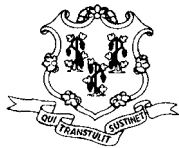


NASDDDS

May 12 – 14, 2004



**Serving People with Co-Occurring Conditions
Through Interagency Collaboration**



State of Connecticut

Department of Mental Retardation

Kathryn duPree, Deputy Commissioner

Steven Robson, Residential Manager

The Successful Components of Interagency Collaboration

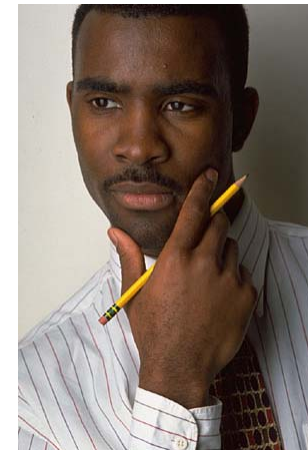
- **Limitation of formal agreements.**
- **Importance of interagency relationships among key professionals.**
- **Regular communication.**
- **Agency orientation.**
- **Respond to organizational needs and respect service and budgetary constraints.**
- **Training and collaboration.**



The Successful Components of Interagency Collaboration

Regular Communication

- **Opportunity to identify barriers and take administrative action.**
- **Identify needs for interagency case conferences and training.**
- **Leads to creative problem solving.**



The Successful Components of Interagency Collaboration

Agency Orientation

- Local regional orientation.
- State level orientation.
- Understanding of the presence of the Waiting List and its impact on effective discharge planning.
- Understanding among DMR administrators of public mental health policy of devoting resources to those who have significant, chronic mental health illness.
- Different service delivery focus from the approach in the MR field providing comprehensive long-term support.



The Successful Components of Interagency Collaboration

Responding to Agency Priorities and Constraints

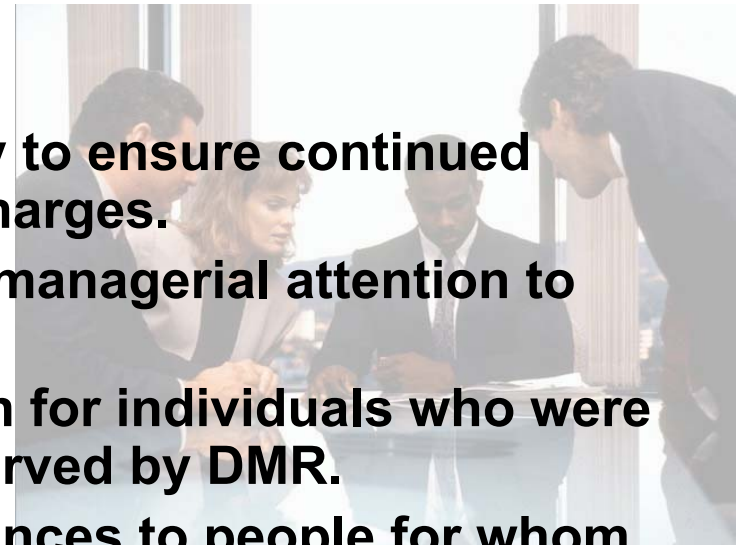
- Identified the problem of untimely, unresponsive discharge planning for people with mental retardation from CLAs served in an inpatient setting.
- Identified lack of pre-planning for youth leaving DCF inpatient facilities.
- Identified the lack of options for people from home who were hospitalized.



The Successful Components of Interagency Collaboration

DMR's Response:

- **Work with the provider community to ensure continued team involvement and timely discharges.**
- **Create a tracking system to bring managerial attention to the problem.**
- **Streamline eligibility determination for individuals who were hospitalized and not previously served by DMR.**
- **Conduct interagency case conferences to people for whom discharge planning remained challenging.**
- **Strengthen collaboration with DCF to better plan community alternatives for adolescents with co-occurring conditions.**
- **Develop a transitional residential setting for adults who could not return to their family home.**



The Successful Components of Interagency Collaboration

Psychiatric Admissions Summary

	Total Number Admitted	Total Remaining Hospitalized	Total Remaining Past Stabilization
FY 01	117	43	14
FY 02	266	34	9
FY 03	216	34	NOT AVAILABLE
FY 04 (TO DATE)	165	14	2

The Successful Components of Interagency Collaboration

Psychiatric Discharge by Facility and Average Length of Stay Number Discharged / Average Length of Stay

	Private Hospital	UCONN	DMHAS
FY 01	42/19	17/16	32/*
FY 02	186/13	26/19	22/108.5
FY 03	140/25	19/15	16/414
FY 04 (TO DATE)	129/21	12/7.6	24/155

*Not tracked

The Successful Components of Interagency Collaboration

Average Length of Stay After Stabilization

	Private Hospital	UCONN	DMHAS
FY 04	.48 days	0	25.75

The Woodbridge Project

The Plan

- **Designed to serve as a step-down unit between inpatient hospitalization and community living.**
- **Design based upon the STAR Model in Massachusetts.**
- **Primary consumer group: people from home or non-funded settings, Long-Term Care (LTC).**
- **Designed to serve six individuals.**
- **Anticipated stay: 30 – 60 days.**



The Woodbridge Project



The Plan *continued*

- **Short-term residential support, assessment, cross systems crisis and community transition planning. Statewide access.**
- **Continued regional responsibility for case management, community transition planning and family support.**



Goals to return people to their family setting or develop a community alternative.

The Woodbridge Project

How It Has Really Worked

- Opened in October 2002.
- October 2002 – February 2004: served 22 individuals; three individuals returned.
- People from home: 10.
- People from either settings: 12.
- Family visits: 11.2 per month.

Average Length of Stay 84.5 days

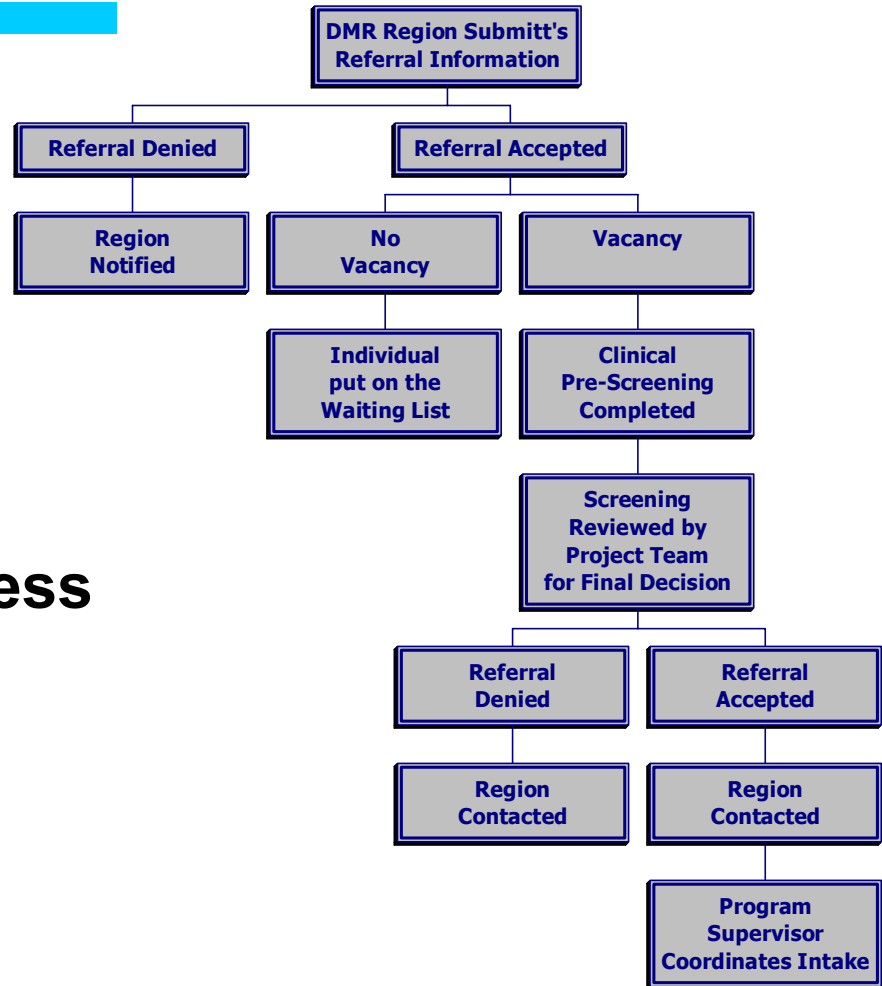
Range of Stay 22 – 151 days

Median Stay 88 days

Serving People with Co-Occurring Conditions Through Interagency Collaboration

The Woodbridge Project

Operations Referral Process



The Woodbridge Project

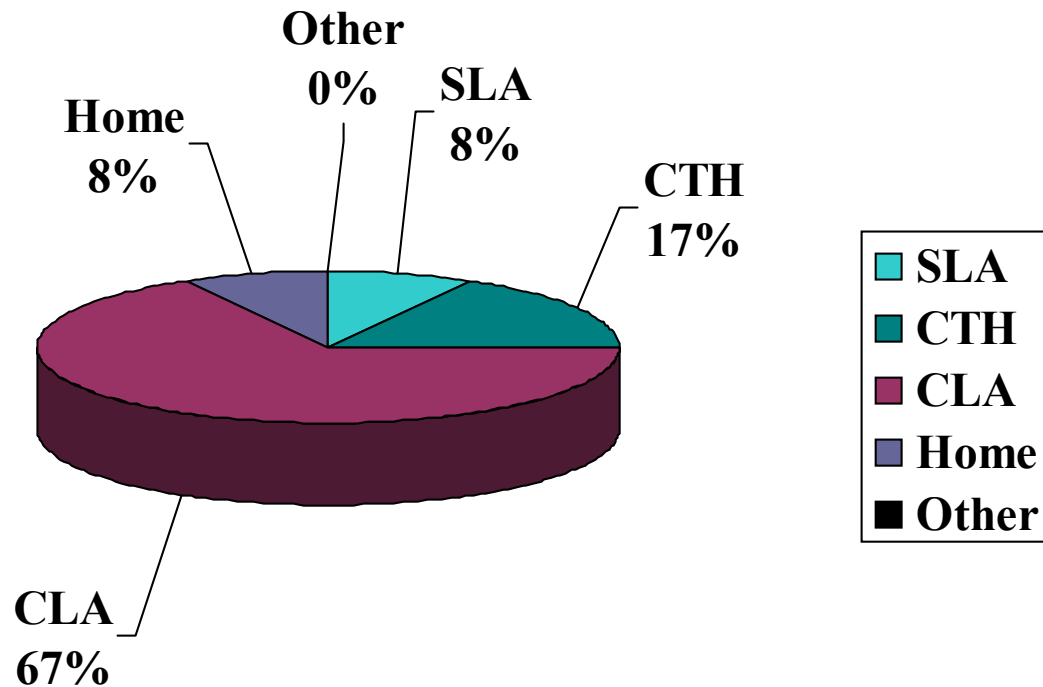
Operation Focus Areas

- Staffing
- Training
- Leadership
- Culture



The Woodbridge Project

Total Discharge Placements By Type



Lessons We Are Learning



- **The goal of everyone from home returning has not been a reality.**
- **The need for planning intensive supports to assist the person at home is critical.**
- **Case managers, family members and existing providers must stay involved from the person's admission.**
- **There is a need for out-of-home interim support for people with co-occurring conditions to prevent hospitalization.**
- **Transition planning needs to involve local mental health resources.**