be communicated to and replicated by other jurisdictions as they begin to implement their own similar initiatives.

The DMHAS leadership is also wise to be placing the goals of a recovery-oriented system in the larger context of how behavioral health services are funded and configured. The mobilization of the Behavioral Health Partnership and the selection of a new Administrative Service Organization offer an opportunity to align both fiscal and operational management of a public sector service system with objectives and measures that are appropriate to recovery. The continuing attention to ensuring the provision of culturally competent care to all of the state's residents will help to ensure that recovery is defined and pursued not just in ways that are appropriate to one subset of the population of persons with mental illnesses, but in ways that promote wellness and empowerment among the many and diverse groups that call Connecticut their home.

The next three to five years will be critical as the state moves forward. There will be both major accomplishments and setbacks along the way. But the vision that the state has articulated – and that has won the support of virtually all of the mental health system's key players – suggests that significant success and real systems change are well within reach.

This is an exciting time to be involved with the mental health system in Connecticut.

Attachment # 1: Agenda for NTAC Connecticut Consultation/Site Visit, October 21-22, 2002

Monday, October 21, 2002

Time	Agenda	Participants
8:45 a.m.	<p><i>Initial meeting with State-level system stakeholders</i></p> <ul style="list-style-type: none"> • Review of recent activities (e.g., self-assessment survey, provider conference, recovery institute) and current status of recovery orientation initiative • Cultural competence and evidence-based practices • Goals and objectives for consultation/site visit • Desired work product to emerge from consultation 	<p>Arthur Evans Larry Davidson Ken Marcus Ruth Howell Karen Kangas Ronna Keil Paul DiLeo Sue Graham Barbara Geller Jim Siemianowski Rick Fisher Jose Ortiz Denine Northrup</p>
10:00 a.m.	<p><i>Meeting with State Board of Mental Health and Addiction Services</i></p> <ul style="list-style-type: none"> • Perspective on recovery orientation initiative • Nature of state board's involvement with initiative • Goals, fears, opportunities, etc. 	Members of State Board
11:00 a.m.	<p><i>Meeting with consumers and self-advocates</i></p> <ul style="list-style-type: none"> • Perspective on recovery orientation initiative • Nature of consumer and advocate involvement with initiative • Goals, fears, opportunities, etc. 	<p>Advocacy Unlimited Inc. Clients' Rights Officers Consumer reps from CAC's and RMHB Representatives from GA Consumer Council</p>
12:00 p.m.	<p><i>Meeting with family members and advocates</i></p> <ul style="list-style-type: none"> • Perspective on recovery orientation initiative • Nature of family member and advocate involvement • Goals, fears, opportunities, etc. 	<p>NAMI CT CLRP RMHBs</p>
1:00 p.m.	<p><i>Lunch</i></p> <p>Discussion of recovery-oriented initiatives in other jurisdictions</p>	Same as 9:00
1:30 p.m.	<p><i>Meeting with mental health service providers</i></p> <ul style="list-style-type: none"> • Provider agency perspectives on recovery orientation initiative: Goals, fears, opportunities, etc. • Provider agency involvement in initiative • Provider agency concerns about initiative 	<p>LMHA Directors CHA - Behavioral Health Council Reps. Provider Advisory Council Trade Association Groups (CCPA, CAN etc.)</p>
3:30 p.m.	<p><i>Cross-system dimensions to recovery orientation initiative</i></p> <ul style="list-style-type: none"> • Integrated treatment of co-occurring substance use disorders • Criminal justice system issues 	<p>Same as 9:00, but also including Gail Sturges Sam Segal Sally Lukeris Peter Mendelson</p>

	<ul style="list-style-type: none"> • Housing and vocational issues • Other issues 	
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Tuesday, October 22, 2002

9:00 a.m.	<p>Nuts and Bolts I: Discussion of the range of policy and treatment issues involved in shift to recovery orientation</p> <ul style="list-style-type: none"> • Major areas for policy development and/or revision (e.g., person-centered recovery planning, client choice and self-determination) • Treatment system configurations (including issues such as employment, involuntary treatment, housing, etc.) • Funding priorities and decisions • Training in recovery-based practices • Cultural competency and evidence-based practices • Systems integration • Use of Recovery Advisory Committee 	<p>Arthur Jim Sue Ken Ronna Ruth Karen Paul Barbara Rick Jose Larry</p> <p>Katherine LaBella and/or Jim Turcio Carol Ferro</p>
11:00 a.m.	<p>Nuts and Bolts II: Discussion of the range of administrative and outcome-related issues involved in shift to recovery orientation</p> <ul style="list-style-type: none"> • Contract structures and contents • Reimbursement methodologies • Data collection and reporting • Outcomes measurement and monitoring • Accountability mechanisms • Quality improvement activities 	<p>Arthur Jim Sue Ken Ronna Ruth Karen Paul Barbara Rick Jose Larry Katherine LaBella and/or Jim Turcio Carol Ferro Denine Northrup</p>
12:30 p.m.	<p><i>Lunch</i></p> <ul style="list-style-type: none"> • Discussion of desired format for systems change blueprint • Structure • Contents • Dissemination and marketing 	<p>Arthur Jim Sue Ken Ronna Ruth Karen Paul Barbara Rick Jose Larry Denine</p>
1:30 p.m.	<p><i>Wrap-up session and debriefing</i></p> <ul style="list-style-type: none"> • Feedback on site visit • Reactions and comments • Discussion of format and structure for systems change blueprint 	<p>Arthur Jim Sue Ken Ronna Ruth Karen Paul Barbara Rick Jose Larry</p>

	<ul style="list-style-type: none">• Review of next steps	Denine
3:00 p.m.	<i>Adjourn</i>	

Attachment #2: List of Stakeholder Participants

State Board of Mental Health and Addiction Services

Richard Stanco
Curt Beck
Whitney Jacobs
Jessica Navarro-Gilmore
Heather McDonald
Brian Reignier
Clair Phelan
Phillipa Coughin
Irene Hernden
John Shea
Karen Roseman

Consumers/Self-Advocates

Alyse Chin (RVC)
Samantha Christian (MHHC)
Omi Saide Ali (DMHAS/SWCMHS)
Steve Fry (DMHAS/SWCMHS)
Steven Stolman (CACID)
Edna Alkin (CMHC/CRO)
John Sims (ABH Consumer Liaison)
Karen Roseman (Office for Persons with Disabilities, Bridgeport)
Irene Hernden (Region II Consumer Rep)
Catherine Ferry (RMNBH Executive Director)
Jessica Navarro-Gilmore (Focus on Recovery United)
Robert Davidson (Eastern Regional MHB)
Lori Tibbens (Eastern Regional MHB)
Margaret Ayer (Eastern Regional MHB)
Susan Byrne (River Valley Services)
Debra Mandre (River Valley Services)
Ken Crowne (Cedarcrest Hospital)
Leslie Kotke (Advocacy Unlimited)
Heather McDonald (Focus on Recovery United)
Ana Lazu (Latino Unidos Siempre)

Family Members/Advocates

Robert Davidson (Eastern Regional Mental Health Board)
Margaret Ayer (Eastern Regional Mental Health Board)
Lori Tibbens (Eastern Regional Mental Health Board)
Whitney Jacobs (NCRMHB)
Sally Lukens (NAMI/CT)
Sheila Amdon (NAMI/CT)

Cheri Bragg (NAMI/Genesis Clubhouse)
Sheryl Breetz (NCRMHB)
Tom Behrendt (CLRP)
Susan Aranoff (CLRP)
Karen Roseman (SWRMHB)
Claire Phenlan (Region II MHB)
Catherine Ferry (Region II MHB)

Mental Health Providers

Anthony Corniello (Harbor Health)
Jessica Navarro-Gilmore (Focus on Recovery United)
Heather McDonald (Focus on Recovery United)
Judy Benton (Inter Community Mental Health Group)
Ralph Despres (Birmingham Group Health Services)
Doreen Elnitsky (Waterbury Hospital)
Marilyn Cornwall (Birmingham Group Health Services)
Michael Brody (Southwest Connecticut Mental Health System)
Mike Lapierre (Genesis Center)
Mike Lieman (Connecticut Valley Hospital)
Pat Rehmer (CRMHC)
Heather Gates (CHR)
Linda Kargill (Value Options)
Upton Butler (CMHA)
Bill Newkirk (SMHA)
Ken Friedenbergl (Newington Human Services)
Bill Gilbert (CPAS)
Art Guema (Todd House)
Barbara Bugella (Midstate Behavioral Health)
Dorothy Shugrue (Midstate Behavioral Health)

State Staff

Art Evans (Deputy Commissioner)
Ellen Weber (Jail Diversion)
Ruth Howell (Employment Project)
Ronna Keil (OOC)
Denine Northrup (Quality Management & Improvement)
Rick Fisher (Education & Training)
Sue Graham (Cedarcrest)
Katherine Jabell (Community Services & Hospitals)
Jose Ortiz (OMA)
Barbara Geller (Statewide Services)
Jim Siemianowski (Special Projects)
Maria O'Connell (Post Doctoral Student)
Larry Davidson (Mental Health Policy)

Attachment #3

State of Connecticut
Department of Mental Health and Addiction Services
Survey Instrument for Identifying
Recovery-Oriented Initiatives Underway in Other States

Dear fellow State Level Mental Health Authority Commissioner:

The State of Connecticut has recently undertaken a significant paradigm shift in the orientation of its publicly funded mental health services. We are seeking to promote a recovery-orientation in the design, mobilization and monitoring of mental health services delivered throughout the state. We define recovery as: *“A process of restoring or developing a positive and meaningful sense of identity apart from one’s condition and then rebuilding one’s life despite, or within the limitations imposed by that condition.”* A copy of my formal policy statement related to the recovery model has been included with this survey for your information and review.

Implementing a recovery-oriented system of care requires significant changes in the way we plan for and fund treatment and support services, as well as the process we use to identify desired outcomes and measure our system’s success at achieving our goals. We are extremely interested in learning from the experiences of other state-level mental health authorities that may have implemented recovery-oriented services in their own jurisdictions or may be contemplating a move in this direction.

We would appreciate your taking a few minutes to complete the following questionnaire and return it to us at your earliest convenience. We will be happy to share the results of this process with you through the National Association of State Mental Health Program Directors.

Thank you for your time and attention to this survey. Feel free to call _____ at _____ if you have any questions about this document.

Thomas Kirk, Commissioner
Connecticut Department of Mental Health and Addiction Services

Name of person responding to survey: _____

Role of individual in state mental health authority: _____

Telephone Number: _____ Email Address: _____

Date survey was completed: _____

Please describe briefly the role of the State Mental Health Authority in your state:

Has your jurisdiction adopted (or is it actively considering) a state-level recovery-orientation policy related to the provision of publicly funded mental health services?

YES

NO

DON'T KNOW

(Please circle one answer)

If your answer to this question is YES:

Could you provide us with a copy of any policy statement or written materials related to recovery-oriented services in your state?

What has been/do you anticipate will be the impact of a recovery-orientation on the configuration of mental health services in your state?

What has been/do you anticipate will be the impact of a recovery-orientation on the ways in which mental health service delivery is funded in your state?

What has been/do you anticipate will be the impact of a recovery-orientation on the ways in which mental health service outcomes are defined and evaluated in your state?

What has been/do you anticipate will be the impact recovery-orientation in your state on the ways in which consumer/self-advocates are involved in the design, provision and evaluation of mental health services?

What have been/do you anticipate will be the most significant changes in mental health services in your state that have resulted/will result from implementation of a recovery-oriented model?

What have been/do you anticipate will be the greatest obstacles or barriers to implementation of a recovery-oriented model?

If your answer to this question is NO:

Are you aware of any local or regional recovery-oriented mental health programs or services that have been successfully implemented in your state?

YES

NO

DON'T KNOW

(Please circle one answer)

Please briefly describe these mental health programs or services:

Could you provide us contact information identifying whom we might contact for additional information about these programs?

Thank you for your time and attention to this survey.