

STATE OF INDIANA

FAMILY & SOCIAL SERVICES ADMINISTRATION

DIVISION OF MENTAL HEALTH AND ADDICTION

RECOVERY SUPPORTS CONSENSUS

MENTAL HEALTH AND ADDICTION PLANNING AND
ADVISORY COUNCIL

RECOVERY SUPPORTS PRIORITY AREA 2
WORKGROUP

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INTRODUCTION

The Indiana Division of Mental Health and Addiction (DMHA) submitted a combined Mental Health and Substance Abuse Prevention and Treatment block grant application for federal fiscal years 2012 and 2013. The complete application focused on four Priority Areas: Housing, Recovery Supports, Prevention, and Primary and Behavioral Health Care Integration.

Each Priority Area of the combined block grant application uses a set of strategies, performance indicators and dashboards. The focus of these is to achieve the stated goals in the application. The strategies in each section are the action steps to achieve the goal. The performance indicators and dashboards are the measures for assuring quality in performance and due dates for completion of the strategies.

This report will focus on Priority Area 2- Recovery Supports. Specifically, this report will detail a recovery supports consensus that was formed by completing the first four strategies in Priority Area 2.

The following sections address (I) Excerpts from the Combined Application and (II) Completed Strategies and Findings. There is an appendix included that contains surveys, results, and graphs that were used in the development of this report.

“Although I have been involved with a number of DMHA initiatives throughout the years and have worked with many of the individuals involved on the workgroup, this has truly been an eye opening experience.”

Workgroup Member

I. Excerpts from the Combined Application

Priority Area 2: Recovery Supports

Goal: To promote and develop statewide recovery supports toward the goal of community integration for persons with mental illnesses and/or addiction.

Strategies

1. Develop and implement a survey to garner consumer input regarding what recovery supports are most helpful for obtaining and maintaining a life in the community.
2. Using the existing annual Community Readiness Assessment of all state hospital consumers, gather and analyze data, by community, regarding the barriers to discharge from the state operated hospitals.
3. Execute a utilization review of recovery support services using data from Access to Recovery and the Community Alternatives to Psychiatric Residential Treatment Facilities demonstrations. Follow with a survey of currently served consumers to identify non-traditional recovery support services and activities consumers believe lead to positive outcomes.

4. Survey public behavioral health providers on what services they believe are included in a good and modern, recovery oriented system of care.

Performance Indicators:

1. Completion of data collection and analysis described in strategies 1 through 4.
2. Develop consensus on recovery support priorities.
3. Completed state-wide gap analysis of identified priorities.

State Dashboard:

- Completion of data collection and analysis described in strategies by March 31, 2012. (completed)
- Development and consensus on recovery support priorities by the end of June 2012. (completed)

“My involvement with the DMHA revolves around providing appropriate support for those with a mental illness.”

Workgroup Member

- Completed state-wide gap analysis of identified priorities by November 30, 2012. (on time)
- Number of key State agencies actively participating on the Mental Health and Addiction Planning and Advisory Council (MHAPAC) and actively participating in data analysis of recovery supports. (determined by the baseline indicated in this consensus, June 30, 2012)

II. Completed Strategies and Findings

Strategy 1

“Develop and implement a survey to garner consumer input regarding what recovery supports are most helpful for obtaining and maintaining a life in the community.”

The first task undertaken by the workgroup was to create a survey that would allow consumers of services the opportunity to tell DMHA what was working for their recovery. After careful deliberations the workgroup produced a survey that would help identify specific individual services that could accurately assist in achieving the priority area goal. Surveys to consumers were distributed and 553 were returned.

A survey to gather family input on recovery supports was created and distributed through the National Alliance on Mental Illness (NAMI). Of the surveys distributed 171 were completed and returned.

Findings:

Analyses of the two surveys identified many non-traditional services and activities as being most helpful and effective in the consumer’s recovery process. Significant consistency was found between consumer and family perspectives of needed and effective recovery supports. The following supports were most frequently identified as essential to recovery:

- Personal Support Networks: Includes support from persons such as families and friends and places which are welcoming.
- Peer Support for both consumers and families: Includes support and self help groups, and others with similar experiences, such as recovery fellowships.
- Hobbies and Interests
- Safe Environments including Housing
- Access to medical and dental care

Both surveys also asked about traditional treatment services and whether or not they had been used and if so, were they effective. It is noteworthy that at least 75% of consumers who indicated they had used each of the traditional services found them helpful. Families found medications, outpatient, intensive outpatient and crisis/emergency services to be most helpful.

See Appendix A- Consumer and Family Survey

The following tables reflect survey results that show: Non-traditional services and supports identified by consumers and families (Table 1) and Detail list of survey items included in recovery supports categories (Table 2).

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Table 1
Non-Traditional Services and Supports Identified by Consumers and Families

***Key- (SA) is Substance Abuse; (MH) is Mental Health; SOF is State Operated Facility**

Consumer Surveys Additional Recovery Supports – 50% & Above (Combined SA & MH)	Consumer Surveys Additional Recovery Supports – 50% & Above (SA)	Consumer Surveys Additional Recovery Supports – 50% & Above (MH)	Family Survey – 50% & Above	Community Readiness SOF Consumer Survey
<i>Personal Support Networks: Includes support from persons such as families and friends and places which are welcoming.</i>	<i>Personal Support Networks: Includes support from persons such as families and friends and places which are welcoming.</i>	<i>Personal Support Networks: Includes support from persons such as families and friends and places which are welcoming.</i>	<i>Personal Support Networks: Includes support from persons such as families and friends and places which are welcoming.</i>	<i>Housing &/or Residential:</i>
<i>Peer Support Services for both consumers and families: Includes support and self help groups, and others with similar experiences; such as, recovery fellowships.</i>	<i>Peer Support Services for both consumers and families: Includes support and self help groups, and others with similar experiences; such as, recovery fellowships.</i>	<i>Peer Support Services for both consumers and families: Includes support and self help groups, and others with similar experiences; such as, recovery fellowships.</i>	<i>Peer Support Services for both consumers and families: Includes support and self help groups, and others with similar experiences; such as, recovery fellowships.</i>	<i>Natural Supports (A combination of Personal Support Networks & Peer Support Services)</i>
<i>Hobbies & Interests</i>	<i>Hobbies & Interests</i>	<i>Hobbies & Interests</i>	<i>Safe Environment (General) including Housing</i>	<i>Social Activities</i>
<i>Prevention & Wellness</i>	<i>Safe Housing</i>	<i>Prevention & Wellness</i>	<i>Hobbies & Interests</i>	<i>Employment</i>
<i>Safe Housing</i>	<i>Service Coordination</i>	<i>Service Coordination</i>	<i>Educational Programs</i>	<i>Education</i>
<i>Spiritual Activities</i>	<i>Supported Employment</i>	<i>Safe Housing</i>		
<i>Service Coordination</i>	<i>Advocacy Services</i>	<i>Advocacy Services</i>		
<i>Advocacy Services</i>	<i>Prevention & Wellness</i>	<i>Spiritual Activities</i>		
<i>Supported Employment</i>	<i>Spiritual Activities</i>	<i>Transportation</i>		
<i>Education and Training Activities</i>	<i>Education and Training Activities</i>	<i>Education, Training, Supported Employment Activities</i>		

Transportation	Transportation			
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Table 2

Detail List of Survey Items included in Recovery Support Categories

Personal Support Networks	A person in my life who has hope for me -- 90.7% (470 of 518)
	A place to go where I feel welcome -- 89.3% (459 of 514)
	Friends and family that I feel close to -- 87.8% (454 of 517)
Peer Support Services	Someone who has had similar experiences -- 85.1% (440 of 517)
	Recovery Center -- 51.1% (214 of 419) -- of those who were offered this support, 89.5% (214 of 239)
	A sponsor -- 62.5% (15 of 24 using this support, per family and friends)
	Peer support for the family -- 87.4% (83 of 95 using this support, per family and friends)
	Peer telephone support, such as a warm line -- 71.4% (15 of 21 using this support, per family and friends)
	AA, NA, GA, CA, and/or others like these -- 62.6% (296 of 473)
	Self-help recovery program -- 55.8% (24 of 43 using this support, per family and friends)
Hobbies & Interests	Hobbies and interests -- 82.6% (423 of 512)
Prevention & Wellness	Help getting medical and dental care -- 63.1% (317 of 502)
	Physical Activity such as an exercise routine, walking -- 77.3% (399 of 516)
Safe Housing	Help finding a comfortable place to live -- 75.7% (376 of 497)
	Help getting access to food and other household items -- 72.6% (366 of 504)
Spiritual Activities	Participating in spiritual activities -- 73.0% (370 of 507)
Service Coordination	Someone that helps me coordinate services, like a Recovery Consultant -- 60.3% (35 of 58)
Advocacy Services	Someone to advocate for me -- 72.5% (364 of 502)
Supported Employment	A job or other volunteer activity -- 71.5% (359 of 502)
	Clubhouse -- 26.2% (112 of 428) -- of those who were offered this support, 76.7% (112 of 146)
Education and Training Activities	Access to education or other training -- 68.8% (341 of 496)
	Money management training -- 59.0% (23 of 39 using this support, per family and friends)
Transportation	Transportation assistance -- 68.5% (343 of 501)

Strategy 2

“Using the existing annual Community Readiness Assessment of all state hospital consumers, gather and analyze data, by community, regarding the barriers to discharge from the state operated hospitals.”

As part of a comprehensive plan for State Operated Facilities, DMHA requires a combined annual assessment of each consumer by the gatekeeping agency and treatment team. Further mandates require that this review contain an assessment of the individual consumer’s readiness for community-based care. In state fiscal year 2012 DMHA included consumer and family recovery goals.

Within the State Operated Facility system 514 consumers were assessed during September 2011. This includes the following populations: 33 Serious Emotional Disturbance (SED), 325 Serious Mental Illness (SMI), 132 Mental Illness Chemical Addiction (MICA), 23 Mental Retardation Developmental Disabilities (MRDD), and 1 Deaf Serious Mental Illness (SMI). Of these assessments 425 of these were completed in face-to-face meetings between consumer, gatekeeper, and social worker. At least 459 of these consumers are consistently assessed with a need for intensive community services. Of the consumers assessed 37% were determined to meet discharge criteria within 6 months of that assessment.

Because the launch of initiatives with recovery focus is relatively new, the assessment tool utilized for this process contained broad recovery categories for discussion. The focus with this assessment was to begin a dialogue of the recovery concept between consumer, gatekeeper, and treatment team members.

Consumers were asked to provide input on recovery in the following areas: natural supports, social activities, education, employment, housing/residential, and/or other. Consumers were also asked to self identify short and long-term recovery goals. Active family members were asked if they had a recovery goal for the consumer. The results of the assessment are contained in the appendix.

“I was very happy that consumer opinions were central to the project as they are central to the recovery process.”

Workgroup Member

Findings:

The analysis of the Community Readiness Assessment shows that consumers in state hospitals believe the following to be needed upon discharge for ongoing recovery:

- Housing, including residential type facilities
- Natural Supports
- Social Activities

See Appendix B- Community Readiness Assessment (CRA)

Strategy 3

“Execute a utilization review of recovery support services using data from the Access to Recovery (ATR), Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF), and Offender Re-entry (Project CARE) demonstrations. Follow with a survey of currently served consumers to identify non-traditional recovery supports services and activities consumers believe lead to positive outcomes.”

The Utilization Review was developed to identify addiction recovery supports that are producing desired outcomes as stated by the consumers of those supports. In keeping with the philosophy of consumer-directed care and consumer-driven services, this review focuses on clearly stating which services consumers’ value as helping them achieve self-stated goals.

The grant demonstration project teams supplied relevant data to researchers who were able to craft a document. This document contains the information DMHA will use going forward as evidence of services beyond those traditionally funded by DMHA that should be sustained based on consumer focused outcomes.

“When talking about mental illness or addiction recovery all members were respectful of those affected by these disorders and addictions.”

Workgroup Member

This utilization review and survey information will prove extremely valuable as this workgroup moves toward future goals. This data will be used in the development of a statewide gap analysis and will provide clear evidence of which recovery supports should be funded.

Findings:

- ATR, Project CARE, and CA-PRTF are similar in their approach to client care. Though the implementation, delivery and populations served

may vary slightly, the programs share the following characteristics:

- Client-driven
- Community-based
- Strengths-based
- Provide access to non-traditional support services (recovery supports), including Care Coordination (i.e. a facilitator that connects clients to necessary services)
- Holistic approach
- Emphasize the development of natural supports
- Not all clients in ATR and Project CARE required formal treatment (59% of ATR clients and 60% of Project CARE clients)

- Over 33% of ATR and Project CARE clients utilized transportation services (33.52% of ATR clients and 33.5% of Project CARE clients)
- Over 14% of ATR and Project CARE clients utilized transitional housing (19.25% for ATR and 14.7% for Project CARE)
- Life skills development or habilitation was utilized by 72.9% of CA-PRTF clients and 30.9% of Project CARE clients
- The data for ATR suggests that clients substantially decreased negative behaviors from intake to follow-up, including:
 - Alcohol Use: -58.46% rate of change
 - Illegal Drug Use: -71.46% rate of change
 - Injection Drug Use: -74.21% rate of change
 - Arrests: -66.82% rate of change
- The data for both ATR (+66.76% employment rate of change, +45.50% education rate of change) and Project CARE (+119.9% combined rate of change) suggest that employment and education advancements are achieved by a meaningful percentage of clients.
- The data for both ATR (+18.15% rate of change) and Project Care (+206.5% rate of change) suggest that finding stable housing is a common positive outcome experienced by clients.
- Similarly, youth receiving CA-PRTF services have a strong rate of improvement in the CANS functioning domain (45% of all grant youth) which includes school, job functioning, and living situation items.
- Data suggests that each of these three programs facilitates positive improvements for program participants around core functioning elements of employment, housing, and education in the community.

See Appendix C- Utilization Review

Strategy 4

“Survey public behavioral health providers on what services they believe are included in a good and modern, recovery oriented continuum of care.”

In September 2011, a brief survey regarding the current Division of Mental Health and Addiction (DMHA) continuum of care and contracting services was sent to 37 persons representing Community Mental Health Centers (CMHC’s) and 26 Managed Care Providers (MCP’s). Responses from 24 of these organizations were received, representing 19 CMHCs and 5 addiction MCP’s.

During the 2011 legislative session, the state statute that defines the continuum of care was revised to allow more flexibility in determining what services and supports are most appropriate and needed at any point in time. The purpose of the survey was to obtain statewide input regarding:

- What parts of the currently required continuum of care should continue to be required,
- What additional services and supports should be added to the continuum,
- Whether some parts of the continuum would be adaptable to a regional model as opposed to requiring each provider to offer the service/support
- Whether the state should financially support evidence-based practices and, if so, which ones

Findings:

The full analysis of the survey responses is included in the appendix to this document. The provider responses to this survey did not include non-traditional or natural supports. However, the following services and activities were identified as essential in a recovery-focused service delivery system:

- Services needed to support consumers in a residential setting that are not reimbursable by a third party
- Providing administrative oversight, support and coordination of activities that assist consumers in acquiring and maintaining safe and affordable housing in the community
- Housing coordination/liaison with property managers
- Outreach/Engagement activities
- Gatekeeping (for state hospital admissions and discharges)
- Mental health promotion and addiction prevention activities
- Non-crisis services to persons without third party payers

“Participation provided me, and our organization, a much more in depth view of how the state plan is developed, implemented, evaluated, as well as a fantastic opportunity to provide feedback to DMHA.”

Workgroup Member

See Appendix D- Continuum of Care Survey Analysis

See Appendix E- Comparison of Continuum Recommendations

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Appendix

Appendix A- Consumer and Family Survey

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Consumer Survey and Family Survey Detail Results

Consumer Recovery Supports

Think about the things and people in your life that influence your recovery. For the following types of support and activities, please tell us if you have used them and whether or not they were helpful to you in reaching your personal recovery goals.

	Used and was Helpful	Used and was Not Helpful	Percent Effective	Not Offered	Response Count
Someone who has had similar experiences	440	28	94.0%	49	517
A person in my life who has hope for me	470	19	96.1%	30	518
A job or other volunteer activity	359	35	91.1%	110	502
Access to education or other training	341	38	90.0%	117	496
Someone I trust to take care of my children	216	23	90.4%	198	437
Hobbies and interests	423	33	92.8%	57	512
Friends or family that I can do things with	444	22	95.3%	53	518
A place to go where I feel welcome	459	24	95.0%	32	514
Friends or family that I feel close to	454	25	94.8%	39	517
Participating in spiritual activities	370	59	86.2%	78	507
Someone to advocate for me	364	34	91.5%	104	502
AA, NA, GA, CA and/or others like these	296	70	80.9%	108	473
Help finding a safe and comfortable place to live	376	28	93.1%	93	497
Transportation assistance	343	27	92.7%	131	501
Help getting medical and dental care	317	25	92.7%	160	502
Physical Activity such as an exercise routine, walking,	399	41	90.7%	76	516
Help getting access to food and other household items	366	31	92.2%	107	504
Someone that helps me coordinate services, like a Recovery Consultant	35	2	94.6%	21	58

Family Recovery Supports

Think about the things and people in your family member's life that influence his/her recovery. For the following types of support and activities, please tell us if your family member has used them and they were effective, used them and they were not effective, were not offered, were offered but not used, you are not sure whether they were offered or not, or were not applicable to your family member.

	Used and was effective	Used and was not effective	Percent Effective	Not offered	Not used	Not sure	Not applicable	Response Count
Family and Friends	115	27	81.0%	10	8	5	0	165
People who express hopefulness for the individual receiving services	95	24	79.8%	14	4	22	6	165
Someone trustworthy to care for the individuals children	23	2	92.0%	6	8	2	124	165
Friends or family to do things with	116	20	85.3%	10	9	7	2	164
A place to go where individual feels welcome	92	15	86.0%	28	15	14	3	167
Friends or family that feel connected to the individual	121	26	82.3%	10	6	4	0	167
Hobbies and interests	87	30	74.4%	16	21	7	4	165
Physical activity, such as exercise	62	21	74.7%	26	41	11	4	165
A sponsor	15	9	62.5%	69	28	11	31	163
Identify self determined goals with assistance from support system	64	28	69.6%	30	18	19	5	164
Crisis plan development by individual and support system	43	20	68.3%	49	23	20	10	165
Money management training	23	16	59.0%	71	25	12	17	164
Someone with similar experience	33	18	64.7%	52	28	19	13	163
An advocate for the individual	60	17	77.9%	51	18	12	6	164
Help coordinating recovery services, such as a Recovery Consultant	18	15	54.5%	71	19	14	27	164
Self-help recovery program	24	19	55.8%	49	29	18	23	162
Clubhouse	4	14	22.2%	70	35	9	32	164
Recovery Center	6	12	33.3%	69	30	14	33	164
Volunteer activity	37	19	66.1%	45	36	16	12	165
Paid employment	49	15	76.6%	47	24	4	24	163
Participation in spiritual activities	50	24	67.6%	26	40	11	15	166

Help finding a safe, affordable and comfortable place to live	60	13	82.2%	34	9	4	45	165
Transportation for individual to access recovery supports	56	10	84.8%	38	19	3	37	163
Peer telephone support, such as a warm line	15	6	71.4%	77	34	12	19	163
Peer support groups/Alcoholics Anonymous/ other 12 step groups	28	27	50.9%	28	33	6	40	162
Peer support for the family	83	12	87.4%	35	23	2	7	162
Mental health education by individual receiving services	59	23	72.0%	38	17	18	10	165
Addiction recovery education	26	19	57.8%	17	18	8	76	164
Formal education or other training	39	29	57.4%	27	31	8	26	160
Mental health education by peers for family	83	10	89.2%	32	19	7	11	162
Groups like Nicotine Anonymous/Celebrate Recovery/ Overcomers	8	10	44.4%	39	31	11	64	163
Help getting medical and dental care	79	9	89.8%	41	6	7	21	163
Help getting food and other household items	75	9	89.3%	31	9	3	39	166

Consumer Recovery Services

Think about the professionals in your life and the services that you have used. For the following types of services, please tell us if you have used them and whether or not they were helpful to you in reaching your personal recovery goals.

	Used and was Helpful	Used and was Not Helpful	Percent Effective	Not Offered	Response Count
Medications	364	37	91%	99	500
Outpatient	342	52	87%	85	479
Intensive Outpatient	232	53	81%	167	452
Inpatient	203	65	76%	178	446
Detoxification	154	44	78%	223	421
Residential	222	31	88%	193	446
Clubhouse	112	34	77%	282	428
Recovery Center	214	25	90%	180	419
Day Treatment	230	26	90%	176	432
Case Management	320	34	90%	99	453
Crisis or Emergency Services	220	48	82%	164	432

Family Recovery Services

Think about the professional support in your family member's life. For the following types of support and activities, please tell us if your family member has used them and they were effective, used them and they were not effective, were not offered, were offered but not used, you are not sure whether they were offered or not, or were not applicable to your family member.

	Used and was effective	Used and was not effective	Percent Effective	Not offered	Not used	Not sure and not applicable	Response Count
Medications	130	27	83%	3	6	1	167
Outpatient Treatment	97	43	69%	8	11	4	163
Intensive Outpatient Treatment	47	18	72%	39	38	17	159
Inpatient	70	27	72%	17	32	17	163
Detoxification	13	12	52%	13	40	82	160
Residential Treatment	30	14	68%	31	40	49	164
Case Management	50	27	65%	31	31	25	164
Crisis and Emergency Services	64	23	74%	26	30	22	165
Having a guardian	26	7	79%	27	38	67	165
Having a payee	44	6	88%	28	28	60	166
Recovery Coach	14	3	82%	64	32	50	163
Certified Recovery Specialist	7	3	70%	63	29	60	162
24 Hour crisis line	23	17	58%	22	60	41	163
24 hour suicide prevention hotline	13	7	65%	18	70	54	162
Other – Please add supports not listed	6	2	75%	5	11	35	59

Effectiveness of Services

	Consumer Percent Effective	Family Percent Effective
Medications	90.8%	82.8%
Outpatient	86.8%	69.3%
Intensive Outpatient	81.4%	72.3%
Inpatient	75.7%	72.2%
Detoxification	77.8%	52.0%
Residential	87.7%	68.2%
Clubhouse	76.7%	22.2%
Recovery Center	89.5%	33.3%
Case Management	90.4%	64.9%
Crisis / Emergency	82.1%	73.6%

Only services asked the same on both surveys included

Appendix B- Community Readiness Assessment (CRA)

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Summary of Community Readiness Assessment

Total Population Count

SOF							
Number of Patients	EPCC	ESH	LCH	LSH	MSH	RSH	Total
Total	9	107	85	48	90	175	514

Total Population Type by SOF

SOF							
Population Type	EPCC	ESH	LCH	LSH	MSH	RSH	Total
SED	9	0	24	0	0	0	33
SMI	0	67	55	31	55	117	325
MICA	0	38	5	8	23	58	132
MRDD	0	2	0	9	12	0	23
Deaf SMI	0	0	1	0	0	0	1
Total	9	107	85	48	90	175	514

Recovery Goals Clients Feel Are Importance

SOF							
Recovery Support	EPCC	ESH	LCH	LSH	MSH	RSH	Total
Declined Input	0	22	13	2	27	34	98
Natural Supports	8	84	64	41	52	100	349
Social Activities	7	78	63	41	54	101	345
Education	9	72	54	40	44	71	290
Employment	2	79	48	39	45	81	294
Housing &/or Residential	7	80	57	38	55	127	364
Other	0	6	2	11	8	8	35

Family Recovery Input by SOF

SOF							
	EPCC	ESH	LCH	LSH	MSH	RSH	Total
No Active Family	1	40	17	11	26	65	160
Declined Input	0	31	10	5	6	32	84
Family Has a Recovery Goal	7	31	44	20	34	43	179
Other	1	3	11	11	23	31	80
No data	0	2	3	1	1	3	10
Unknown	0	0	0	0	0	1	1
Total	9	107	85	48	90	175	514

Appendix C- Utilization Review

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Recovery Support Services

I. Introduction

Substance abuse, mental illness and incarceration can infiltrate an individual's life in every domain, and their needs may vary from behavioral health treatment, to the integrated support of access to services that address physical health, housing options, social relationships, educational history and ability to get employment (Bryan Overby, Personal Communication, February 15, 2012). A recovery-oriented approach entails a service delivery method that integrates both formal treatment and informal community resources and support. This model spans siloed service delivery systems, coordinates within systems, identifies and leverages community level resources and supports, and creates a network for sustained recovery from substance use and mental health disorders in the community. The goal of this integrated model is to service both formal and informal recovery support needs through system coordination and structured and sustainable informal community support. This blended model presents opportunities for behavioral health and community level service providers as well as community level social networks consisting of peer support groups.

The Indiana Division of Mental Addiction was awarded multiple grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office of Medicaid Policy and Planning (OMPP) to offer intensive community based services as an alternative to psychiatric hospitalization for individuals aged 6 through 20 who are Medicaid eligible. A recovery-oriented service approach was used in these projects in order to meet the complex needs of a broad demographic. This person-centered approach focuses on meeting a wide demographic of individual's needs in multiple service delivery systems while creating a community level network of formal and informal support to sustain long-term recovery.

Three pilot programs facilitated by the Indiana Division of Mental Health and Addiction focus on a recovery-oriented service delivery system that address a client's behavioral health needs in their community. The first of these programs, Access To Recovery (ATR) funded by SAMHSA, provides consultation and vouchers for formal treatment in addition to Recover Support Services recovery in their community to treat substance use and co-occurring substance use and mental health disorders. This approach connects individuals to needed formal behavioral health treatment while helping a client access must needed recovery support services in their community. The second of these programs, Project CARE, asserts that access to behavioral health services in the community is an essential need for ex-offenders reentering communities. Project CARE uses a Recovery Coach to coordinate with systems and service providers to meet a client's formal treatment needs while creating networks of recovery services and support in a client's community. The third program, Community Alternatives to Psychiatric Residential Treatment Facilities (CAPRTF), provides community alternatives to children and youth, ages 6 through 20, who are classified as SED or SMI respectively, , and are at risk of placement in a psychiatric treatment facility or hospitalization due to intensive psychiatric needs. CAPRTF is able to intercept an individual from institutional service delivery systems and addresses their needs in the community.

The systems involved in servicing these individuals are all working towards a same long-term goal, which is the individual management of chronic substance abuse and mental health disorders at the community level. For these populations, this approach will reduce contact with criminal justice professionals and institutions. This report summarizes three state pilot programs that provide specific behavioral health needs for individuals throughout various service delivery systems and different service areas. It describes the need of the programs, each program's approach to service delivery, in particular recovery

support services, provides program outcomes as well as a discussion on recovery-oriented programming and the function of recovery support services.

II. Access To Recovery (ATR)

A. Intro

Indiana Access to Recovery (INATR) is a four year federal grant awarded in October 2010 to the Division of Mental Health and Addiction (DMHA) by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). INATR assists clients who want to get in recovery from substance use problems and disorders or need assistance maintaining their recovery. INATR pilots a recovery-oriented approach to care and helps clients gain access to a network of clinical, community and faith-based organizations who provide treatment and recovery support services to eligible individuals.

The goal of INATR is to provide a continuum of recovery services, regardless of where the person is in their recovery. The first step is to connect the client to a Recovery Consultant (RC) of their choice who will coordinate services in cooperation with the client, whether the services are funded by INATR or free in the community. The RC assists the client in developing a personal recovery plan and schedules meetings to discuss plan progress and needed modifications.

The recovery-oriented approach utilized by INATR aims to help people with substance use problems and disorders in a holistic way. It considers all aspects of the individual affected and provides a menu of services that can help address any barriers on their road to recovery by leveraging free or low-cost federal, state, and community services, including those funded by Indiana Access to Recovery (INATR). This approach builds on client strengths and addresses needs in a comprehensive way. A recovery-oriented system:

- Is person-centered
- Is inclusive of family and other allies
- Is anchored in the community
- Is strengths-based
- Is responsive to personal belief systems
- Offers integrated services
- Incorporates ongoing monitoring and outreach
- Is culturally responsive
- Offers peer recovery support services
- Provides individualized comprehensive services across the lifespan

INATR is a client choice program. This means that the client decides and designs the recovery plan that best fits them. The client will work with the RC to evaluate strengths and identify barriers to recovery. Next, the client will develop a personal recovery plan with the RC to address these barriers. INATR can fund clinical treatment on a limited basis, as well as appropriate recovery support services.

B. Need

In order to address individual-level needs and barriers to re-integration, an Indiana Access to Recovery service delivery approach is utilized. The Substance Abuse and Mental Health Services Administration (SAMHSA) funded the state of Indiana \$14.5 million over three years to increase

Indiana's treatment services through the Indiana Access to Recovery Program (INATR). Starting up in October of 2010, the INATR programming is in the process of laying down recovery networks in communities previously underserved by formal substance abuse services and a community support network.

C. Demographics of ATR population

The target population for the INATR program is diverse and includes active and ex-military, individuals recently released from the prison, those in diversion courts, pregnant women, women with children, and methamphetamine users. Indiana's ATR is designed for those in an underserved area often because of lack of appropriate level of care, knowledge about their disease, and lack of payer source.

INATR eligible clients must meet ALL of the following criteria:

- a. Must live in one of the eleven INATR counties (Allen, Clark, Elkhart, Floyd, Johnson, Lake, Marion, Monroe, St. Joseph, Vanderburgh or Vigo) or if military, must reside within the state of Indiana
- b. Household must be at or below 200% of the Federal Poverty Line or, if military, must be at or below 500% of the Federal Poverty Line
- c. Must have a substance abuse or dependence problem and be motivated to work toward recovery
- d. Must be a legal adult

The following demographic information represents the 3,795 clients that have been enrolled since the start of the ATRIII grant (October 1, 2010):

AGE: 642 (16.9%) 18-24 years old; 1,381 (36.4%) 25-34 years old; 902 (23.8%) 35-44 years old; 670 (17.7%) 45-54 years old; 196 (5.2%) 55-64 years old; 3 (0.1%) 65+ years old

GENDER: 2,233 (58.8%) male; 1,562 (41.2%) female

RACE: 2,227 (58.7%) White; 1,328 (35.0%) African American; 87 (2.7%) American Indian; 35 (0.9%) Multi-Racial; 9 (0.2%) Asian; 7 (0.2%) Hawaiian or Pacific Islander; 3 (0.1%) Alaska Native; 99 (2.6%) None of the Above

ETHNICITY: 132 (3.5%) Hispanic/Latino

INCOME LEVEL: Household must be at or below 200% of the Federal Poverty Line or, if military, must be at or below 500% of the Federal Poverty Line per ATR program guidelines

D. Service Approach

Indiana's Access to Recovery (INATR) program is funded by a four-year federal grant awarded to the Indiana Division of Mental Health and Addiction (INDMHA) by the Substance Abuse and Mental Health Services Administration (SAMHSA). Beginning in October of 2010, INATR program began assisting clients in accessing both formal and informal services in order to address substance use disorders in their community. INATR pilots a recovery-oriented approach to those with underserved behavioral health needs and helps clients gain access to a network of

clinical, community and faith-based organizations that provide treatment and recovery support services to eligible individuals.

This program funds services such as: recovery consultation, clinical assessment, outpatient treatment groups, individual addictions treatment, integrated treatment of co-occurring disorders, medication-assisted treatment, transitional housing, alcohol and drug screening and assessment, peer coaching, family and marital counseling, employment services, faith-based and/or community support, parenting services education or respite care, and GED and supportive education services.

The INATR program is client focused and directed and meets the client where they're at, focusing on providing a continuum of services to clients in every stage of their recovery. The first step in the INATR program is to connect a client with a Recovery Consultant, who will act as a coach and guide through the recovery process. This Recovery Consultant will initially coordinate services for the client, whether those services are free in the community, or funded by INATR. The client and the Recovery Consultant will identify individual strengths and specific barriers to recovery that are community specific and client driven, and this information is used to formulate a personal recovery plan.

E. Recovery Support Services

During the ATRII grant cycle, from October 1, 2007 to December 31, 2010, the following services were utilized by 10,384 ATR clients:

Service Category	Unique Client Count	Percent
Alcohol & Other Drug Screening	2610	25.13%
Child Care	15	0.14%
Clinical Services (Assessment, IOP, OP, Individual Addictions Treatment)	6164	59.36%
Community/Faith-Based Support	1107	10.66%
Community-Based Continuing Care	119	1.15%
Co-Occurring Treatment	162	1.56%
Detoxification	341	3.28%
Employment Services	1019	9.81%
Employment Supplies	384	3.70%
Family and Marital Counseling	407	3.92%
G.E.D. Support Services	233	2.24%
Medication-Assisted Treatment	664	6.39%
Parenting Education	80	0.77%
Peer Services	530	5.10%
Recovery Consultation	10187	98.10%
Substance Abuse Prevention/Education	703	6.77%
Transportation	3481	33.52%
Transitional Housing	1999	19.25%

The ATRIII grant cycle covers the October 1, 2010 to September 30, 2014 time period. The following table contains service utilization data for 3,617 clients enrolled from the start of the grant cycle to May 3, 2012:

Service Category	Unique Client Count	Percentage
Alcohol & Other Drug Screening	672	18.58%
Clinical Services (Assessment, IOP, OP, Individual Addictions Treatment)	1796	49.65%
Community/Faith-Based Support	157	4.34%
Community-Based Continuing Care	14	0.39%
Co-Occurring Treatment	49	1.35%
Detoxification	13	0.36%
Employment Services	120	3.32%
Family and Marital Counseling	226	6.25%
G.E.D. Support Services	6	0.17%
Medication-Assisted Treatment	300	8.29%
Parenting Education	18	0.50%
Peer Services (Certified Recovery Specialists)	206	5.70%
Recovery Consultation	3519	97.29%
Substance Abuse Prevention/Education	177	4.89%
Transportation	1228	33.95%
Transitional Housing	479	13.24%

F. Outcomes

To measure client outcomes, all ATR clients are asked a specific series of questions at intake, follow-up (5-8 months after intake), and discharge. This survey is mandated for all Center for Substance Abuse Treatment (CSAT) discretionary grants as outlined by the Government Performance and Results Act (GPRA). The following tables highlight GPRA data for clients that enrolled in ATRII (between October 1, 2007 and December 31, 2010) and clients that have enrolled so far in the ATRIII (October 1, 2010 to September 30, 2014).

ATRII GPRA Data (7,061 clients represented):

GPRA Item - increase % of individuals receiving services who report (in past 30 days):	Intake %	Follow-up %	Rate of Change*
C1 - Housed in Own Home/Apartment	35.83%	42.29%	18.02%
D1 - School/Training Program – Enrolled Full or Part-time	9.06%	13.20%	45.63%
D3 - Employment – Full or Part-time	24.29%	40.46%	66.59%
G1 - Participation in Voluntary Self-Help Groups	39.26%	44.07%	12.27%
G2 - Participation in Religious/Faith-Affiliated Groups	19.78%	16.68%	-15.68%
G3 - Participation in Other Groups	16.10%	17.11%	6.24%
G4 - Interaction with Supportive Family and/or Friends	88.80%	92.14%	3.76%
G5 - Have Someone to Turn to When in Trouble	93.10%	95.30%	2.36%
B1a - Alcohol Use	37.88%	15.71%	-58.54%
B1c - Illegal Drug Use	37.54%	10.71%	-71.48%
B3 - Injection Drug Use	4.93%	1.27%	-74.14%
C6b - Have Child under Child Protection	8.74%	6.63%	-24.15%
E1 - Arrested	12.22%	4.06%	-66.74%
E4 - Committed Crimes	40.99%	12.31%	-69.97%
F3b - Unprotected Sexual Contact	36.48%	31.50%	-13.66%
F3c1 - Unprotect Sex with HIV Pos Partner	0.11%	0.08%	-25.00%
F3c2 - Unprotect Sex with Inject. Drug User	1.53%	0.52%	-65.74%
F3c3 - Unprotect Sex with Someone High	5.93%	2.05%	-65.39%
F5a - Experienced Serious Depression	45.31%	28.27%	-37.61%
F5b - Experienced Anxiety or Tension	52.13%	34.27%	-34.26%
F5c - Experienced Hallucinations	3.41%	1.35%	-60.58%
F5d - Trouble with Comprehension/Memory	30.53%	17.92%	-41.33%
F5e - Trouble Controlling Violent Behavior	9.11%	5.11%	-43.86%
F5f - Attempted Suicide	1.12%	0.30%	-73.42%
F5g - Prescribed Medication	12.76%	10.31%	-19.20%

* Rate of Change is the speed at which a variable changes over time which is calculated by taking the percent at the status/follow-up/discharge interview minus the percent at intake divided by the percent at intake; and then multiplied by 100.

Highlights from ATRII:

- Only 24.29% of those starting the program had full or part time employment, whereas 40.46% had full or part time employment at their first follow up meeting (66.59% rate of change).
- 4.93% of participants had injected drugs in the past 30 days at baseline, whereas only 1.27% of clients had at their first follow up meeting (-74.14% rate of change)
- 37.54% of clients had were using illegal drugs at baseline, whereas only 10.71% of clients were using illegal drugs at their first follow up meeting (-71.48% rate of change)
- 41.99% of clients had committed a crime in the past 30 days at baseline, whereas only 12.31% of clients had at their first follow up meeting (-69.97% rate of change)
- 12.22% of clients had been arrested in the past 30 days at baseline, whereas only 4.06% reported arrests at their first follow-up meeting (-66.74% rate of change)
- Many clients experienced depression (45.31%), anxiety or tension (52.13%), had trouble with comprehension or memory (30.53%), or had trouble controlling violent behavior (9.11%) at

intake, whereas there was a substantial improvement in these mental health outcomes at follow-up with only 28.27% that experienced depression (-37.61% rate of change), 34.27% that experienced anxiety or tension (-34.26% rate of change), 17.92% that had trouble with comprehension or memory (-41.33% rate of change), and 5.11% that had trouble controlling violent behavior (-43.86% rate of change).

ATRIII GPRA Data (1,645 clients represented) for follow-up completed on or before April 30, 2012:

GPRA Item - increase % of individuals receiving services who report (in past 30 days):	Intake %	Follow-up %	Rate of Change*
C1 - Housed in Own Home/Apartment	44.19%	52.16%	18.02%
D1 - School/Training Program – Enrolled Full or Part-time	14.10%	18.42%	30.60%
D3 - Employment – Full or Part-time	32.58%	50.70%	55.60%
G1 - Participation in Voluntary Self-Help Groups	54.53%	64.01%	17.39%
G2 - Participation in Religious/Faith-Affiliated Groups	21.22%	24.56%	15.76%
G3 - Participation in Other Groups	23.95%	29.06%	21.32%
G4 - Interaction with Supportive Family and/or Friends	94.71%	95.87%	1.22%
G5 - Have Someone to Turn to When in Trouble	95.26%	97.75%	2.62%
B1a - Alcohol Use	23.65%	11.73%	-50.39%
B1c - Illegal Drug Use	26.26%	8.51%	-67.59%
B3 - Injection Drug Use	4.19%	1.16%	-72.46%
C6b - Have Child under Child Protection	8.75%	5.71%	-34.72%
E1 - Arrested	7.96%	4.26%	-46.56%
E4 – Committed Crimes	28.75%	9.97%	-65.33%
F3b - Unprotected Sexual Contact	35.68%	29.36%	-17.72%
F3c1 - Unprotect Sex with HIV Pos Partner	0.00%	0.00%	0.00%
F3c2 - Unprotect Sex with Inject. Drug User	1.70%	0.61%	-64.29%
F3c3 - Unprotect Sex with Someone High	4.38%	1.95%	-55.56%
F5a - Experienced Serious Depression	42.01%	33.25%	-20.84%
F5b - Experienced Anxiety or Tension	53.86%	41.52%	-22.91%
F5c - Experienced Hallucinations	2.74%	2.98%	8.89%
F5d - Trouble with Comprehension/Memory	31.55%	20.85%	-33.91%
F5e - Trouble Controlling Violent Behavior	8.27%	4.86%	-41.18%
F5f - Attempted Suicide	0.67%	0.55%	-18.18%
F5g - Prescribed Medication	15.22%	13.64%	-10.36%

* Rate of Change is the speed at which a variable changes over time which is calculated by taking the percent at the status/follow-up/discharge interview minus the percent at intake divided by the percent at intake; and then multiplied by 100.

Highlights from ATRIII:

- Only 32.58% of those starting the program had full or part time employment, whereas 50.70% had full or part time employment at their first follow up meeting (55.60% rate of change).
- 4.19% of participants had injected drugs in the past 30 days at baseline, whereas only 1.16% of clients had at their first follow up meeting (-72.46% rate of change)
- 26.26% of clients had were using illegal drugs at baseline, whereas only 8.51% of clients were using illegal drugs at their first follow up meeting (-67.59% rate of change)
- 28.75% of clients had committed a crime in the past 30 days at baseline, whereas only 9.97% of clients had at their first follow up meeting (-65.33% rate of change)
- Participation increased in voluntary self-help groups across all varieties of groups, such as a 21.32% rate of change increase in participation in general self help groups, a 15.76% rate of change increase in religious groups, and a 17.39% rate of change increase in participation in other voluntary self-help groups.

The analyzed data suggests that INATR has been effective in guiding clients through recovery, and accomplishing important benchmarks such as securing education or housing stability, reducing criminal activity, reducing drug and alcohol use, and accessing informal community support services.

IV. Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF)

A. Intro

Indiana was awarded over \$27 Million from Center for Medicare and Medicaid Services (CMS) to implement the CA-PRTF Demonstration Grant. The goal of the demonstration is to serve individuals classified as Severely Emotional Disturbed (SED) age 6-17 and Seriously Mentally Ill (SMI) age 18-20 with high level of need successfully in the community with intensive community based services. Indiana enrolled the first participant on January 31, 2008 and has enrolled over a total of 1,000. The Grant ends on September 30, 2012 due to CMS inability to prove that PRTF is an institutional level of care and have it included with the 1915(c) waiver guidelines.

B. Need

Due to Indiana's success with implementation of the Grant, CMS awarded an additional \$23 million for sustainability of our efforts. We are putting a 1915(c) waiver in place to serve individuals that were enrolled with CA-PRTF on the final day. The waiver will remain until the last participant no longer meets level of care. Indiana plans to write a 1915(i) to work with individuals classified as SED age 6-17 that need additional supports in the community to be successful. Indiana will be amending our Money Follows the Person Operational Protocol to include children/youth transitioning from a PRTF.

G. Demographics of CAPRTF Population

Age: Average age at admission was 12.05 years, but more teens than young children have received grant services. On June30, 2011, the average age was 13.66 , range of 6 to 21years.

GENDER: 837 (71.5%) boys

RACE: 873 (69.1%) white 233 (18.4%) African American, 10 (.8%) Native American, 1 (.1%) Asian, 51 (4%) Multi-racial, 3 (.2%) Other Race

ETHNICITY: 44 (3.5%) Hispanic

INCOME LEVEL: Youth were within 150% of national poverty per guidelines or eligible for Medicaid

MOST COMMON DIAGNOSES:

Diagnosis	% Primary Diagnosis	% Secondary Diagnosis
ADHD	29%	24%
Bipolar and Major Depressive Disorders	24%	13%
Oppositional Defiant Disorder	18%	21%
Conduct Disorder	8%	7%
Post Traumatic Stress Disorder	7%	6%
Anxiety	3%	4%
Developmental Disorders	3%	4%

D. Service Approach

Services provided through CAPRTF follow the wraparound model of care. Wraparound is an intensive, holistic method of engaging with individuals with complex needs so that they can live in their homes and communities and realize their hopes and dreams (National Wraparound Initiative [NWI], 2012). As such, all CAPRTF services are intensive community-based, team-based, client driven, and guided by a Wraparound Facilitator.

Wraparound care is not a treatment in and of itself, but rather a model for service provision that aims to achieve positive outcomes through a more holistic, creative, and individualized treatment approach (NWI, 2012). Each plan of care is developed by a team of participants engaging to work towards improving the life of the client, and the plans of care are tailored to meet the individual needs of the youth and their caregivers such that a range of life areas are addressed (NWI, 2012). Families and their teams meet at least once a month to discuss progress towards goals, and what they do and do not think is working well. There is a focus on integrating the youth into the community and building a strong network natural supports such that all improvements are sustainable (NWI, 2012). In addition to grant services, youth also have access to public physical and mental health services.

The CAPRTF grant provides access to Wraparound services not typically covered by Medicaid. These services include:

- Transportation to community services written in the plan of care
- Training and support for the child, their family members, and/or other caretakers
- Consultative Clinical and Therapeutic Services provided by professionals in psychology, social work, counseling and behavior management. The service includes assessment, development of a home treatment/support plan, training and technical assistance to carry

out the plan, monitoring of the participant and other providers in the implementation of the plan and compensation for participation in the Child and Family Team meetings.

- Respite care to provide a short-term break for caregivers. This may be planned ahead of time or used for an emergency.
- Flexible funds to purchase one-time/occasional things related the child's plan of care.
- Habilitation services to improve a child's functioning, increase skills and self-confidence.
- Wraparound Facilitation, including crisis/emergency planning and intervention and facilitating the child and family teams

All youth and their families choose their own providers from a list of qualified agencies

E. Recovery Support Services*

Service	Frequency (n=1093)	% total
Non-Medical Transportation	45	4.1%
Training	163	14.9%
Consultative Clinic	314	28.7%
Respite	337	30.8%
Flex Funds	508	46.5%
Habilitation	797	72.9%
Wraparound Technician	521	47.7%
Wraparound Facilitation	1020	93.3%

*Data on Medicaid billing claims

F. Outcomes

The Child and Adolescent Needs and Strengths (CANS, Lyons, 2009) is used to monitor progress for youth receiving CAPRTF services. Reliable change is measured by averaging CANS items within dimensions (mental health needs, functioning, risks, child strengths, youth needs, and caregiver needs and strengths). The average is multiplied time 10 to create dimension scores. Based on Indiana data, the amount of statistically significant change for each dimension (reliable change index) has been calculated for each dimension.

Improvement for youth on the grant, n = 845:

Domain	All Grant Youth* (n=845)
Behavioral Health	30%
Functioning	42%
Risks	38%
Strengths	30%
Caregiver Strengths & Needs	27%
Any 1 Domain	62%

*Based on "Indiana CA-PRTF Grant Evaluation Update, October 14, 2011", Betty Walton, Lauren Stanisic & Matthew Moore

Improvement in any 1 CANS Domain based on most common primary diagnoses, for youth with one completed episode of care (improvement data only available for 863 of 1093 youth):

Most Common Primary Diagnoses	Total number with this diagnosis	Total % to Improve in Any 1 Domain
ADHD	167	81%
Bipolar and Major Depressive Disorders	158	82%
Oppositional Defiant Disorder	102	77%
Conduct Disorder	44	84%
Post Traumatic Stress Disorder	41	73%
Anxiety	17	71%
Developmental Disorder	16	68%
All	642	81%

Improvement in any 1 CANS Domain based on most race/ethnicity/gender, for youth with one completed episode of care (improvement data only available for 863 of 1093 youth):

Demographic	Total number	Total % to Improve in Any 1 Domain
White	744	64%
African American	172	63%
Native American	9	67%
Multiracial	33	61%
Male	690	62%
Female	271	68%

Improvement in any 1 CANS Domain based on services received, for youth with one completed episode of care (improvement data only available for 863 of 1093 youth):

Service Received	Total # to receive this service	Total % to Improve in Any 1 Domain
Wraparound	1020	61.8%
Wraparound Technician	312	52.5%
Transportation	45	n/a
Training	163	n/a
Consultative Clinic	314	49.5%
Respite	337	48.1%
Flex Funds	508	52.5%
Habilitation	797	58.4%

G. Factors Predicting Improvement:

In October 2011, a multiple linear regression analysis was used to determine who most benefited by the grant, for the 462 youth who had been discharged from grant services and thus has at least one complete episode of care.

Based on other research and prior analysis of the grant, data for the following items were entered into the analysis to see if they are related to change: fidelity to the wraparound model (as measured by the Wraparound Fidelity Index), age, gender, race, ethnicity (Hispanic), co-occurring disorders, services received, and Baseline CANS scores. To this model, the following service Medicaid claims information was added: total grant services, acute inpatient, PRTF, individual therapy, medication management, psychotropic medications, etc.

H. Finding Highlights:

- Higher wraparound fidelity increased the likelihood of improvement
- Two wraparound elements also predicted improvement: Community-Based and Outcomes-Based services.
- Higher initial levels of oppositional behavior and adjustment to trauma needs predict the likelihood of improvement.
- Receiving grant services in conjunction with public mental health treatment (state plan services) increases the likelihood of improvement
- Higher levels of needs in the Risks Domain, Functioning Domain, and Strengths Domain on the Baseline CANS were associated with improvement
- *There was a lack of significant findings related to age, gender, race, ethnicity and caregiver strength and needs. This indicates that no significant differences were found for youth with specific descriptive or cultural characteristics as pertains to improving from grant services.*

Wraparound Fidelity Scores

	Level of Fidelity	% of youth
High		41.8%
Adequate		36.7%
Borderline		14.7%
Very low		6.8%
June 2011		

I. Factors Predicting NO improvement:

- Youth who received inpatient psychiatric care during their time on the grant were less likely to improve.
- Youth who received higher levels of psychotropic medication during their time on the grant were less likely to improve.
- Youth who received higher levels of case management were less likely to improve.
- Youth with co occurring needs (SU and DD) improve at a lower rate than youth without co occurring needs

- *There was a lack of significant findings related to age, gender, race, ethnicity and caregiver strength and needs. This indicates that no significant differences were found for youth with specific descriptive or cultural characteristics as pertains to lack of improvement from grant services.*

J. Youth with co-occurring needs

Substance Abuse:

- 117 youth, or 10.7% of all youth on the grant, were identified as having substance abuse/dependence. These youth were identified by a primary or secondary diagnosis of substance dependence, and/or a score of 2-3 on the CANS substance abuse item.
- The longer youth with SU needs are on the grant, the more likely they are to improve. However, this group has a tendency to end grant services quickly, without improvement
- Boys and multi-racial youth with SU needs are less likely to improve
- Using Reliable Change Index to measure improvement in CANS domains, those youth with substance abuse needs were less likely to improve from receiving grant services, in nearly every domain, than grant youth as a whole.

Domain	All SU Youth (n=117)	All Grant Youth* (n=845)
Behavioral Health	29%	30%
Functioning	17%	42%
Risks	37%	38%
Strengths	21%	30%
Caregiver Strengths & Needs	24%	27%
Any 1 Domain	57%	62%

*Based on “Indiana CA-PRTF Grant Evaluation Update, October 14, 2011”, Betty Walton, Lauren Stanisic and Matthew Moore

K. Developmental Impairment:

- Approximately 236 youth, or 19.5% of all youth on the grant, were identified as having some level of developmental impairment. These youth were identified by a primary or secondary diagnosis of developmental impairment, and/or a score of 2-3 on the CANS developmental item.
- Most recent data shows that 78 youth have a formal diagnosis of developmental impairment. A total of 23 of those youth have a diagnosis of Autism.
- Higher wraparound fidelity predicted improvement
- The Community-Based element was very strongly associated with improvement for these youth
- Youth who receive inpatient psychiatric care are less likely to improve
- Receipt of inpatient psychiatric care corresponds with a decreased likelihood for improvement
- Using Reliable Change Index to measure improvement in CANS domains, those youth with developmental impairment were less likely to improve from receiving grant services, in nearly every domain, than grant youth as a whole.

- Notably, youth with SU needs had a higher rate of improvement in the Risks domain in comparison to all grant youth.

Domain	All DD Youth (n= 236)	All Grant Youth* (n=845)
Behavioral Health	26%	30%
Functioning	39%	42%
Risks	33%	38%
Strengths	23%	30%
Caregiver Strengths & Needs	22%	27%
Any 1 Domain	56%	62%

*Based on “Indiana CA-PRTF Grant Evaluation Update, October 14, 2011”, Betty Walton, Lauren Stanistic & Matthew Moore

Youth with co occurring Substance Abuse or Developmental needs have a lower rate of improvement in each domain, in comparison with overall grant youth.

L. DCS Involvement:

- Approximately 494 youth, or 47% of youth have some level of DCS involvement as reported by Wraparound Facilitators
- High fidelity in Community-Based and Outcomes-Based domains are associated with improvement
- Baseline needs in Behavioral Health, Functioning, and Caregiver are linked to improving
- Being of Hispanic ethnicity is linked with improvement

V. Project Community And Reentry Enhancement (CARE)

A. Introduction

Despite a decade (2000-2009) of declining rates of crime, the number of people in prison in Indiana increased by more than 40%; “this rate of increase was three times faster than what other states in the region experienced” (Justice Center, 2010). Compounding this growing criminal justice problem is the fact that 81% of Indiana offenders in the corrections system have been identified as having a chronic addiction and 17% have a diagnosable mental illness. Moreover, only a small percentage of offenders receive treatment for substance abuse or co-occurring disorders, due to lack of resources and lack of readiness to change which manifests itself into a 37.9% recidivism rate (based on IDOC 2008 release cohort data).

It costs nearly \$54 a day to incarcerate just one offender. Releasing appropriate offenders to community corrections supervision, which costs just \$11 a day, can alleviate both the financial and overcrowding burden facing the state of Indiana. However, returning back into the community can be a rocky transition for many offenders. When an offender is released from the Indiana Department of Corrections (IDOC), they face many initial challenges: adequate living arrangements, employment, access to recovery programs, medical expenses, and social support.

These challenges oftentimes hinder an individual from making a successful transition back into the community. Facing the previously mentioned challenges combined with the stress of an addiction and a potentially undiagnosed mental health disorder creates a unique struggle for men and women trying to reintegrate back into the community from state prison.

It is imperative that innovative programming be implemented before many offenders find themselves back in the criminal justice system, creating a revolving door syndrome that is costly in both economic and societal terms. With a solid understanding that our consumer base is the same, The Division of Mental Health and Addiction (DMHA) and the Indiana Department of Correction (IDCO) jointly submitted and were awarded the 2009 Substance Abuse and Mental Health Administration (SAMSHA) Offender Reentry Grant known as Project Community and Reentry Enhancement (CARE).

The main goal of Project CARE is to prevent individuals from returning to state prison; bridging the gaps between formal treatment systems, the Criminal Justice System and the community accomplishes this aim. This pilot program transcends boundaries between individual case management, the Criminal Justice system, and the community. Project CARE's approach focuses on providing individualized wraparound services for each client that addresses specific barriers to reintegration as expressed by the client. Tailored to the specific needs of each client, Project CARE has developed a blended approach to recovery-oriented services, or a Blended ROSC that is inclusive of treatment providers, the Criminal Justice System, and the community including family, peers, and other agents of social support. With an emphasis on personal transformation and recovery, Project CARE is the missing piece for many individuals reentering the community (Grove-Paul, Overby & Kirkpatrick, 2011; Kirkpatrick, Lammert, Grove-Paul & Rowland, 2012).

Highlighting Project CARE in the Recovery Support Workgroup Utilization Report was fundamental to the DMHA review of recovery supports because Project CARE is one of three DMHA federal grant programs that utilizes a multi-dimensional approach to care that is consumer driven, strength based, and offers treatment and recovery support services.

B. Need

A nationally accepted definition of reentry was presented by Blas Nuñez-Neto (2008), who reported to Congress on Offender Reentry, in preparation for requesting the funding stream for the Second Chance Act. He defines offender reentry as a process that can include "all the activities and programming conducted to prepare ex-convicts to return safely to the community and to live as law-abiding citizens." He suggests that most planning and treatments begin during incarceration and extends through and assists the offender's integration in a community. Programs that address a wide range of individual needs such as behavioral health treatment, education, employment, and transitional and stable housing are emerging in the literature as effective models for what works in reentry.

Aftercare services are very strong predictors of reentry success. Yet the continuity of care from prison to the community seems to pose one of the biggest challenges to the reentry process, as individuals are released to the community with few resources to access treatment or appropriate care (Burdon, Messina, & Prendergast, 2004). For each day of aftercare services, chances of recidivating decrease by 1% (Burdon, Messina, & Prendergast, 2004). Individuals with mental illness leaving prison are at an extreme disadvantage in obtaining continuity of care,

aftercare services and access to psychiatric medication and intervention as the systems in prison do not extend and link to the community and most individuals are released from prison with little or no money and no health coverage (Slate & Johnson, 2008).

Project CARE serves men and women being released by the Indiana Department of Correction (IDOC) to the following 6 southern Indiana counties: Bartholomew, Crawford, Harrison, Monroe, Orange, and Washington. It is important to note that upon initiation of Project CARE in these targeted counties, there was no existing reentry apparatus or coordinated services for individuals leaving the department of correction; in fact, these areas were chosen because of their lack of infrastructure to be able to provide offender reentry support. Participants are identified by the IDOC as non-violent, have a history of substance abuse issues or co-occurring substance abuse and mental health issues and be under post-release supervision in one of the six identified counties served by the program. Participants are under the supervision of Parole, Probation or Community Corrections and oftentimes a combination of these for the duration of their time in Project CARE.

C. Demographics of CARE population

AGE: 42.1% between the ages 30-39 years

EDUCATION/EMPLOYMENT: 52.8% 12th grade level or equivalent education; 74.1% unemployed at intake

GENDER: 197 Project CARE clients are male (78.2%); 21.8% female

RACE: 84.8% White; 8.6% African American; 2.5% Native American

ETHNICITY: 2.5% Hispanic/Latino

INCOME LEVEL: These clients live below the federal poverty level (92.0%) and 76.1% have incomes below ¼ of the federal poverty level, qualifying them for access to various treatment services.

At intake, most clients are living in a correctional facility (50.3%) and are reporting to be in “good” physical health (44.7%). Serious depression, anxiety, and problems concentrating are commonly reported mental health symptoms at intake (37.1%, 51.3%, and 35.0%, respectively). Clients are typically between the ages of 10 and 14 when they first use any substances (46.8%) and have been in a substance abuse treatment program at least once before (77.5%).

D. Service Approach

Project CARE is a recovery- oriented pilot program for prisoner reentry in Indiana. Project CARE utilizes a Blended Recovery Oriented System of Care (B-ROSC) which provides integrated access to both formal treatment and informal community support: this model spans siloed service delivery systems, coordinates within a system of care, identifies and leverages community level resources and sources of support and creates a network for the sustained reintegration of ex-offenders in the community.

A federally funded program providing individualized care, access to treatment, and community support services to men and women leaving the Indiana Department of Correction (IDOC) in 6 southern Indiana counties, the main goal of Project CARE is to keep individuals from re-offending. The Substance Abuse and Mental Health Services Administration (SAMHSA) funds project CARE in partnership with the Indiana Division of Mental Health and Addiction, the Indiana Department of Corrections, and Centerstone of Indiana to implement a project that offers individualized and complex wrap-around services to adults in a community setting, focusing on the transitional period between a state correctional institution and a community in an identified county. Wrap-around services include but are not limited to mental health and substance abuse treatment, vocational services, assistance with finding housing, and community support. Project CARE provides an effective and fiscally responsible system of support for reentry offenders with multiple service needs, using research-based best practices that cost significantly less than incarceration, especially for rural counties that are often lacking reentry support mechanisms.

Project CARE utilizes a multi-disciplinary, holistic approach to reentry, focusing on behavioral modification and public safety while at the same time being fiscally responsible. Over 90% of Project CARE clients have been in some kind of treatment before though with little if any successful outcomes. This project offers a valued added combination of traditional treatment services coupled with help with basic needs and wants in order for clients to begin to stabilize in their communities upon reentry. Project CARE seeks to meet the client’s substance abuse and mental health needs while consistently focusing on helping them reconnect with their community. In addition, the project aims to help clients achieve personal goals and objectives such as going to college and vocational classes.

E. Recovery Support Services

Service	Frequency	% total (out 191 clients)
Formal Treatment	114	59.7%
Case Management	187	97.9%
Medical Services	50	26.2%
Dental	32	16.8%
Shelter	2	1.0%
Life Skills Development	59	30.9%
½ Way Housing	28	14.7%
Vocational Rehabilitation	22	11.5%
Utilities Assistance	27	14.1%
School	12	6.3%
Rent	47	24.6%
Food	47	24.6%
Clothing	54	28.3%
Transportation Assistance	64	33.5%

	Intake	6-month	Rate of change (%)*
Percentage of clients that used drugs	5.0%	14.9%	198.0%
Avg. # of days > 0	15	11	-26.7%
	Intake	6-month	Rate of change (%)*
Percentage of clients that used alcohol	5.8%	15.7%	170.7%
Avg. # of days > 0	10	7	-30.0%

* Eligible individuals for CARE are incarcerated at intake so little to no opportunity exists for consuming drugs or alcohol, a minimal number of CARE clients have been through treatment while incarcerated so their desire and ability to consume alcohol and drugs is dormant with little to no recovery skills developed, and clients become more honest about use one therapeutic alliance is developed hence the increased admission at the 6-month follow up.

F. Additional Outcomes

GPRA Measure	# Valid Cases	Percent @ Intake	Percent @ 6-Months	Rate of Change
Crime and Criminal Justice: had no past 30 day arrests.	122	100%	88.5%	-11.5%
Employment/Education: currently employed or in school.	122	24.6%	54.1%	+119.9%
Health/Behavioral/Social Consequences: experienced <u>no</u> alcohol or illegal drug related health, behavioral, social consequences.	122	95.9%	87.6%	-8.6%
Social Connectedness: were socially connected.	122	91.0%	91.8%	+0.9%
Stability in Housing: had a permanent place to live in the community.	122	12.3%	37.7%	+206.5%

VI. Discussion

ATR, CAPRTF, and Project CARE are all working to develop a sustainable network of support that can service individuals seeking recovery support and integration into their community. An approach that is recovery oriented addresses varying client needs in a multitude of environments. For the purposes of this discussion, ATRII data, which represents a larger sample size (7,072) than ATRIII (1,649), will be used.

By supporting individuals in their own recovery process, individuals will be involved in every decision, identify supports and opportunities, services and resources that makes sense. It should be acknowledged that whether we are dealing with system or community level goals or focusing on the needs of the individual, the goals are all the same with the larger end goal of successful reintegration into the community. This model spans siloed service delivery systems, coordinates within a system of

care, identifies and leverages community level resources and sources of support, and creates a sustainable network for the client makes sense for reentry programming.

Findings from each program's data support that a range of successes are experienced as a result of the services and supports provided.

- The data for both ATR (+66.76% employment ROC, +45.50% education ROC) and Project CARE (+119.9% combined ROC) suggest that employment and education advancements are achieved by a meaningful percentage of clients
- The data for both ATR (+18.15% ROC) and Project CARE (+206.5% ROC) suggest that finding stable housing is a common positive outcome experienced by clients
- Similarly, youth receiving CAPRTF services have a strong rate of improvement in the CANS Functioning domain (45% of all grant youth), which includes the school, job functioning, and living situation items.

Data suggests that each of these 3 programs facilitates positive improvements for program participants around core functioning elements of employment, housing, and education in the community.

Fostering social connectedness is another important aspect of these programs, as it is a key element of community involvement. Different programs yielded varying results regarding this aspect of community integration. ATR participants had an overall +12.32% ROC in terms of the number of participants who attended voluntary self-help groups. Project Care only experienced a 0.9% increase in the number of participants who are socially connected. This could be due to the way this data is grouped for Project CARE. If clients answer "yes" to any of the social connectedness questions on the GPRA survey (connected to voluntary self-help groups, faith-based groups, other groups, or friends/family supportive of recovery), then they are considered socially connected. At intake, 91% of clients answered "yes" to one of those questions. This high level of social connectedness at intake may be the reason the increase at follow-up is minimal. So, while these programs did help their participants to be more socially connected, the level of improvement was not overall very strong. This suggests that perhaps that either there are aspects of helping individuals to be socially connected that are not addressed in the programs or that the data is not providing enough information to generate conclusions on social connectedness.

Unlike the other programs, CAPRTF is specifically for youth and not all participants have a co-occurring mental or substance abuse needs. Notably, however, youth with co-occurring Substance Abuse or Developmental needs have a lower rate of improvement in each domain, in comparison with overall grant youth. This suggests that there are unique challenges presented by those with co-occurring needs which are not addressed in the program.

Appendix D- Continuum of Care Survey Analysis

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Continuum of Care Survey October 4, 2011

Analysis and Results

On September 21, 2011, a brief survey regarding the current DMHA continuum of care and contracting services was sent to 37 persons representing Community Mental Health Centers (CMHC) and 26 Managed Care Providers (MCP). As of the close on business on October 3, 2011, twenty-four (24) responses were received representing 19 CMHCs and 5 MCP addiction providers.

Purpose of the Survey

During the 2011 legislative session, the state statute that defines the continuum of care was revised to allow more flexibility in determining what services and supports are most appropriate and needed at any point in time. The specific services and supports defining the continuum of care will continue to be promulgated through the administrative rule-making authority of the Family and Social Services Administration, Division of Mental Health and Addiction (DMHA). The purpose of the survey was to obtain state-wide input regarding:

- what parts of the currently required continuum of care should continue to be required,
- what additional services and supports should be added to the continuum,
- whether some parts of the continuum would be adaptable to a regional model as opposed to requiring each provider to offer the service/support
- whether the state should financially support evidence-based practices and, if so, which ones

Summary Results

Note to Reader: Percentages are used the following summary. With a total number of respondents this small (24), percentages may be misleading. For example, 4.2% of 24 is actually one (1).

1. By a difference of 13%, more respondents indicated that not all providers which receive funds from DMHA should be required to provide the full continuum of services. (See Table and Chart for Question 4)
2. By a smaller margin (4.2%), providers would support DMHA contracting for some parts of the continuum through specialty providers. An equal number of respondents (4.2%) answered "Do not Know" to this item possibly indicating that the concept was not well defined in the item. (See Table and Chart for Question 5)
3. Detoxification Services were most frequently recommended for regionalization (68.2% of respondents. No other service was recommended by at least 50% of the respondents. (See Table for Question 6)
4. For Mental Health Services, over 50% of respondents recommended that all current continuum of care services and supports be required of comprehensive mental health and addiction providers. Acute Stabilization Services and Residential Services received the highest percentages recommending that they be eliminated from the required continuum [35% and 30% respectively.]. (See Table for Question 7)
5. For Addiction Services, only Detoxification Services at 46% of respondents was not recommended for retention in the required continuum by at least 50% of respondents. Residential Services, Psychosocial Rehabilitation, and Acute Stabilization services received the

highest percentages recommending that they be eliminated from the required continuum [46%, 38% and 38% respectively]. (See Table for Question 8)

6. Integration of mental health and addiction services, Systems of Care for youth, Habilitation Services, and Outreach/Engagement Services were recommended by 75% or more of all respondents to be added to the continuum [100%, 81%, 75%, and 75% respectively]. Mental health promotion and addiction prevention was most frequently recommended to be required on a regional basis [44%]. (See Table for Question 9).
7. All services listed on the survey as services currently without a funding source which are needed to promote recovery received a response rate of 66% or higher. (See Table for Question 10)
8. Support for using the current funding for ACT to support other evidence-based practices, including ACT, was expressed by 54.2% of respondents. However, 45.8% of respondents indicated either disagreement with this suggestion or no opinion. (See Table and Chart for Question 11)
9. Models to support integration of behavioral and primary health care and Illness Management and Recovery were most often cited (66.9%) by respondents as the most important evidence-based practices (of those listed) to be targeted for special funding. The three listed evidence-based practices for youth received the lowest recommendations for special funding. (See Table for Question 12)

The following pages contain tables and graphs for the survey questions.

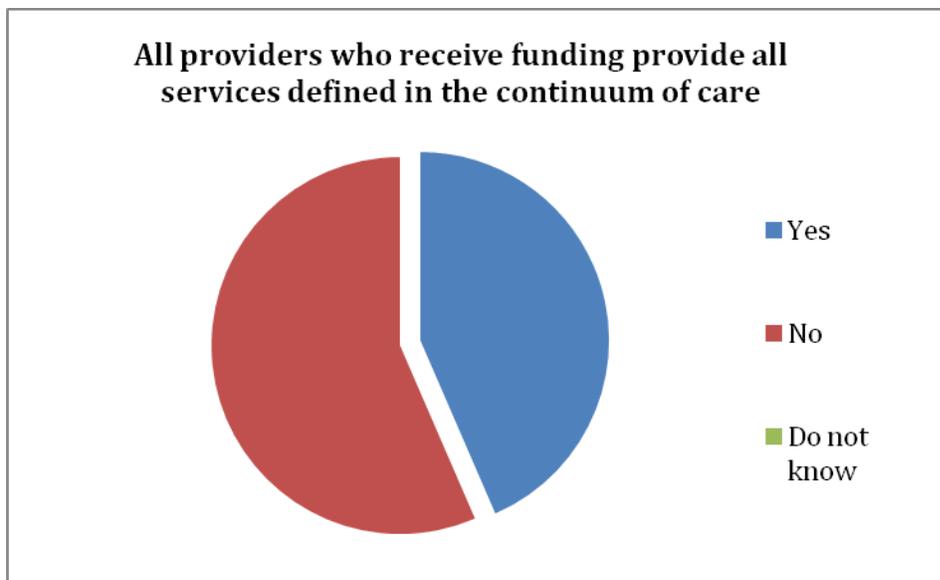
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Type of Certification (Multiple selections allowed):

	Response Percent	Response Count
CMHC	75.0%	18
MCP	79.2%	19

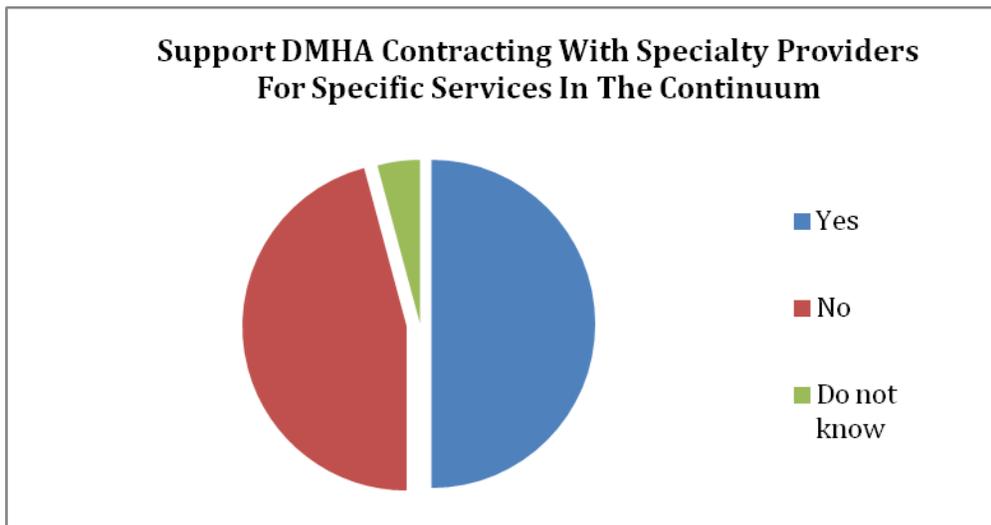
Question 4: Should all providers who receive service funding from DMHA be required to provide all services defined in the continuum of care?

	Response Percent
Yes	43.5%
No	56.5%
Do not know	0.0%



Question 5: Would you support DMHA contracting with specialty providers for specific services in the continuum? This could be a CMHC, Addiction Provider, or other community provider.

	Response Percent
Yes	50.0%
No	45.8%
Do not know	4.2%



Question 6: Which of the following services do you recommend be facilitated regionally through a specialty contract rather than required of all comprehensive providers (currently CMHC/MCPs)?

	Response Percent
Detoxification services	68.2%
Sub-Acute - residential	45.5%
Inpatient hospitalization	36.4%
Transitional Residential Services	31.8%
Mental health promotion and addiction prevention activities	31.8%
Peer Operated Services, such as drop-in center or a Recovery Support Center	27.3%
Group Home - residential	22.7%
Supportive Housing	18.2%
Family support services	18.2%
Other	18.2%
Twenty-four (24) hour crisis services	9.1%
Semi-Independent Living	9.1%
Case management/care coordination	4.5%

Question 7: Which of the following services do you recommend continue to be in the certification requirements of a comprehensive provider of mental health services.

REQUIRED SERVICE -

Mental Health

	Keep	Eliminate
Individualized treatment planning	100%	0%
Case management (care coordination)	100%	0%
Substance abuse services	100%	0%
Counseling and treatment	100%	0%
Medication Evaluation and monitoring	96%	4%
Twenty-four (24) hour crisis services	91%	9%
Psychosocial Rehabilitation	83%	13%
Intensive outpatient services	74%	22%
Family Support Services	74%	17%
Residential services	65%	30%
Safety Net Services (Services to prevent unnecessary treatment and hospitalization, for example risk screening and clinical needs assessment and referral, gatekeeping)	65%	22%
Other outpatient services	61%	26%
Acute stabilization services, including detoxification services	61%	35%

Question 8: Which of the following services do you recommend continue to be in the certification requirements of a comprehensive provider of addiction services. REQUIRED SERVICE -

Addiction	Keep	Eliminate
Individualized treatment planning	100%	0%
Case management (care coordination)	100%	0%
Substance abuse services	100%	0%
Counseling and treatment	96%	4%
Intensive outpatient services	92%	8%
Twenty-four (24) hour crisis services	83%	13%
Family support services	79%	13%
Medication evaluation and monitoring	79%	13%
Other outpatient services	63%	25%
Safety Net Services (Services to prevent unnecessary treatment and hospitalization, for example risk screening and clinical needs assessment and referral, gatekeeping)	63%	25%
Acute stabilization services, including detoxification services	54%	38%
Psychosocial Rehabilitation	54%	38%
Residential services	46%	46%

Question9: What services/activities, not currently required, do you recommend become part of Indiana's continuum of care? POTENTIALLY REQUIRED SERVICE

Required for Comprehensive Providers

	Response Percent
Integrated mental health and addiction treatment (co-occurring specialty services)	100%
Systems of Care for youth using wraparound services	81%
Habilitation Services	75%
Outreach/Engagement	75%
Supported Employment Service	69%
Supported (or Supportive) Housing	69%
Peer Recovery Services	63%
Integrated behavioral and primary health care	56%
Mental health promotion and addiction prevention activities	44%

Required Regionally

	Response Percent
Mental health promotion and addiction prevention activities	44%
Supported Employment Service	38%
Supported (or Supportive) Housing	38%
Integrated behavioral and primary health care	38%
Habilitation Services	31%
Peer Recovery Services	25%
Systems of Care for youth using wraparound services	19%
Integrated mental health and addiction treatment (co-occurring specialty services)	13%
Outreach/Engagement	13%

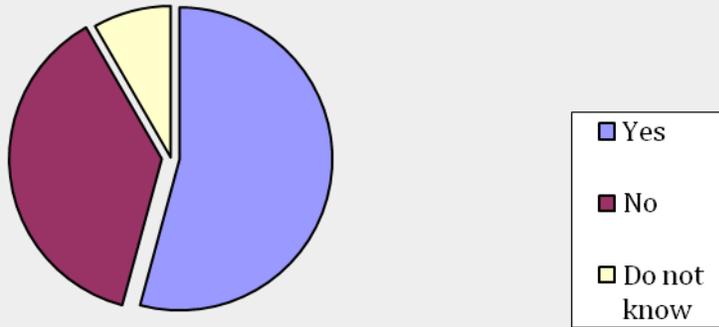
Question 10: What services/activities that currently do not have a third party reimbursement are needed to promote recovery?

	Response Percent
Services needed to support consumers in a residential setting that are not reimbursable by a third party	95.2%
Providing administrative oversight, support and coordination of activities that assist consumers in acquiring and maintaining safe and affordable housing in the community	90.5%
Housing coordination/liaison with property managers	81.0%
Outreach/Engagement activities	76.2%
Gatekeeping	76.2%
Mental health promotion and addiction prevention activities	66.7%
Non-crisis services to persons without third party payors	66.7%

Question 11: DMHA currently targets funding for the support of Assertive Community Treatment (ACT) Teams. Would you support the continued targeting of these dollars to support evidence-based practices, which may continue to include ACT?

	Response Percent
Yes	54.2%
No	37.5%
Do not know	8.3%

Support Targeting Dollars To Support Evidence-based Practices, Which May Continue To Include ACT



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Question 12: Which of the following evidence-based practices do you think would be most important for the state to support with targeted funding? The following list is not considered to be all inclusive

Evidence Based Practice	Response Percent
<i>Models to support integration of behavioral and primary health care</i>	60.9%
<i>Illness Management and Recovery</i>	60.9%
Supported Employment	52.2%
<i>ACT</i>	47.8%
<i>Motivational Interviewing</i>	47.8%
<i>Person-Centered Planning</i>	43.5%
<i>Integrated Dual Diagnosis Treatment (SAMHSA Toolkit)</i>	43.5%
<i>Supported (or Supportive) Housing</i>	39.1%
<i>Cognitive Behavioral Therapy</i>	39.1%
<i>Matrix Model</i>	39.1%
Integrated Treatment of Co-Occurring Disorders (DDCAT)	34.8%
Family Functional Therapy	17.4%
Multi-Systemic Family Therapy	8.7%
Therapeutic Foster Care	8.7%

Appendix E- Comparison of Continuum Recommendations

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**Establishing a New Continuum of Care for Mental Health and Addiction
(Comparison of Current, Newly Legislated, and Ideal Continuum of Care)**

Priority Area 2: Recovery Supports

Strategy 4: Survey public behavioral health providers on what services they believe are included in a good and modern, recovery-oriented continuum of care.

Completed by: 3 surveys/interviews conducted June-October 2011

Populations Addressed: Adult (SMI & CA) and Adolescent/Youth

Comparison of Current, New, & Recommended Continuums:

Current Continuum Of Care	New Continuum of Care	Provider Surveys on Ideal Continuum (3)
Twenty-four Hour Crisis Intervention	Integrated Primary & Behavioral Health	Supported Employment
Individualized Treatment Planning	Prevention & Wellness	Peer Recovery Services
Acute Stabilization	Engagement Services	Integrated Behavioral & Primary Care
Day Treatment	Outpatient Services	Intensive Supports
Services to Prevent Unnecessary Hospitalization	Community, Recovery, & Resilience Supports	Prevention & Wellness
Residential Services	Acute Intensive Services	Habilitative Supports
Case Management	Safety Net	Outreach & Engagement
Outpatient Services	1915 (i) Medicaid State Plan Amendment	Supported Housing
Medication Eval & Monitoring		Safety Net Services
Family Support		Residential Services
		Specialized Recovery Groups
		Wrap-Around Services (Youth Specific)

- Potential elements noted in provider feedback not noted in “new” continuum are matched with associated pink and blue colors and may fall within the “new” elements definition as a service.