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Submitted to The Substance
Abuse and Mental Health
Administration
Center for Mental Health
Services

September 2006

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Families, and Private & State Agency
Partners
on behalf of
the Honorable
M. Jodi Rell, Governor

Grant #SM57456
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Mental Health Transformation State Incentive Grant

A Comprehensive Mental Health Plan for the State of Connecticut



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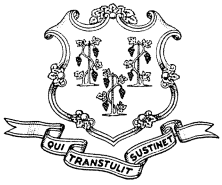
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Acknowledgements

This document is the culmination of contributions of time and expertise of many of Connecticut's mental health community. Special thanks to members of the Mental Health Transformation State Incentive Grant (MHT SIG) work groups who volunteered to participate in the process of creating and pursuing a vision of mental health transformation for our state and to the work group conveners who continue to hold up that vision as a guidepost for change. Without the dedicated and passionate participation of these groups this document could not exist.

Appreciation is also due to members of the MHT SIG Oversight Committee who continue to provide input and direction to ensure that transformation is more than a vision. The steadfast commitment of this group representing individuals in recovery, advocacy groups and 31 state and private agencies provides the accountability that change not only will occur, but will be meaningful.

The efforts exhibited by all involved in the MHT SIG over the past year are indicative of the shared perception that now is the time. Now is the time to partner with individuals in recovery and families, members of the mental health workforce, state and private agency administrators, government and citizens. Together we can create communities in which all people can live, work, learn and participate fully.




M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT
EXECUTIVE CHAMBERS

One year ago, on behalf of Connecticut, I accepted a grant award of \$13.7 million dollars from the Administrator of the federal Substance Abuse and Mental Health Services Administration, Mr. Charles Curie for what has become known as the Mental Health Transformation State Incentive Grant (MHT SIG). Connecticut was one of seven states in the nation to receive this award to assist with the transformation of the Mental Health system in the state.

Fourteen key state agencies and the Judicial Branch entered into a Memorandum of Agreement to transform mental health services to a recovery-oriented system of mental health care that will offer the State's citizens meaningful choices from among an array of effective services and supports responsive to diverse cultural backgrounds and across the lifespan. These services and supports will build on personal, family, and community assets, and will be offered in an integrated and coordinated fashion within the context of locally-based systems of care, thereby ensuring continuity of care both over time and across agency boundaries.

The Comprehensive Mental Health Plan that follows documents the efforts of many in the first year of this initiative. These efforts will serve as initial steps leading the state closer to what was envisioned by the President's New Freedom Commission, the "enhanced mental and physical health and well being of the state's citizens, increased productivity of the workforce", and "a life in the community for everyone."


M. Jodi Rell
Governor

Executive Summary

In July of 2003, a Presidential commission released a report describing how mental health services are delivered across the nation. The first such report in a quarter century, it depicted a national mental health system that is falling far short in its task of serving adults and children with mental health needs.

The report of the New Freedom Commission on Mental Health described a mental health system that is fragmented, uneven in quality and focused on managing or stabilizing people's symptoms rather than on promoting recovery and resilience. It called for fundamental changes to the nation's approach to mental health care.

The New Freedom Commission report outlined six goals, which, if attained, would transform the way Americans view and receive mental health care. In a transformed system, according to the commission's vision, there will be fewer gaps in mental health services, a better and more coordinated system of care and no stigma associated with mental health disorders. Most important, a transformed system will center around and build on the personal strengths of every man, woman and child who seeks its services, and hold out recovery and resilience as treatment expectations.

In a transformed mental health system, the New Freedom Commission states:

- Americans understand that mental health is essential to overall health;
- mental health care is consumer and family driven;
- disparities in mental health services are eliminated;
- early mental health screening assessment and referral to services are common practice;
- excellent mental health care is delivered and research is accelerated; and
- technology is used to access mental health care and information.

In October of 2005, the federal government awarded Connecticut and six other states a Mental Health Transformation State Incentive Grant (MHT SIG) to continue reform efforts. The five-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) is to be used to make fundamental structural changes to the system of delivering services to people with mental health concerns.

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

As a group, we began our work by thoroughly examining Connecticut's resources and needs in the area of mental health. We reviewed more than 150 reports; conducted several surveys including a telephone survey of 557 state residents; and created a matrix to review the information in a comprehensive, cross-agency way. We formed six work groups and

asked each one to explore the issues around one of the New Freedom Commission's mental health transformation goals. We agreed that workforce development and training also are critical to transforming Connecticut's mental health system and we formed a seventh work group to study that topic.

We prioritized the work groups' 48 recommendations according to their feasibility and impact. Eight recommendations form the core of the state's first Comprehensive Mental Health Plan. Six recommendations correlate with the New Freedom Commission's goals for systemic transformation, the seventh addresses workforce issues and an eighth will be added to address the rights of people with mental illness.

The elements of Connecticut's first Comprehensive Mental Health Plan include the following recommendations to:

- *Expand upon the suicide prevention guidelines issued by the Department of Education in 2004 by encouraging local school districts to disseminate and adopt suicide prevention and anti-stigma modules as part of comprehensive school health curricula.*
- *Develop, implement and provide incentives to programs to adopt a recovery-oriented performance measures system, including a universal satisfaction survey (for children and adults), that is informed by individuals in recovery and family members and that provides feedback to individuals in recovery/families and programs on programs' performance and outcomes.*
- *Develop an integrated information system across agencies and the Judicial Branch and their providers and payers that establishes a uniform data collection system and uses common variables and data definitions to facilitate identification, monitoring and elimination of behavioral health disparities.*
- *Increase timely access to services by maximizing Medicaid funding, identifying and addressing regulatory changes and waivers necessary to overcome policy barriers, leveraging federal matching reimbursement dollars, coordinating and aligning funding streams and developing a reimbursement mechanism for prevention, screening, assessment, consultation and treatment.*
- *Prevent or minimize further criminal justice involvement by creating systemic and policy changes to identify and divert children and youth involved in the juvenile and criminal justice systems into evidence-based prevention and intervention programs.*
- *Develop a consumer-, family- and provider-friendly resource information system, including a web site that increases access to and information about a range of recovery-oriented services and appropriate behavioral, physical health and social service resources.*
- *Train the mental health workforce and other health and human services personnel.*
- *Protect and enhance the rights of people with mental health disorders. With guidance from Connecticut's Mental Health Transformation Oversight Committee, we will reconvene a work group to identify and more fully develop a plan to address how Connecticut will continue to protect and enhance the rights of people with mental illness.*

We further refined these to read:

- Prevent suicide and increase mental health awareness through health education in schools.
- Give individuals and families a voice regarding mental health services through a universal feedback tool.
- Identify and eliminate mental health disparities through standardized data collection.
- Expand access to prevention, screening, early intervention and treatment by maximizing state and federal dollars.
- Prevent youth from becoming involved in or having repeated involvement in the juvenile justice system through the use of evidence-based practices.
- Provide Connecticut citizens with a first of its kind comprehensive mental health website to improve access to mental health information and resources.
- Expand and enhance mental health training throughout Connecticut's workforce.
- Protect and enhance the rights of persons with mental illness.

The Comprehensive Mental Health Plan will propel Connecticut more quickly along the road to a transformed system that offers integrated services and supports that are recovery and resilience oriented, culturally responsive and evidence based. The plan addresses the full range of mental health promotion, prevention, early intervention, treatment and recovery services for all of our citizens.

The recommendations set forth in the plan have the potential to fundamentally change the way Connecticut citizens view mental health to understand that good mental health is part of overall physical health, and as such is good business and should be everybody's concern.

The recommendations also will fundamentally change how mental health services and supports are delivered in Connecticut. That's because the plan addresses issues whose very complexity until now has hindered reform. Through the MHT SIG, we have the resources and opportunity to tackle these challenges anew. We propose to realign funding streams, revise data-collection methods across departments and agencies and design new performance measurement tools. We also propose to coordinate prevention and intervention programs and make a deeper commitment to the quality of our workforce.

Through these and other initiatives, Connecticut will begin to achieve the overarching goal: a coordinated system of care guided by the principles of recovery and resilience and driven by the people who receive services and their families so that they can live, work, learn and participate fully in their communities.

The Comprehensive Mental Health Plan is a work in progress. In the second and subsequent years of the grant, efforts will focus on translating the vision into action. Along the way, we may revise some of the goals. We also will prioritize the work groups' remaining goals and continue to incorporate many of them into the plan. We look forward to updating regularly the comprehensive blueprint for an improved system of care for all citizens of Connecticut who have been touched in some way by the risk or realities of mental health issues.

INTRODUCTION

In July of 2003, the New Freedom Commission on Mental Health released a report to the President describing the condition of the mental health care delivery system across the nation. The groundbreaking report has served as a catalyst to transform the mental health system from one dictated by outmoded bureaucratic and financial incentives to one driven by the needs of individuals in recovery and their family and grounded in promoting recovery and resilience.

Through its many recommendations, the report paints a picture of what the nation's mental health system should look like. In a transformed mental health system, according to the New Freedom Commission's vision, discrimination against people with mental health concerns has ended. Americans feel no shame or discomfort in seeking care for their mental health needs. Gaps in services no longer exist, and services and supports are delivered through coordinated systems of care that offer people choices. Services keep pace with a person as he or she progresses through life. Care is delivered in ways that respond to the needs of the person seeking it, and it is grounded in practices that have been proven to be the most effective.

Most importantly, a transformed mental health system centers around and builds on the personal strengths of every man, woman and child who seeks its services. It asks everyone – including individuals in recovery of services, their family members and mental health professionals and personnel – to believe that recovery from and resilience around mental health disorders are not only possible but also expected.

What do recovery and resilience look like?

Recovery is a “process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite or within the limitations imposed by that condition” (Commissioner's Policy Statement # 83, DMHAS, September 2002). Promoting resilience in children and families involves building capacities to cope with stress, trauma and the potentially disabling impact of serious emotional disturbance.

The New Freedom Commission report offers a more detailed discussion of recovery, stating that it is the process by which people are able to live, work, learn and participate fully in their communities. For some people, recovery is the ability to live a productive, fulfilling life despite a disability. For others, it is the reduction or remission of symptoms. For many people, recovery is mainly about discovering who one can become. Building resilience, the analogous concept that some agencies and professionals use for children and young people, involves strengthening the factors that allow a person to overcome adversity (Transforming Mental Health Care in America, The Federal Action Agenda: First Steps, U.S. Department of Health and Human Services, July 2005).

To turn the components of this imagined world into a reality, the New Freedom Commission listed six goals, which, if put into practice as envisioned, would change the

very form and function of the nation's mental health system. The six New Freedom Commission goals are:

Goal #1

Americans Understand that Mental Health Is Essential to Overall Health.

Goal #2

Mental Health Care Is Consumer and Family Driven.

Goal #3

Disparities in Mental Health Services Are Eliminated.

Goal #4

Early Mental Health Screening Assessment and Referral to Services Are Common Practice.

Goal #5

Excellent Mental Health Care Is Delivered and Research Is Accelerated.

Goal #6

Technology Is Used to Access Mental Health Care and Information.

Mental Health Transformation State Incentive Grant

To jump-start the fundamental overhaul in the way Americans view, deliver and receive mental health care, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in 2005 awarded grants to seven states, including Connecticut. SAMHSA requires that the grant money be used to assess the state's mental health programs, activities and funding streams, and to change this "infrastructure" in ways that are consistent with the New Freedom Commission's vision.

The grant, called the Mental Health Transformation State Incentive Grant (MHT SIG), enables Connecticut to continue moving toward a recovery- and resilience-oriented system for its citizens. With guidance from Governor Jodi Rell, 14 state agencies and the Judicial Branch are working as never before to achieve this seismic shift in attitudes and practices around mental health care in the state.

A Collective Effort

Connecticut's transformation project is not an effort only of state government. The people who use mental health services, their families and service providers, along with advocates, payers and a host of other groups and individuals, have come together around the task. These stakeholders through their representatives have shattered barriers and moved beyond differences, including differences in the use of language, as expressed in acronyms, jargon and definitions. It is only fitting that the language of this document reflect the spirit in which it has been created, with every person, family, group and agency having a vital and equal say.

We therefore present this report, Connecticut's first Comprehensive Mental Health Plan, in a collective voice. The plan will guide the state as it creates a more coordinated system of mental health care that is based on the expectation that every citizen who has been touched by the risk or realities of mental illness can cope successfully with life's challenges, given the appropriate supports and services.

THE PAST

Before we address the present challenges, it is helpful to understand how Connecticut's public and private mental health systems have evolved. During the early 1950s, the state provided funded psychiatric inpatient services at three state hospitals: Norwich State Hospital, Fairfield Hills Hospital and Connecticut Valley Hospital. Combined, the three institutions had more than 9,000 beds. Private facilities offered additional inpatient beds. Care provided in these settings was largely custodial and focused on stabilizing illnesses and managing symptoms.

Public Mental Health

With the U.S. Food and Drug Administration's (FDA's) approval in the 1950s of the antipsychotic drug, chlorpromazine, followed by FDA approval of subsequent medications designed to treat the symptoms of mental illness, the standards of psychiatric care and treatment began to change. During the 1960s and 1970s, federal court rulings acknowledged the rights of people with mental health disorders to seek treatment and to receive treatment in the least restrictive setting. These developments, along with new or changing Medicaid policies, resulted in the sweeping transition of people from hospitals and other institutions to community-based settings for care. Psychiatric rehabilitation services in the community, including case management and vocational services, grew during the 1980s. Connecticut formed Local Mental Health Authorities (LMHAs) to serve the mental health needs of people within defined geographic regions. With services increasingly being provided through LMHAs, the need for hospital beds declined, and 1995 and 1996 saw the closure of Fairfield Hills Hospital and Norwich State Hospital, respectively.

Services for children also began to embody many of the core values of the recovery movement. The implementation starting in the late 1990s of Connecticut Community KidCare, a system-of-care model designed to support children with serious emotional disturbances and their families in the community, represents but one initiative the state has undertaken to transform children's mental health services.

Private Mental Health

Meanwhile, dramatic changes also were occurring in private-sector mental health. Managed care ushered in new rules and financial incentives that profoundly affected how people accessed mental health care, how mental health providers were paid for their services and which mental health benefits health insurance plans covered.

Another important change occurred in 1999, when Connecticut passed a law requiring private health insurance plans to cover mental health disorders in the same manner as other physical disorders or diseases. Until the passage of the mental health parity law, many plans were more restrictive in their coverage of mental illnesses (P.A. 99-284, Special Session; Sections 27-28). Mental health advocates hailed the new law as a major step forward. At the same time, they noted that the law fell short of providing full parity for mental health conditions because it granted exceptions to some employers based on how they paid for their employees' health care coverage.

Other disparities in the delivery of mental and physical health care continued. Within private health plans, management mechanisms such as requiring patients to get insurance-company approval for services or medications before receiving them are perceived to be more stringent when applied to mental illnesses than to physical illnesses. Finally, health insurers sometimes reimburse mental health providers for their services at rates that are proportionately lower than reimbursement rates for physical health services (Connecticut Mental Health Cabinet Report, Lieutenant Governor's Mental Health Cabinet, 2005).

Connecticut Responds

To explore concerns about the provision of mental health services in the state, the Connecticut governor appointed a Blue Ribbon Commission on Mental Health in 2000. Representatives of public and private service providers came together for the first time with people who used those services, their family members and other stakeholders to examine the mental health system. The commission's report that year acknowledged that progress had been made in the shift toward community-based services. The report also highlighted an array of needs, including the need for greater access to children's mental health services and for expanded peer-support and other non-traditional services for adults that could be made available through Medicaid, the federal-state health insurance program for low income people and people with disabilities.

Recovery and Resilience

Two years after the Blue Ribbon Commission's work, a single word representing an important concept - recovery - formally made its way into Connecticut policies. In September of 2002, the DMHAS commissioner issued Policy Statement #83, promoting a service system oriented toward recovery. "The concept of recovery shall be the guiding principle and operational framework for the system of care provided by the partnership of state and private agencies and services operated by individuals in recovery that comprise the Department's healthcare system," the policy states. "Services within this system shall identify and build upon each recovering individual's strengths and areas of health in addressing his or her *needs*."

DMHAS is the state agency responsible for administering mental health treatment services and substance abuse prevention and treatment services in Connecticut. The substance abuse prevention services serve citizens of all ages. For treatment services in both mental health

and addictions, the department focuses on serving people over 18 years of age who lack the financial means to pay for such care. DMHAS operates according to the belief that most people with mental illnesses and substance use disorders should receive services in community settings, and that *inpatient treatment should be used only when absolutely necessary to meet a person's best interests*.

With DMHAS, two other state agencies provide and pay for most of the public mental health services available to citizens. Children and adolescents under age 18 receive care through the Department of Children and Families (DCF). DCF offers young people and their families services in child protection, behavioral health and juvenile justice and prevention. The Department of Social Services (DSS) serves elderly people, people with disabilities and families and individuals who need help maintaining or achieving their full potential for self-direction, self-reliance and independent living. DSS also administers the Medicaid program in Connecticut.

DMHAS, DCF and DSS are guided by principles that embrace the importance of community life for people with mental health issues. The consistency of charge and mission among the three agencies serves as a critical platform for mental health transformation in Connecticut.

Multi-agency Effort

But three state agencies working together, while undoubtedly a good thing, is not what SAMHSA had in mind when it awarded Connecticut the MHT SIG. Recognizing that mental health cuts across all facets of life, SAMHSA required that the transformation effort comprise, first and foremost, individuals in recovery of mental health services and their families. The federal agency also required that the effort include the participation of representatives of the dozens of agencies, entities and groups that have contact with people with mental health concerns and their families.

Connecticut was well positioned to apply for the grant. Governor Rell, whose office was awarded the MHT SIG, has demonstrated a strong commitment to improving the quality and effectiveness of Connecticut's mental health services by working across state agencies and the Judicial Branch. Her actions have included:

- instructing the Department of Correction (DOC) to establish a mental health-specific correctional facility to meet the needs of offenders with mental health disorders;
- enhancing educational opportunities for all schoolchildren, with a special focus on early childhood education;
- appointing a DMHAS representative to the state Jail/Prison Overcrowding Commission and Alternatives to Incarceration Committee to ensure that the behavioral health needs of offenders are addressed;
- establishing a Mental Health Cabinet in 2004 to recommend actions to improve the availability and effectiveness of mental health care; and
- supporting innovative strategies for improving Connecticut's mental health system through funding the Community Mental Health Strategy Board, KidCare and other

initiatives designed to support in the community people with psychiatric disabilities and their families.

Each state entity that has pledged to the Governor’s Office and to SAMHSA its commitment to the transformation effort has a unique role and specific responsibilities to contribute. The entities, which are listed in Table 1, have embraced this unprecedented opportunity to remake a mental health system that is directed by individuals in recovery, coordinated and effective, and which helps Connecticut citizens with mental health concerns and their families to live more meaningful, productive and hope-filled lives.

Table 1: The 15 state entities working to transform Connecticut’s mental health system

<u>Key State Agency Cabinet Members</u>	<u>Key Roles/Responsibilities</u>
Dept. of Mental Health/Addiction Services (DMHAS)	State Mental Health Authority & Single State Agency. Adult public, behavioral health system of care.
Dept. of Children/Families (DCF)	Behavioral health services for children/youth. Child protective services.
Dept. of Correction (DOC)	Safe, secure and humane supervision of offenders. Supportive community reintegration.
State Dept. of Education (SDE)	Primary education.
Dept. of Higher Education (DHE)	Higher education.
Dept. of Social Services (DSS)	Services to elderly, people w/disabilities, families & individuals. Public housing.
Dept. of Public Health (DPH)	Public health policy/advocacy. Comprehensive network of health services.
Office of Policy and Management (OPM)	CT’s budget agency. Provides info/analysis to the Governor. Assists state agencies in implementing policy decisions.
Dept. of Mental Retardation (DMR)	Services to individuals (across lifespan) w/mental retardation.
Judicial Branch Court Support Services Division (CSSD)	Intake, assessment & supervision services for court-involved youth and adults.
Dept. of Information Technology (DOIT)	Improves government operations by leading state agencies in the effective use of technology.
CT Insurance Department (CID)	Administers/enforces insurance laws set forth in CT General Statutes. Licenses insurers, healthcare centers & provider networks.
Dept. of Labor (DOL)	Protects/promotes interests of CT workers.

Dept. of Veteran Affairs (DVA)	Provides comprehensive health, social and rehabilitative services to veterans.
Commission on Aging (CoA)	Advocates on behalf of elderly people. Monitors impact of current & proposed initiatives.

THE PRESENT

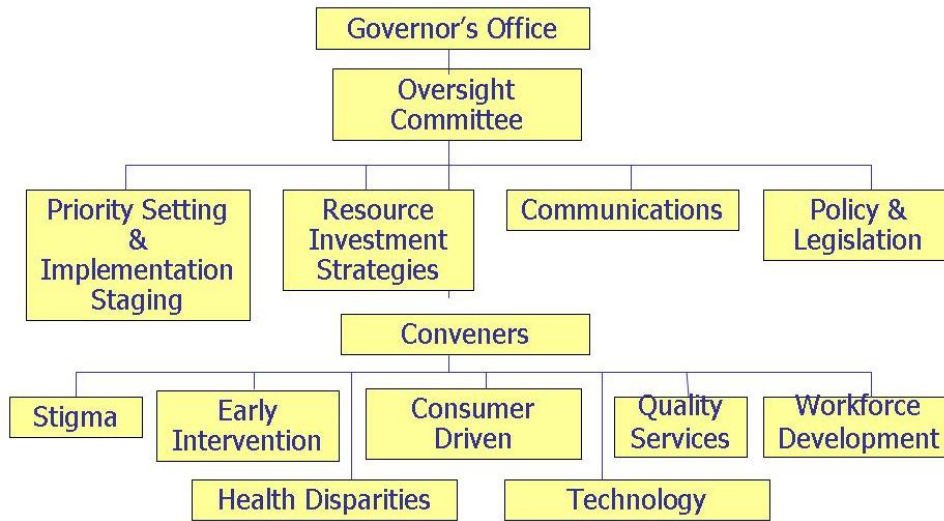
The MHT SIG provides funds over five years to improve and enhance the form and function, or infrastructure, of Connecticut’s mental health services delivery system. The grant requires us in the first year to thoroughly review existing mental health programs, activities and resources across the 14 state agencies and the Judicial Branch, and determine what and where the unmet needs are. This information has guided the development of our Comprehensive Mental Health Plan.

Committee Structure

As we began the work of transformation, we formed several committees that brought together individuals in recovery, families, advocates, the academic sector, private non-profit providers and community hospitals, among others. The state agencies responsible for providing mental health care, as well as state entities with some regular connection to mental health services, also participated. The structure is shown in Table 2.

Table 2: Transformation committees and work groups

Committee Structure



An Oversight Committee comprising individuals in recovery, family organizations, leaders from state agencies and the Judicial Branch, advocacy groups, hospital and private non-profit organizations is guiding our transformation process. Four subcommittees are responsible for handling different areas of interest: priority setting and implementation; resource investment strategies; communications; and policy and legislation.

About 150 stakeholders participated in seven work groups. Six of the work groups are consistent with and named for each of the six New Freedom Commission goals. A seventh work group, the Workforce Transformation Work Group, focuses on planning in connection with the professionals and personnel who make up Connecticut’s mental health workforce. In its application for the MHT SIG, Connecticut recognized that systemic transformation can be achieved only if the workforce understands and supports the mission. The Workforce Transformation Work Group sought to assess the knowledge and training of the current workforce; the capacity and needs of the workforce for transformation to a fully recovery-oriented system of care; and perceptions of staffing needs by multiple stakeholders.

We asked the work groups to develop recommendations in their topic area that would move Connecticut closer to realizing the New Freedom Commission’s vision. Each work group included representatives of the diverse stakeholder community.

State agency employees convened each work group. The conveners met regularly to ensure that the process remained clear and consistent and to avoid duplicating areas of focus. Conveners managed their group’s work, which included writing a final report to the Oversight Committee with recommendations on how to transform the mental health system.

Language

Different stakeholders use different terms to express important mental health concepts. One helpful tool to bridge differences of language was a chart or “crosswalk” from the article, “The Concept of Recovery: “Value Added” For the Children’s Mental Health Field?” (Friesen, 2005) The crosswalk helped to bridge the language of recovery used for adult services and the language of resilience and system-of-care (SOC) terminology used for children’s services. The crosswalk bridges the three models by identifying correlations and areas of overlap among the concepts and principles. It also identifies the unique contributions of each model. Table 3 presents and attempts to correlate the differences in language used by the resilience, system-of-care and recovery models.

Table 3: The crosswalk: a bridge to understanding differences in language

Resilience Core Concepts	SOC Principles	Recovery Elements
	1. Comprehensiveness	Holistic
Specification of elements: Reducing risk Enhancing protective factors	2. Individualized services	Individual- and person-centered Strength-based
	3. Community-based	(Assumed)
Racial Socialization Healing historical trauma	4. Culturally and linguistically competent	Healing historical trauma
Solid basic and applied research base for prevention and early	5. Early intervention	

intervention		
	6. Family and youth participation Family-driven Youth-guided, -directed	Empowerment Self direction
	7. Service coordination	
	8. Interagency coordination	
	9. Protection of rights	Respect, stigma reduction
	10. Support for transition	Life planning
Future orientation Optimism		Hope, optimism

Needs Assessment and Resource Inventory

The Resource Inventory

Our first task was to create an inventory of Connecticut's existing mental health resources. We received technical assistance and other help from SAMHSA's MHT SIG staff and from the National Research Institute (NRI) of the National Association of State Mental Health Program Directors. The NRI consultant customized for Connecticut a Protocol for Compiling Need and State Agency Inventory Data. MHT SIG staff modified the protocol to help us collect information that was as detailed as possible.

Fiscal representatives from the 14 state agencies and the Judicial Branch were responsible for collecting the information that was then aggregated to make up the resource inventory. The group's charge was to:

- compile all mental health and substance abuse expenditures, unduplicated client counts, revenue and policies, from State Fiscal Year (SFY) 2005;
- ensure that compiled data reflected services that are controlled by the state agency, or for which the agency has oversight or reporting requirements;
- ensure that compiled data represented all services regardless of revenue source (Medicaid, Medicare, general revenue, etc.);
- footnote data that might be duplicated, meaning that other agencies might also report the information; and
- provide the most specific data available for the following: provider name, type of provider, target population, target age and service category.

To compile the resource inventory in a consistent format and to identify and eliminate duplicated information, MHT SIG staff worked with Yale University's Program for Recovery and Community Health (PRCH).

The resulting resource inventory may be the most comprehensive yet in Connecticut to list the state's total mental health resources and how they are allocated across 15 state entities.

The Needs Assessment

Meanwhile, we also were determining what mental health services, activities and programs are lacking for Connecticut's citizens. To complete the needs assessment we undertook the following range of collection and analytical activities.

Connecticut Citizens Survey

This telephone survey collected basic epidemiological data and information about how people from a random sample of Connecticut households seek help for mental health concerns. The PRCH evaluation team at Yale University developed a survey instrument that assessed demographic data; prevalence of mental health-related symptoms for the person over the age of 18 who answered the phone; prevalence of mental health-related symptoms of additional household members; information about the degree to which the symptoms affected the life of the respondent or household member; any efforts to seek help, including from whom and the degree of satisfaction with the help; barriers to receiving help; and recommendations for mental health system transformation. The University of Connecticut's Survey Center administered the survey. No identifying information was collected from respondents. The institutional review boards of Yale University, the University of Connecticut and DMHAS approved the procedures and survey.

The final survey of 557 citizens includes a sample of the general population and an over-sample of rural and urban minority residents. The questions explored symptoms based broadly on the criteria for major mental disorders delineated in the American Psychiatric Association's *Diagnostic and Statistical Manual-IV* (DSM-IV), and were not intended to establish a diagnosis. Respondents were asked to consider only the past year when answering the questions.

Probabilistic Population Estimation

The Probabilistic Population Estimation (PPE) is a statistical procedure that estimates the number of people who are represented in data sets (without the use of unique personal identifiers) to identify overlap among populations. We collected data sets from the following sources: DMHAS, DOC, State Administered General Assistance (SAGA), Temporary Assistance to Needy Families (TANF) and the Department of Mental Retardation (DMR). Bristol Observatories performed the PPE procedures. The PRCH evaluation team provided further analysis.

Department of Mental Health and Addiction Services: Agency Recovery Self-Assessment

The DMHAS Agency Recovery Self-Assessment is a 64-item inventory that assesses

how well a behavioral health service provider meets some of the criteria that are important to a recovery-oriented system. The assessment tool attempts to gauge the degree to which a mental health or addiction service agency incorporates a variety of recovery principles in its practices. We distributed this inventory to the directors of DMHAS-funded service agencies, and received 114 completed surveys.

Elements of a Recovery Facilitating System

Yale University has developed a tool that helps differentiate a recovery-oriented mental health system from a traditional system of care or one that does not emphasize recovery and resilience. The tool relies on a core set of 16 principles called Elements of a Recovery Facilitating System (ERFS). ERFS evaluations are potentially useful in measuring the progress of local systems as they shift their orientation toward recovery in line with transformation goals and public policies.

The tool asks individuals in recovery to rate their local system of care on the extent to which the core principles are present and practiced. Individuals in recovery also rate their own met and unmet needs. Yale is refining the tool and a more elaborate system-of-care assessment will be designed and used during subsequent years of the MHT SIG. During the second year of the MHT SIG, we will schedule daylong events to educate stakeholders, celebrate recovery in people's lives and gather further data to promote transformation to a recovery-oriented system of care. There are plans to adapt the tool for use with children and families.

Department of Children and Families: Mental Health Transformation Survey

The DCF Mental Health Transformation Survey is a self-reported questionnaire that solicited input from parents and providers throughout Connecticut on the ways in which the form and function of the state's mental health system could be improved. Respondents were asked to rate the priority of each of the New Freedom Commission goals using a Likert scale of 1 to 6 (1 = highest priority and 6 = lowest priority). Respondents also were asked to answer questions related to each goal.

The survey asked the following questions about the New Freedom Commission goals:

- Goal 1: What recommendations do you suggest occur to better integrate mental health and physical health care and reduce stigma?
- Goal 2: How can Connecticut's mental health system better ensure that it is family driven?
- Goal 3: What infrastructure ideas do you have to make the mental health system more culturally competent and to eliminate disparities?
- Goal 4: What suggestions do you have to support early mental health screenings, assessment and interventions?
- Goal 5: How can the quality of mental health care in Connecticut be improved?
- Goal 6: Please prioritize the following three ways to use technology to support the Mental Health System transformation (1 = highest priority, 3 = lowest):

- Automated information and tools to help a provider make the best decision about a child's care. This might include such things as aids to diagnosis and aids to prescribing medications.
- Automated tools to help providers, state agencies and others know about the various services a child has already received in order to plan a child's care.
- Automated information and tools that parents can use to learn about a child's mental health issues and available resources. This might include resource information about topics of interest and other things a resource center or library might provide.

Workforce Focus Groups and Planning Meetings

To address the knowledge and preparedness of the mental health workforce around a recovery-oriented system of care, Connecticut created a Workforce Transformation Work Group as one of the seven work groups investigating an aspect of transformation. Research and state agency reports have informed the Workforce Transformation Work Group's efforts. The work group also held more than 40 focus groups and conducted individual interviews with diverse stakeholders around the state about the status of the mental health workforce, including its needs and the existing resources to help meet those needs.

The work group also convened planning meetings on specialized topics. The work group convener and MHT SIG staff met with representatives of the state's public and private colleges and universities to discuss the interface between public behavioral health and higher education. They also met with a representative of the state Department of Information Technology (DOIT) to discuss its efforts to acquire an electronic platform for distance learning that would be available to all state agencies.

To ensure that the special workforce needs of children, youth and families were addressed, the work group scheduled a daylong retreat attended by DCF representatives, mental health providers, educators and primary health care providers. Parents accounted for one quarter of the participants and helped to lead some of the sessions. Larke Huang, Ph.D., the newly appointed senior advisor on children to the SAMSHA administrator, gave a keynote presentation.

State and Stakeholder Reports

Various state entities and other stakeholders submitted more than 165 reports containing a wide range of qualitative and quantitative information that included existing mental health assets and needs, barriers to care and recommendations for addressing mental health care needs across the life span. We categorized this information into 34 topic areas that coincided with the sub-goals and priorities outlined in the New Freedom Commission report.

Organizing the Information

The next step was to organize our information in a way that would advance the transformation effort. Two documents provided overarching organizational structure: the New Freedom Commission goals and a template adapted from the Ohio Department of Mental Health Needs Assessment and Inventory of Resources.

First, we created a table in which we listed the six New Freedom Commission goals. Next to each numbered goal we listed associated themes, which we took from the New Freedom Commission report, as shown in Table 4.

Table 4: New Freedom Commission goals defined

New Freedom Commission Goal	Major Themes Represented in Goal
1. Mental Health is Essential to Overall Health	Financing; fragmentation of services; coordination between mental health and physical health; mental illnesses being left untreated; suicide; and stigma
2. Mental Health Care is Consumer and Family Driven	Federal financing; complexity of service system; overlapping program efforts; mental health services in correctional institutions; state-level fragmentation; restraints and seclusion; involvement of individuals in recovery and family members with individualized plans for care, evaluation and services; unnecessary institutionalization; employment; income supports; affordable housing; and community-based care
3. Disparities in Mental Health Services are Eliminated	Cultural issues affecting service providers; rural America needs; minority populations as underserved and facing barriers to receiving appropriate care
4. Early Mental Health Screening, Assessment, and Referral to Services are Common Practices	Schools; primary care settings; early assessment and treatment across the life span; co-occurring disorders
5. Excellent Mental Health Care is Delivered and Research is Accelerated	Reimbursement policies which do not foster converting research to practice; workforce problems; too few people benefit from available treatment; delay in research to practice; not enough research on long-term use of medications, trauma, disparities or acute care
6. Technology is Used to Access Mental Health Care and Information	Technology; access to reliable health information; using technology to improve access to care for rural and other underserved areas; enhanced medical records

Next, we overlaid on the grid of the New Freedom Commission goals a template that we adapted from the Ohio Department of Mental Health. The template allowed us to further assign our information to one of 10 categories important to the development of mental health public policy. These categories appear as alphabetized letters in our matrix. Table 5 contains the list of the 10 matrix categories and their descriptions.

Table 5: Definitions of matrix categories

Category	Description
a. Policies	Information about federal, state and community laws, codes, agreements, protocols, policies, procedures and memoranda of understanding
b. Practices/Services	Information about activities, programs, actions, interventions and strategies
c. Workforce/Training	Information about 1) individuals and groups who work with or impact people who are mentally ill and/or 2) education, training and skills development that will enhance care
d. Organization/Collaboration	Information about people, organizations or systems working together to address common goals and objectives
e. Data	Information from reliable sources that is organized and useful—includes references to studies, quality assurance and process and outcome indicators
f. Financing	Pertains to the allocation of resources to support system efforts and initiatives

Category	Description
g. Consumer/Family Involvement	Information pertaining to the involvement of people in recovery/individuals in recovery/service users and family members in any level of service development, evaluation or provision
h. Facilities and Equipment	Pertains to the physical location or structure required for implementing a particular type of service or care
i. Other	Other (not related to funding)
j. Other Funding	Information about federal or local grants, contracts, allocations or other funding sources

Finally, each state agency and the Judicial Branch provided information to complete the matrix. Mental health resources or assets and mental health needs or barriers were listed according to the appropriate New Freedom Commission goal (1 – 6) and the appropriate descriptive category (a – j).

The data collection, organization and analysis described above constituted the Needs Assessment and Resource Inventory process that informs Connecticut’s Comprehensive Mental Health Plan. Due to the sheer amount and complexity of the information we obtained, we continue to examine the draft Needs Assessment and Resource Inventory Report for accuracy and reliability and to ensure that it uses reasonable assumptions.

Developing and Prioritizing Recommendations

We asked the seven transformation work groups to develop recommendations that could be turned into action. The recommendations had to be consistent with the six New Freedom Commission goals and Connecticut’s workforce transformation goal. The work groups’ final reports contained well over 60 recommendations. We consolidated those that had common themes and areas of interest into 48 summary recommendations. Table 6 lists the work groups’ summary recommendations and then groups them by the appropriate descriptive category (a-j).

Table 6: Mental health transformation work group summary recommendations

A: Policies*: Federal, state and community laws, codes agreement, protocols, policies, procedures, memoranda of understanding.
A. 1. Engage and involve individuals in recovery/families in all aspects of planning (e.g., strategic, program, etc.), delivering and evaluating State agency and provider organization services as a condition of continued funding/participation.
A. 2. Expand and strengthen existing bodies (e.g., Protection & Advocacy) or create an interagency entity to monitor and enforce compliance with all state and federal laws regarding patients’ rights.
A. 3. Improve access, accountability and the sharing of information by developing and/or coordinating policies, regulations, standards, etc.; and streamlining funding related to recovery-oriented services such as housing, employment and treatment.
A. 4. Provide timely access to appropriate services within the continuum of care as an alternative to incarceration and nursing home placement, and to ease emergency department gridlock.
A. 5. Prevent or minimize further criminal justice involvement by creating systemic and policy changes to identify and divert children and youth involved in the juvenile and criminal justice systems into evidence-based prevention and intervention programs.
B. Practices/Services: Activities, programs, actions, interventions, strategies.

<p>B. 1. Prevent unnecessary institutionalization by increasing service-supported housing resources for people with psychiatric illness leaving institutional settings and youth transitioning from youth status.</p>
<p>B. 2. Review, develop, pilot and implement mental health screening, assessment and intervention protocols and standards that are comprehensive, strength-based, culturally competent, goal and individual- centered within a vast array of service settings.</p>
<p>B. 3. Fulfill the continuum of care and enhance quality improvement initiatives by: B. 3. a. employing self-identified people in recovery and family members in the service system; B. 3. b. supporting peer employment roles that allow opportunities to accumulate experience and education needed to advance along a career path; B. 3. c. developing peer- and family-operated programs to deliver mental health services.</p>
<p>B. 4. Co-locate developmentally informed mental health professionals and resource coordinators and fund consultation-liaison arrangements to improve access to mental health prevention, screening, referral, consultation and intervention services within early care, school and primary care settings/systems.</p>
<p>C. Workforce/Training: Individuals/groups who work with or impact people who are mentally ill (e.g., policy makers, school teachers, police and probation officers, therapists) and/or education, training, skills development that will enhance care.</p>
<p>C. 1. Expand upon the suicide prevention guidelines issued by the Department of Education in 2004 by encouraging local school districts to disseminate and adopt suicide prevention and anti-stigma modules as part of comprehensive school health curricula.</p>
<p>C. 2. Develop and implement core competency curricula that address: C. 2. a. age and developmental stages; C. 2. b. culture, race and health disparities; C. 2. c. supervision in accord with a common set of standards.</p>
<p>C. 3. Develop a culturally and linguistically diverse workforce by offering: C. 3. a. loan forgiveness programs to providers in rural communities and designated Health Professional Shortage Areas; C. 3. b. leadership-development opportunities; scholarships, training stipends and other incentives.</p>
<p>C. 4. Develop curricula to implement broad-based training opportunities for the public on: C. 4. a. suicide; C. 4. b. stigma; C. 4. c. the availability of mental health services/resources and the use of technology to access information and coordinate mental health care.</p>
<p>C. 5. Create a <i>Connecticut Behavioral Health Workforce Collaborative</i> charged with planning, coordinating and implementing interventions to strengthen the workforce such as “Centers for Excellence” serving as regional resources in behavioral health practices.</p>
<p>C. 6. Create and implement a web-based training system for the specialty workforce, other health and human service personnel, people in recovery, children, youth and families.</p>
<p>C. 7. Train the mental health workforce and other health and human service personnel in : C. 7. b. mental illness and co-occurring disorders; C. 7. c. racism prevention; C. 7. d. employment; C. 7. e. housing; C. 7. f. suicide; C. 7. g. stigma.</p>
<p>D. Organization/Collaboration: People, organizations or systems working together to address common goals and objectives (e.g., task force, association, interagency, boards, councils, providers, agencies, systems of care, partnerships, advisory committees, facilitated process, structure).</p>
<p>D. 1. Convene a high-level (Governor-endorsed and -appointed) statewide mental health Anti Stigma Task Force to conduct an annual policy review and propose a set of policy recommendations that if enacted serve to reduce stigma and eliminate barriers to employment, housing and overall community integration.</p>
<p>D. 2. Increase levels of interagency coordination by leveraging community-based employment resources, identifying and disseminating best practices across all systems (DMR, DCF, DSS, DMHAS, DOL) and building transition protocols among key agencies.</p>

D. 3. Make decent, safe, affordable housing units available statewide by developing a statewide resource list and collaborating with existing advocacy efforts.
D. 4. Establish a state Office of Multicultural Affairs and allocate at least one full time equivalent in each state agency to promote quality assurance; develop, train, oversee and coordinate cultural competence initiatives across state agencies and state-funded service providers.
D. 5. Establish a model and conduct a public information campaign about the availability of a coordinated interagency collaboration that builds upon the existing system of care that is comprehensive, coordinated, flexible and driven by individuals in recovery.
D. 6. Create a state-wide center for the identification, promotion and implementation of evidence-based and “effective” practices for mental health services across the life span.
E. Data: Information from reliable sources and systems that is organized and useful, including references to studies, quality assurance and process and outcome indicators.
E. 1. Develop, implement and provide incentives to programs to adopt a recovery-oriented performance measures system, including a universal satisfaction survey (for children and adults) that is consumer- and family-informed and that provides feedback to individuals in recovery/families and programs on programs’ performance and outcomes.
E. 2. Develop an integrated information system across agencies, the Judicial Branch, their providers and payers that establishes a uniform data collection system and uses common variables and data definitions to facilitate identification, monitoring and elimination of behavioral health disparities.
E. 3. Develop a consumer-, family-, provider–friendly resource information system including a web site that increases access to and provides information on a range of recovery-oriented services and appropriate behavioral, physical health and social service resources.
E. 4. Create and implement a single portable Electronic Medical Records/Electronic Health Records including advance directives and the ability to obtain/coordinate input of individuals in recovery, their families and providers.
E. 5. Increase accountability through the measurement and tracking of employment outcomes.
F. Financing: Allocation of resources to support system efforts and initiatives.
F. 1. Design and pilot a flexible funding system in order to implement an individual driven (self-directed) service delivery system for adults with mental illnesses and children with serious emotional disturbances using lessons learned and models employed from national pilots (SAMHSA-funded) and the Department of Mental Retardation (DMR).
F. 2. Ensure the availability, accessibility and quality of behavioral health care in rural and remote geographical areas, and among populations for whom barriers impede access to care by utilizing and expanding current reimbursements for innovative technologies such as telemedicine, mobile health vans, interpreters and non-traditional services such as outreach provided by community health workers.
F. 3. Increase timely access to services by maximizing Medicaid funding, identifying and addressing regulatory changes and waivers necessary to overcome policy barriers, leveraging federal matching reimbursement dollars, coordinating and aligning funding streams and developing a reimbursement mechanism for prevention, screening, assessment, consultation and treatment.
G. Consumer/family involvement: Involvement of people in recovery/individuals in recovery/service users and family members in any level of service development.
G. 1. Establish and promote a statewide consumer advocacy movement.
G. 2. Increase the number and percentage of people in recovery and family members at all levels of the public and private behavioral health workforce.
I. Other: Other (not related to funding).
I. 1 Develop, implement and evaluate multi-faceted awareness campaigns to: I. 1. a. promote awareness of mental health rights and responsibilities; I. 1. b. increase recruitment of behavioral health workers by implementing a multi-media campaign that highlights career and job

<p>opportunities in behavioral health;</p> <p>I. 1. c. promote the positive role of employment in recovery, assist individuals in recovery in advancing in their careers and increase the visibility of employment opportunities.</p>
<p>J. All Relevant Funding: Federal or local grants, contracts, allocations or other funding sources.</p>
<p>J. 1. Charge existing suicide prevention networks and advisory boards with identifying state and federal funds currently available for suicide prevention activities, and with implementing and evaluating a statewide suicide prevention campaign based on the strategies and recommendations from the state’s Comprehensive Suicide Prevention Plan developed in 2005 by the Inter-Agency Suicide Prevention Network.</p>

*The summary recommendations of the transformation work groups have been consolidated and grouped according to categories used in the needs assessment, resource inventory and evaluation processes.

We grouped the summary recommendations according to the matrix categories previously described in Table 5. One subcommittee of the Oversight Committee, the Priority Setting and Implementation Staging Subcommittee, designed a process for rating the recommendations based on their impact and feasibility. Committee members also sought feedback from stakeholders about the recommendations; the comments and suggestions inform the completed Impact and Feasibility Rating Form. (See Appendix 1.) The Oversight Committee used the forms to rank the recommendations.

The highest-ranking recommendation from each of the seven work groups became the priority goal. Together the seven priority goals form the basis of Connecticut’s Comprehensive Mental Health Plan. (See Table 7.) They represent the steps that we intend to take in Year 2 of the state’s mental health transformation. SAMHSA’s recognition of the need for flexibility in putting the recommendations into place is appreciated, given the ever-changing needs and environment within the state.

Table 7: Priority recommendations

Prioritized Recommendations
<p>C. 1. Expand upon the suicide prevention guidelines issued by the Department of Education in 2004 by encouraging local school districts to disseminate and adopt suicide prevention and anti-stigma modules as part of comprehensive school health curricula.</p>
<p>E. 1. Develop, implement and provide incentives to programs to adopt a recovery-oriented performance measures system, including a universal satisfaction survey (for children and adults), that is informed by individuals in recovery and family and that provides feedback to individuals in recovery/families and programs on programs’ performance and outcomes.</p>
<p>E. 2. Develop an integrated information system across agencies, the Judicial Branch, their providers and payers that establishes a uniform data collection system and uses common variables and data definitions to facilitate identification, monitoring and elimination of behavioral health disparities.</p>

<p>F. 3. Increase timely access to services by maximizing Medicaid funding, identifying and addressing regulatory changes and waivers necessary to overcome policy barriers, leveraging federal matching reimbursement dollars, coordinating and aligning funding streams, and developing a reimbursement mechanism for prevention, screening, assessment, consultation and treatment.</p>
<p>A. 5. Prevent or minimize further criminal justice involvement by creating systemic and policy changes to identify and divert children and youth involved in the juvenile and criminal justice systems into evidence-based prevention and intervention programs.</p>
<p>E. 3. Develop a consumer/family/provider–friendly resource information system including a web site that increases access to information about a range of recovery-oriented services and appropriate behavioral, physical health and social service resources.</p>
<p>C. 7. Train the mental health workforce and other health and human service personnel.</p>

THE FUTURE

As Connecticut moves forward with the Comprehensive Mental Health Plan, the state will do so according to the vision, values and principles articulated in the application for mental health transformation funding. The vision is as follows:

Connecticut envisions a recovery-oriented system of mental health care that will offer citizens of all ages an array of accessible services and recovery supports from which they will be able to choose to effectively address their particular mental health condition or combination of conditions. These services and supports will be responsive to a person’s culture and gender. They will build on the strengths of the person and his or her family and community. They will have as their primary and explicit aim the promotion of the person/family’s resilience, recovery and inclusion in community life. Finally, citizens will receive services and recovery supports in an integrated and coordinated manner in a locally managed system of care. These supports and services will be provided in collaboration with the community, thereby ensuring continuity of care over time and across agency boundaries and maximizing the person’s opportunities for establishing or reestablishing a safe, dignified and meaningful life in the communities of his or her choice.

This vision is based on the following underlying values:

- the shared belief that recovery from mental illness is possible;
- an emphasis on the role of positive relationships, family supports and parenting in maintaining recovery, achieving sobriety and promoting personal growth and development;

- the priority of an individual's or family's goals in determining the pathway to recovery, stability and self-sufficiency;
- the importance of cultural inclusion, cultural competence and gender- and age-responsiveness in designing and delivering mental health services and recovery supports;
- the central role of hope and empowerment in changing the course of an individual's life; and
- the need for state agencies, community providers and consumer and recovery communities to come together to develop and adopt a comprehensive continuum of mental health promotion, prevention, early intervention, treatment and rehabilitative services.

In addition, the following guiding principles have been distilled from four years of Connecticut's experiences in introducing recovery and resilience, cultural competence and evidence-based practices:

- Recovery is a process in which a person with a mental health condition engages in order to minimize the destructive impact of his or her condition and maximize his or her overall quality of life. Like other forms of learning and growth, recovery involves an interactive process in which the person plays an active role. In addition to minimizing symptoms and illness, recovery-oriented care entails enhancing access to opportunities and providing the supports needed for people to successfully take advantage of the opportunities.
- Recovery happens within the context of the person's overall life and is not confined to the parameters of the formal service system. Care is effective to the degree that it decreases a person's reliance on formal services and increases his or her level of interdependence with the local community and its natural resources. A key focus for recovery-oriented care is the rights and responsibilities associated with self-determination and community membership. This involves supporting people in having and making the choices that will foster their own health and the well being of the community as a whole.
- Culture is an integral aspect of who an individual is and what he or she aspires to become. Unfortunately members of some communities can access or benefit from mental health care more easily than others. Such disparities need to be identified and redressed for all citizens to participate equally in the promise of recovery.
- Communities are not only the natural homes of people with mental health conditions but they also offer a range of resources and opportunities that can be crucial in the promotion of resilience and recovery. A culturally responsive and recovery-oriented system recognizes that identifying and building on these assets is a primary strategy for preventing the onset of mental illness and for promoting resilience and sustained recovery in the face of mental health concerns.

- Finally, systems transformation efforts must involve at all levels and in all respects the active participation and leadership of people in recovery and their loved ones. Besides offering hope and role models for the possibility of recovery, this community possesses the primary source of wisdom about recovery.

In our plan for transforming Connecticut’s mental health system, the vision, values and principles provide the overlay. The recommendations of the seven transformation work groups provide the structure. And the information obtained through the needs assessment and resource inventory process provides the foundation.

Comprehensive Mental Health Plan

The following sections provide greater detail about Connecticut’s seven goals and recommendations for action, and comprise our Comprehensive Mental Health Plan. The recommendations prioritized by our Oversight Committee represent the initial areas of focus during the coming year. We have aligned our recommendations according to the goals of the New Freedom Commission. (See Table 8 on page 57.)

Our plan further incorporates the 10 principles required by SAMHSA. Briefly, the plan is consumer-, youth- and family-driven. It focuses on recovery and resilience. It contains a continuum of promotion, prevention, early intervention, treatment and recovery services that cross all agencies and systems, and cover the life span. It seeks to eliminate disparities or gaps in services. And it addresses critical workforce training issues.

These recommendations will provide a starting point for transformation. Strategies and action steps associated with implementing the recommendations can be replicated, expanded and adapted to ensure that the principles of transformation are adhered to and sustained on a system-wide basis.

Section 1: New Freedom Commission Goal 1

<p>Goal #1</p> <p>Americans Understand that Mental Health Is Essential to Overall Health.</p> <p>1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.</p> <p>1.2 Address mental health with the same urgency as physical health.</p>

The New Freedom Commission report stated that “in a transformed mental health system Americans will seek mental health care when they need it – with the same confidence that they seek treatment for other health problems.” Too often, people in Connecticut fail to seek this care because of the stigma that surrounds it. In addition, people with mental illness or their family members often are unaware of the range of effective treatments available.

Consider the numbers. Nearly one quarter of the state’s adult population is estimated to have any form of mental illness; 5.4 percent of the adult population, or 144,252 adults, is

estimated to have a serious mental illness. In 2005, DMHAS reported providing inpatient and outpatient services to about 41,450 adults, including about 12,000 who received case management or intensive case management services. That left 102,802 adults with a serious mental illness who received services through the private sector or who received no services, according to Yale University researchers. The researchers used information and assumptions from the state and federal governments, including the 2005 U.S. Estimated Census, to calculate the estimates.

Among children and adolescents in Connecticut, at least 6 percent, or an estimated 50,338 of the young people through age 17, meet the criteria for serious emotional disturbance (SED). Yet in 2005 only 17,735 children with SED received DCF-funded behavioral health services. That means the rest, nearly 65 percent, received services through the private sector or received no services at all, according to the estimates.

In the Connecticut Citizens Survey, respondents were asked to disclose their own or a family member's experiences of mental health symptoms. In seeking help for their mental health concerns, the respondents said they mainly turned to family members, friends, general practice physicians and private mental health practitioners. These supports fall outside of the traditional scope of public-sector mental health; they suggest valuable avenues for mental health screening and intervention efforts, community education about stigma and integrating primary and mental health care.

The Internet and clergy are additional sources of mental health support for some people, while school-based providers and family guidance centers are used for some children and youth. Even so, too many people seek no help for mental health concerns, suggesting that additional strategies and targets are needed to increase the visibility of and access to care. Figures 1 and 2 (below) illustrate differences in how Caucasians and all other ethnic groups in Connecticut seek help for mental health concerns, according to the Connecticut Citizens Survey. In Figure 1, 22 percent of Caucasians said they turned to private mental health providers; 20 percent turned to general practitioners; 17 percent turned to family and friends; and 17 percent said they turned to no one.

Figure 1: Where Caucasians (whites) with mental health symptoms turned for help

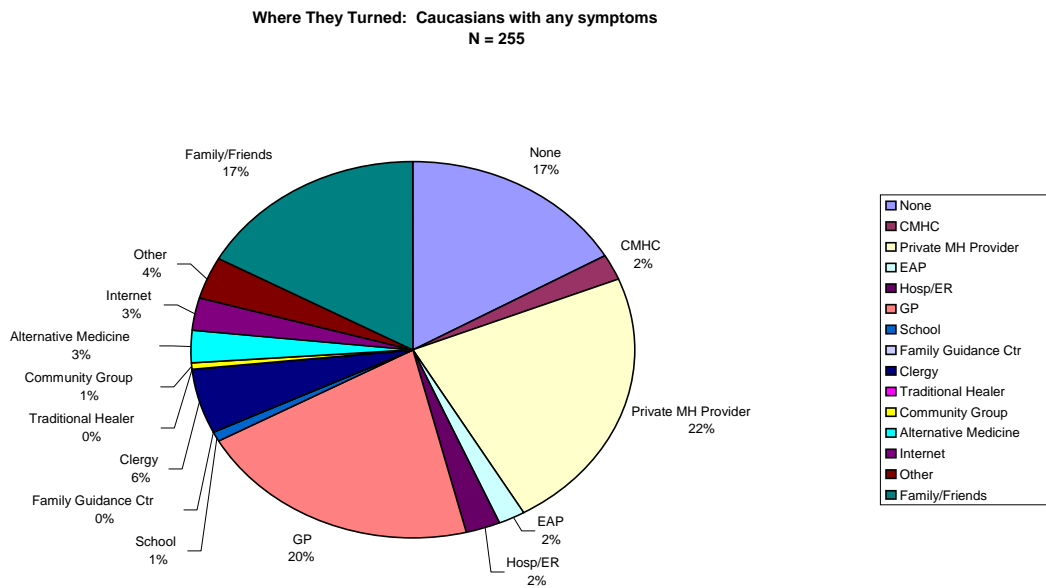


Figure 2: Where all other ethnic groups with mental health symptoms turned for help

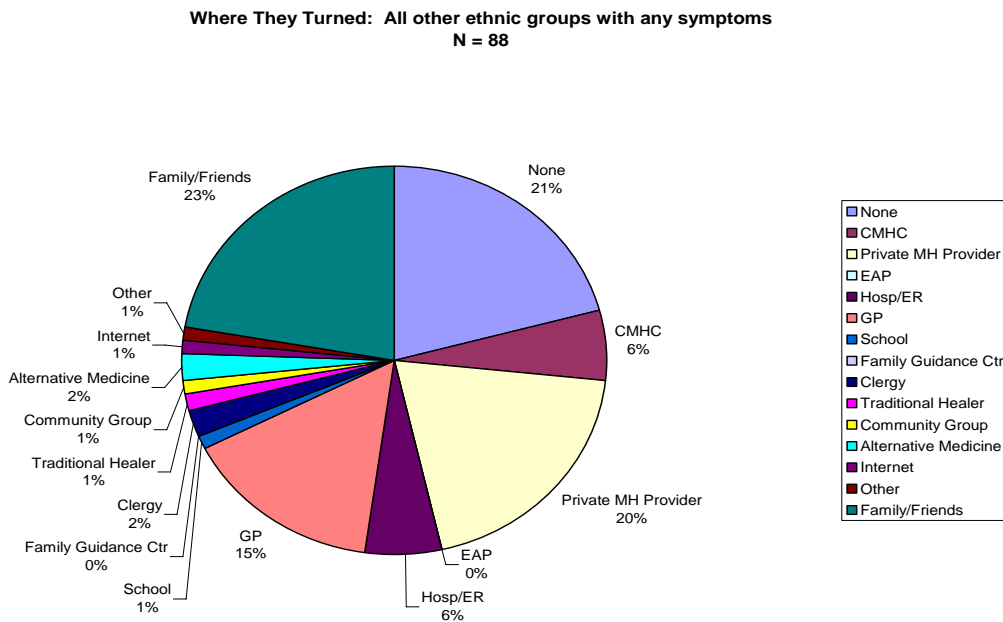


Figure 2 shows that 23 percent of all other ethnic groups said they turned to family and friends; 21 percent turned to no one; 20 percent turned to private mental health providers; and 15 percent turned to general practitioners.

As Figures 1 and 2 suggest there are myriad opportunities for early mental health screening and intervention. But even in conventional settings such as doctors' offices, professionals may be inadequately trained to recognize the signs and symptoms of serious mental illness. A transformed mental health system will recognize the importance of integrating primary and mental health care. Strategies also must focus on eliminating barriers that prevent people from accessing mental health or physical health care.

It's clear that our efforts must go beyond conventional settings and focus on important community institutions such as schools, day care centers, businesses and church organizations. People spend large portions of their day in these settings, yet troubling symptoms can often go unheeded.

We must pay special attention to critical periods in human development when individuals may be at greater risk for suicide or for the onset of mental health problems. According to the Connecticut 's 2005 Comprehensive Suicide Prevention Plan, "twenty percent of any high school population will think about suicide, 8 % will try to commit suicide and 3% will require acute medical attention after a suicide attempt." Schools, colleges and universities must be included in a comprehensive mental health strategy and their staff must be given the tools and resources to enable them to identify and help people with mental health concerns.

Finally, culture contributes significantly to the decisions people make about accessing mental health care. Traditional health and mental health systems often are not welcoming to people of different cultures, alienating adults and children from needed care.

A transformed mental health system will acknowledge the important role of culture in determining whether and how people seek mental health services. A transformed system will better serve the needs of our population in all its diversity by developing appropriate approaches for service delivery and community education.

One theme that resounded across state agencies through the needs assessment, and among ordinary citizens through the Connecticut Citizens Survey, was the need for public awareness campaigns and education about mental illness. Parents and providers affiliated with DCF suggested several measures for reducing stigma and better integrating mental health and physical health care. In surveys, parents and providers said the mental health field should: focus on minor mental health problems as well as more severe difficulties; encourage the sharing of success stories; make community education a priority; develop positive marketing and mental health awareness plans; educate and train primary care physicians, nurses and school personnel on mental health issues and assessment; make mental health assessments a standard practice in schools and primary care; and improve collaboration between mental health and physical health providers.

Lack of knowledge about mental health treatment and stigma against people with mental illness contribute to Connecticut's suicide rates. While the state places considerable emphasis on suicide prevention, more work remains to be done. Resources must be better coordinated and they must target individuals who may be at the highest risk for suicide.

Certain groups may developmentally be at greater risk for suicide yet reluctant to access traditional health and mental health care. Their isolation from the general health care system places them in a vulnerable position at the time they could be benefiting most from mental health supports.

The transformation work group identified through an informal survey the activities related to suicide prevention that are already occurring in the state. Several work group members also described their involvement in a range of suicide prevention activities. These activities include the Interagency Suicide Prevention Network facilitated by the Department of Public Health (DPH), which was responsible for developing the State Comprehensive Suicide Prevention Plan. A Youth Suicide Advisory Board facilitated by DCF exists, and initiatives are also occurring through the state Department of Education (SDE) and the DMHAS. A review of the suicide prevention activities makes it clear that mental health transformation activities should build on the initiatives already approved or in place.

Group members stressed that early screening and intervention across the life span were critical to preventing suicide, and they recommended that suicide prevention activities be expanded into primary health care settings, schools and school-based health clinics and universities. Nursing homes and agencies serving elderly people who may be at greater risk for suicide also should be targeted for prevention programs. Special emphasis on screening should focus on gay and lesbian youth who are at much higher risk for suicide than other young people and who are more likely to be isolated from community support. Group members agreed that these interventions must be part of a comprehensive suicide prevention campaign.

As revealed in the needs assessment and resource inventory process, only a few formal policies involving suicide appear to exist within state agencies. A more exhaustive search might reveal additional policies, but on the face of things, robust suicide prevention standards appear to be needed.

We hope that all Connecticut citizens come to recognize that “good mental health” contributes to overall physical health. Good mental health is good business and as such should be everybody’s concern. A transformed mental health system will empower individuals in recovery to make informed decisions about their overall health care. This means eliminating the barriers that prevent people from accessing care by increasing awareness about treatment interventions and decreasing stigma and discrimination against people with mental health disorders.

To help all Connecticut citizens better understand mental illness, suicide and stigma the Oversight Committee through the use of the Impact and Feasibility Rating Form identified the following recommendation.

Recommendation: *Expand upon the suicide prevention guidelines issued by the Department of Education in 2004 by encouraging local school districts to disseminate and adopt suicide prevention and anti-stigma modules as part of comprehensive school health curricula.*

To achieve this recommendation, the work group suggests that suicide prevention and anti-stigma curricula in school health settings should:

- include information about mental health, mental illness, risk factors and resources;
- be sufficiently flexible so as to allow for modifications that address the special needs associated with children in pre-school, and elementary, middle and high school; and
- consider the various cultural differences for families and communities in matters of mental health, mental illness, death and suicide.

This recommendation places particular emphasis on educators and school-age children and will be coordinated with Connecticut's newly awarded Suicide Prevention Initiative. Additional suicide prevention initiatives are underway in Connecticut for other populations. The State Comprehensive Suicide Prevention Plan targets people who are experiencing developmental or life-stage transitions that leave them at increased risk for mental illness or suicide.

During the past year, several state agencies serving people with physical, developmental and mental disabilities collaborated with Connecticut Public Television to air a special series highlighting the successes and sharing the stories of people with disabilities to dispel myths and reduce stigma. In addition, DMHAS is participating in national anti-stigma initiatives. Many of these efforts are ongoing, and while they currently receive no direct funding from the MHT SIG, they will contribute significantly to transforming Connecticut's mental health system.

To evaluate change in Connecticut's mental health system resulting from this recommendation the following Government Performance Results Act (GPR) Outcome Measures may be used:

- increased number of schools receiving suicide prevention guidelines
- increased number of schools receiving anti-stigma modules
- increased number of people/schools/school districts receiving training in modules
- increased number of schools/school districts adopting the modules

Section 2: New Freedom Commission Goal 2

Goal #2

Mental Health Care Is Consumer and Family Driven.

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

Goal #2 of the New Freedom Commission includes transformation objectives that focus on the people who use mental health services. According to the New Freedom Commission vision, individuals in recovery, with service providers, will actively participate in designing and developing the services they need and use. Each person will have a health management program tailored specifically to his or her needs, with appropriate treatment and supports oriented toward recovery and resilience. Individuals in recovery and providers will have a bigger role in managing the funding for their services, with enhanced choices.

Meeting this goal also will mean better coordinating services and programs among state agencies, streamlining federal and state regulations to improve access and accountability and promoting new structures for funding streams. These initiatives are extremely important and worthy of considerable reflection in any mental health transformation effort. Fortunately, work group members were equal to the task, coming as they did from varied backgrounds, experiences and perspectives. This diversity provided depth and richness to the discussions that led to the final recommendations and strategies.

As the work group considered this goal, members strove for an approach that was as open and inclusive as possible in order to gain the broadest perspective and the greatest number of comments, suggestions and ideas. Membership was wide-ranging and open to anyone who wanted to participate. The group especially sought the participation of family and individuals in recovery. Of this work group's 37 "active" members, two are advocates in the adult mental health system, two are family members of adults with a serious mental illness, seven are child or family advocates and 10 are individuals in recovery. Members also include five service providers and 11 representatives of various state agencies.

Most of the members are not defined by one constituency group, but rather interact with the mental health system in several different roles. For example, one member is a mental health professional whose spouse has a mental health disorder, while another may be a mental health worker who is also a person in recovery. Members with multiple connections to the mental health system bring to the table a deeper understanding of the challenges faced and possible solutions. Unfortunately, the work group lacked adequate representation by young people, whose participation proved difficult because of the timing of meetings. To include this important voice, the work group created or took advantage of other opportunities to gain the ideas, comments and suggestions of young people. Venues for this purpose

included the Transitional Youth & Young Adults Turning 18 Conference and DCF's Youth Advisory Council.

Work group members were given documents intended to describe the vision and provide inspiration and direction. One important document was SAMHSA's 2006 National Consensus Statement on Mental Health. The document's 10 Fundamental Components of Recovery forged the vision to be achieved. The components also provide the basis for measuring future success of a transformed mental health system that is driven by individuals in recovery and their families. The 10 basic components of a recovery-focused mental health system are:

1. **Self-Direction** - Individuals in recovery lead, control, exercise choice over and determine their own path of recovery.
2. **Individualized and Person-Centered** - There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma) and cultural background.
3. **Empowerment** - Individuals in recovery have the authority to choose from a range of options and to participate in all decisions including the allocation of resources that will affect their lives, and are educated and supported in so doing.
4. **Holistic** - Recovery encompasses an individual's whole life, including mind, body, spirit and community.
5. **Non-Linear** - Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience.
6. **Strengths-Based** - Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals.
7. **Peer Support** - Mutual support including the sharing of experiential knowledge and skills and social learning plays an invaluable role in recovery.
8. **Respect** - Community, systems and societal acceptance and appreciation of individuals in recovery including protecting their rights and eliminating discrimination and stigma are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital.
9. **Responsibility** - Individuals in recovery have a personal responsibility for their own self-care and journeys of recovery.
10. **Hope** - Recovery provides the essential and motivating message of a better future – one which recognizes that people can and do overcome the barriers and obstacles that confront them.

The most striking aspect of the work group was the enthusiasm and commitment with which the participants approached their task. This is best summarized by one member who stated that she “cleared her calendar” to attend work group meetings because she found them to be informative, thought provoking and a forum for new and shared ideas.

Sub-goal 2.1 of the New Freedom Commission report focuses on individualized treatment plans, but the perspective the sub-goal encompasses has a more expansive vision of empowerment. Approaches to mental health services that center around adults and young people are at the heart of this transformation objective, with individualized treatment plans being but one component of a broader strategy. We therefore explored all aspects of how

individuals in recovery are cared for in the mental health service system.

“You keep talking about getting me in the ‘driver’s seat’ of my treatment and my life... when half the time I’m not even in the damn car!” - quote from a woman in recovery on her experiences of treatment planning (Tondora, et al, 2005).

As this person’s words suggest, several important elements must be in place before a person can “drive” or direct his or her care. While treatment practices have shifted significantly in recent years from a disease-oriented to a recovery-oriented perspective, individuals in recovery and their families still may lack some of the basic skills needed to feel comfortable in the “driver’s seat.” For empowerment to occur, individuals in recovery and families must be informed about their choices and have the training and supports to follow through on their decisions. Individuals in recovery, mental health providers, from agency directors to line staff, and others must have the tools needed to successfully accomplish this system change.

The work group identified the following challenges or barriers to empowerment:

- Lack of real choice in the system because reimbursement to providers for services is typically based on medical necessity, not individual choice.
- An individual in recovery’s belief that he or she does not have the right to decide his or her treatment, and the perception that people with mental illness cannot construct a meaningful treatment plan.
- Lack of support and help to families at the outset to understand and participate in planning services for a child.
- The need to improve coordination of services for families and children across all involved organizations and agencies.
- Lack of leadership and commitment.
- Defining “self determination” as it relates to people instead of systems.
- Learning to view individual plans of care as dynamic (ever-changing) plans, not papers to be completed and put in a drawer.
- Children’s mental illnesses are often difficult to diagnose due to developmental issues.
- The need for a system-oriented approach to understanding families and mental illness.
- Providers need to be more educated about the federal Individuals with Disabilities in Education Improvement Act (IDEA) and be available to help parents.

In response to these challenges, the work group identified a vision of what could be. Tenets of this vision include:

- Consider an individual in recovery's goals across life domains as the primary driver in a person's treatment plan. The goals should be stated in the person's own words so that he or she can be proud and take ownership of them. The individual in recovery should have relationships with others who can help promote and sustain his or her recovery.
- Increase staff training to promote the move toward a person-centered system of care.
- Help individuals in recovery navigate the system; individuals in recovery should have choices and the right supports to make those choices.
- Secure solid commitments from agency commissioners to adjust budgets to create a system grounded in self-determination.
- Re-educate professionals against having an "authoritative role" over a person in treatment.
- Staff every provider organization with a person (paid or volunteer) whose sole job is to help the agency move toward a consumer- and family- driven model of practice.
- Create a comprehensive database of agencies and services to help individuals in recovery and those who support them understand their choices. Develop a "menu" of services for people in recovery.
- Develop a practice model that requires additional "wrap around" services to be standard for every child and family or individual in recovery. Each person would choose his or her own team of supportive people, including paid professionals and informal or "natural" supports such as family members and friends.
- Provide access to more trained family advocates to help support the process of planning for services.
- Develop a behavioral health workforce that understands the concept of healthy family systems, family dynamics and family experiences with recurrent illnesses.
- Promote a workforce that continues to address a person's treatment needs and includes the family and addresses the family's need for education and support beyond treatment issues.

Out of these recommendations came a unified vision:

Develop a strength-based, community-based, culturally competent and consumer-driven system of care that crosses all state departments and meets the emotional, behavioral and mental health needs of adults and children and the family members, friends and other people who support them.

Information obtained through the needs assessment process reflects and supports much of what the work group discussed. Results from the DMHAS Agency Recovery Self-Assessment, a tool that measures how well programs incorporate recovery-oriented principles, reveal that most state departments recognize the importance of involving individuals in recovery and their families in all aspects of services. Yet those areas were ones in which the agencies surveyed for this evaluation were actually rated lowest.

Advocacy activities have long been a part of the mental health landscape in Connecticut, and these activities are increasing. Even so, there is a sense that the depth and breath of involvement of individuals in recovery and their family members could be expanded. People in recovery and family members have unique insight into and experience with the process of recovery and effective strategies for navigating systems of care and support. DMHAS' newly published Practice Guidelines for Recovery-Oriented Behavioral Health Care (DMHAS, 2006) identifies eight domains of a recovery-oriented service system and offers examples of ways in which a provider can incorporate them into practice. Although designed and written for DMHAS-funded providers that serve adults, the guidelines are applicable and adaptable to private providers serving people of all ages.

A tool developed by Yale University is helping to better gauge satisfaction of individuals in recovery and family members. The tool relies on a core set of principles called Elements of a Recovery Facilitating System (ERFS), and it can be used to help differentiate a recovery-oriented mental health system from a traditional system of care or from one that does not emphasize recovery and resilience. ERFS evaluations are potentially useful in measuring the progress of local systems as they shift their orientation toward recovery in line with transformation goals and public policies.

Using the ERFS tool, individuals in recovery rank their local system of care on the extent to which the 16 core principles are present and practiced. Individuals in recovery also rate their met and unmet needs. Education about ERFS evaluations can increase knowledge about basic recovery principles and help individuals in recovery, families, providers and others understand and clarify how a recovery-oriented system operates. ERFS also can help define what such a system looks and feels like in practical terms. If individuals in recovery and providers heed the results of ERFS assessments, they can create a constituency for change, sparking and shaping planning and change efforts in local systems of care.

Satisfaction surveys are another way to gain information about services. In the matrix, several state agencies emphasized the need for more feedback from individuals in recovery and the need to increase involvement of individuals in recovery and family members in all aspects of care. This is especially true for individuals from diverse cultural backgrounds. Yet the same report discusses the inability to share data across departments. This inability creates a "data vacuum" where valuable information is potentially lost or viewed as an isolated experience rather than a theme that permeates many agencies and is therefore worth heeding. Universal survey tools would permit agencies to collect consistent information at all stages of a person's life that could then be aggregated and analyzed. This would create a

mechanism for continuous quality improvement as individuals in recovery and family involvement increases in all aspects of planning, delivering and evaluating services.

To involve individuals in recovery and family members in meaningful ways in shaping the mental health service system the Oversight Committee identified the following priority recommendation.

Recommendation: *Develop, implement and provide incentives to programs to adopt a recovery-oriented performance measures system, including a universal consumer satisfaction survey (for children and adults), that is consumer and family informed and that provides feedback to individuals in recovery/families and programs on programs' performance and outcomes.*

Potential strategies that support achievement of the recommendation include:

- Establish measures for inclusion in a universal satisfaction survey using the Practice Guidelines for Recovery-Oriented Behavioral Health Care, along with the associated principles of resilience and the ERFS tool.
- Modify or adapt the ERFS tool with guidance from experts and stakeholders to reflect concerns appropriate to the age and stage of life of the person receiving services.
- Capture non-identifiable demographic information on the universal satisfaction survey and use it as an adjunct to other data to assist in identifying and eliminating health disparities.
- Engage consumer- and family-run businesses or organizations to help design and administer the surveys.

Potential GPRA Outcome Measures to be used in the evaluation process include:

- Evidence of incentives to programs to adopt a recovery-oriented performance measurement system that includes a universal satisfaction survey
- Increased number of agencies that use the recovery-oriented performance measurement system
- Evidence of the provision of feedback to individuals in recovery and families on program performance and outcomes
- Evidence of the provision of feedback to programs on programs performance and outcomes

Section 3: New Freedom Commission Goal 3

Goal #3

Disparities in Mental Health Services Are Eliminated.

3.1 Improve access to quality care that is culturally competent.

3.2 Improve access to quality care in rural and geographically remote areas.

Mental health care that successfully centers on the needs of the person will be, by definition, care that is ethnically, culturally and linguistically appropriate. Mental health services that achieve these goals are considered culturally competent. Strategies in providing culturally competent care include policies, funding mechanisms, approaches and decisions, physical structures and services and practices that respect and respond to demographic diversity in terms of “race” and ethnicity, language, gender, sexual orientation, physical abilities, immigration, age and place of residence.

In Connecticut, Caucasians account for about 82 percent of the population; blacks and African Americans account for about 10 percent; Latinos, 9 percent; and Asians, 2 percent, according to 2000 U.S. Census data. People served by DMHAS include over-representations of people of color, and correspondingly those residing mainly in the state’s largest cities.

Overall, African Americans and people described as Mixed/Other use inpatient care to a greater degree than their distribution in the population. Within state-operated hospitals, Caucasians claim 57 percent of the beds, while African-Americans claim 22 percent and people who describe themselves as Mixed/Other account for 21 percent. Within community-based services, Caucasians represent more than half of those served; one in five served is African-American and fewer than 1 in 10 served describe themselves as Mixed/Other. Among Hispanics, about the same percentage reported using inpatient care (19 percent) as community-based services (18 percent).

Among children and youths, nearly a quarter of those served by DCF are Hispanic, while children and youth from other ethnic groups requiring mental health care include Polish, Portuguese, Asian, Cambodian, West Indian and Vietnamese.

The 2000 census data also found that 11 percent of Connecticut residents were born in foreign countries. Of this population, 43 percent of adults speak English “less than very well,” and 29 percent of young people (17 and under) speak English “less than very well.” Within DSS, members of communities of color and non-English speaking communities participated in services at rates of less than 7 percent.

Eliminating disparities in care requires a commitment to ensuring, at a minimum, that a person’s basic needs are met. This means that discussions about institutional racism, poverty, self-sufficiency, housing and educational and vocational opportunities must be prominent components of Connecticut's transformation dialogue. Policies must promote an environment of access and equal opportunity to members of minority groups in a mental health system that is free of racism and discrimination.

Much is being done in Connecticut to address treatment disparities for women. Individuals in recovery/people in recovery, providers, DMHAS and the Connecticut Women's Consortium have formed the Women's Services Practice Improvement Collaborative (WSPIC). Two national experts in gender-responsive services for women, Stephanie Covington, Ph.D., and Barbara Bloom, Ph.D., have provided consultation. Their work in recent years has culminated in the Treatment Guidelines for Gender Responsive Treatment of Women with Substance Use Disorders. Several programs throughout Connecticut are beginning to use the guidelines.

No mental health system that holds out recovery and resilience as the ultimate goal can reach that goal unless it can ensure that all its citizens, including minorities and residents in rural and geographically remote areas, have access to services that are culturally welcoming.

One barrier to accomplishing this in Connecticut is that we lack the information that would tell us where and the extent to which the disparities in mental health care exist. The state does not collect that information in a consistent way across all state agencies and the Judicial Branch. In a large mental health system, data collection is the only way to ascertain with any certainty where the gaps are. We must be able to better assess the strengths and gaps in care for diverse populations and determine the extent to which staff diversity matches the diversity of individuals in recovery.

Despite the state's information void, we know from national experience that minorities and residents of remote areas bear a disproportionately high rate of disability from untreated mental health disorders. In Connecticut, each state agency has articulated a goal to provide services in a culturally competent way. To have a mental health care system that is free of disparities, we need more services and programs that are trauma-focused, specific to ethnicities and genders, and linguistically and culturally appropriate. We also need to enhance existing services by training mental health practitioners about how to provide such care. Finally, we need to enhance and establish policies, procedures and standards on delivering culturally appropriate care.

When providers and families affiliated with DCF's system of care were asked for ideas about how to eliminate disparities in care or make the mental health system more culturally competent, responses included: to make sure all families have comparable access to mental health services; provide services and documents in a person's primary language; make services available across all geographic regions, including rural areas; mandate cultural competency training and practices among staff; develop stringent standards for cultural competency and involvement of individuals in recovery; educate the police and court systems about mental illness; require sensitivity training of all staff; encourage universities and colleges to enroll and support qualified, culturally diverse candidates; and create cultural centers in each community.

Responses from the Connecticut Citizens Survey also included ideas for eliminating disparities in care. Among the suggestions were increasing the number of therapists for

women, increasing the therapy services available to Hispanic women and reaching out more to Hispanics.

Another tool, the DMHAS Agency Recovery Self-Assessment, offers insight into the degree to which state-provided mental health services are culturally competent. The tool measures how thoroughly a mental health or addiction agency's practices incorporate various recovery-oriented principles. Two such principles are cultural competence and recovery orientation. Despite considerable efforts by the state in recent years to improve in these two areas, they still receive the lowest ratings of the survey's indicators. This finding does not necessarily suggest that the efforts are failing. Rather, it may reflect the time lag that predictably accompanies system-wide change. Or it may stem from rising expectations due to recent efforts to promote awareness of the importance of culturally competent and recovery-oriented practices and services.

The state needs accurate, reliable information to know how best to go about eliminating disparities in mental health care in Connecticut. Through the needs assessment, we have identified several limitations in the area of collecting, sharing and reporting information that hinder our progress toward a more culturally competent system. The needs that stem from these limitations include:

- Enhancing the availability of technology and equipment in many facilities, and increasing computer resources for children and youth. Departments also identified the need for equipment that lets them share information with each other.
- Establishing new databases, developing automatic reporting tools and identifying common data fields.
- Enhancing data sharing across all agencies.
- Revamping data collection methods to allow the state to ascertain the extent to which staff diversity matches the diversity of individuals in recovery served. Mapping each agency's fiscal, physical plant and staffing allocations across Connecticut's 141 townships and other selected geographic areas would yield information that could be used to assess whether enough services are available in rural areas and whether the design of services and diversity of staff are consistent with the needs of various populations throughout the state.

Recommendation: *Develop an integrated information system across agencies and the Judicial Branch and their providers and payers that establishes a uniform data collection system and uses common variables and data definitions to facilitate identification, monitoring and elimination of behavioral health disparities.*

Agencies should collaboratively establish and use common variables and data definitions related to cultural competency and disparities in mental health care. These variables should include, but not be limited to, the following:

- race
- age
- disability status
- gender

- housing status
- income source
- insurance
- ethnicity
- religion/spirituality
- employment
- language
- income
- educational level
- literacy
- sexual orientation
- acculturation

Potential strategies that support achievement of the goal include:

- Engage agencies in the analysis of their data to assess for system-wide parity in access to services, engagement and retention in services, and service quality and outcomes; and make needed adjustments to improve the services that are offered across populations.
- Establish and enforce, through an interagency collaboration, uniform standards for data collection for the purpose of improving service quality as it relates to mental health disparities.
- Create a statewide report, at established intervals, that identifies current and projected trends related to behavioral health disparities.

Potential GPRA Outcome Measures to be used in the evaluation process include:

- Evidence of an integrated information system across agencies, the Judicial Branch, providers and payers
- Evidence of a uniform data collection system
- Increased number of agencies that are linked with the information system
- Increased number of policies developed across agencies and departments involving an integrated information system

Section 4: New Freedom Commission Goal 4

Goal #4

Early Mental Health Screening, Assessment and Referral to Services Are Common Practice.

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

Research shows that children and adults whose mental health concerns are identified and addressed early have the best chances of living life at the highest levels of quality and daily functioning. Early identification of mental health disorders and referral to services also can ease the strain on the mental health treatment system by helping people before their needs reach crisis levels, requiring expensive services.

Making services available to people early can help to address inconsistent mental health care standards and inequities in treatment delivery. For example, people with co-occurring mental health and substance abuse disorders often encounter pronounced inequities as they seek care, partly because some funding streams do not permit providers to address multiple health problems.

In a transformed system, mental health providers will be able to serve the whole person, meeting an essential tenet of a recovery- and resilience-oriented system. A transformed system also will ensure that early screening and referral services are available in the places where children and youth, adults and elderly people are likely to be or visit: the offices of general health care practitioners, schools and nursing homes, for example. We could expand the list to include a host of other venues: detention centers and jails or prisons, group homes, transition centers and homeless shelters, to name a few.

From a mental health provider's standpoint, early screening and assessment is a welcome opportunity to speak a "common language" with professionals across the spectrum, including education, transition and physical health personnel. Together these practitioners can promote wellness by helping to identify a person's needs, guide him or her to appropriate services and supports and provide benchmarks of progress. Such commonalities enhance accountability for decision-making. They also encourage collaboration among mental health, substance abuse, health care, education, child protection, child advocacy and juvenile justice systems by streamlining health care practices and providing uniform information.

The services of early screening, assessment and intervention are nothing short of transformational because of their potential to prevent or interrupt the devastation that an untreated mental illness or serious emotional disturbance can bring to people and their families. These services truly promote recovery in adults and resilience in children by enabling them to live fulfilling and productive lives from the earliest possible moment.

Unfortunately, one barrier to early screening, assessment and referral is that many services that fall within this continuum are considered non-traditional in that Medicaid and private insurers typically have not funded them. Adequate funding is critical to the state's ability to offer a range of prevention, early intervention and treatment services to people of all ages.

A transformed mental health system harnesses existing and additional resources to break through funding and other barriers. Combining or blending federal and state dollars, realigning or establishing more flexible funding streams and using more options available through Medicaid are just some of the ways Connecticut plans to transform its mental health system to include early intervention, non-traditional and other services that promote recovery and resilience.

Connecticut has taken several important steps to get funding for non-traditional services. One avenue is through Medicaid's Home and Community Based Waiver, which provides enhanced community supports and services to beneficiaries who, without these services,

would remain in nursing homes and other institutions. In 2005, the Connecticut General Assembly passed Public Act 05-280, whose Section 85 required the commissioners of DSS and DMHAS to jointly study the feasibility of obtaining the Medicaid waiver. If approved by the federal government, the waiver would allow mental health providers to be paid for non-traditional services to adults with mental health concerns to help them live in home-based settings instead of nursing homes. The non-traditional services might include respite care, home modifications and non-medical transportation.

Before states may offer some Medicaid-reimbursable services they must show how the cost of the added services would affect the costs of existing services to the populations involved. To assess whether the equation would be “cost neutral” in the case of the Home and Community Based Waiver, the DSS-DMHAS task force used clinical profiles of five people living in Connecticut nursing homes. Each profile described and estimated the cost of the services the person would need in the community compared to the cost of his or her nursing home placement. The financial analysis found that the Medicaid cost neutrality requirement was met. Compared with the cost of their nursing home stay, all five people had lower Medicaid costs for each of the three years following their discharge from nursing homes.

The General Assembly supported the task force’s proposal to move forward with the federal waiver application. The state gave DMHAS money for the task, and DMHAS and DSS are working on starting the waiver program. It is expected to be implemented during the state’s 2007 fiscal year.

Another avenue for offering services is through Medicaid’s Rehabilitation Option. Connecticut currently offers one service under this option that focuses on building the skills and independence of people who live in mental health group homes. DMHAS is introducing two more services under the option: Assertive Community Treatment (ACT) and Community Psychiatric Support. These services will help more adults gain the skills and resources needed to live and function as independently as possible in the community.

Connecticut adults already enrolled in ACT and case management services will have greater choice among service providers once the option is in place. These additional services will contribute greatly to Connecticut’s goal of promoting recovery for people with mental health concerns. Another benefit of participating in the option is that the state qualifies for federal matching funds. Public Act 05-280 directed the state to seek an amendment to Connecticut’s Medicaid state plan to provide these two services. The state expects to submit the amendment to the federal government by the end of 2006.

A third example of finding ways to offer more non-traditional services lies in partnership of DSS and DCF. The agencies formed the CT Behavioral Health Partnership (CT BHP) “to plan and implement an integrated public behavioral health service system for children and families.” The partnership goals include:

- To provide enhanced access to and coordination of a more complete and effective system of community-based behavioral health services and supports and to improve member outcomes.

- To better manage state resources and increase federal financial participation in the funding of behavioral health services.

The partnership “is designed to eliminate the major gaps and barriers that exist in the current children’s behavioral health delivery system,” its literature states. DSS and DCF “are committing resources to develop a full continuum of behavioral health services for children that include evidenced-based programs, non-traditional support services and community-based alternatives to restrictive institutional levels of care. Through collaboration with family members, providers and social support systems, the CT BHP promotes a strengths-based treatment approach that focuses on client success. Particular attention is given to the cultural needs and preferences of the child and family and treatment planning reflects this focus on cultural competency.”

The partnership offers traditional and non-traditional services to children and families enrolled in the HUSKY state health insurance program and for children with special behavioral needs involved with DCF. The non-traditional services include intensive case management, peer specialists for children and for their families and transportation to and from appointments or services.

One important aspect of the partnership is the emphasis it places on integrating physical and behavioral health care, particularly for young people at risk for or experiencing co-morbid conditions. The partnership accomplishes this integration through:

- screening processes administered by a medical provider;
- availability of primary care and behavioral health specialists for consultation with one another;
- coordination and ongoing collaboration between the entities responsible for managing both the medical and behavioral health benefits and services; and
- the provision of medical and behavioral health services within school-based clinics.

Current DCF policy requires that children who are entering foster care and those who are removed from their homes be screened for physical and mental health issues using the Multidisciplinary Evaluation (MDE). In addition, DCF has incorporated clinical services and evaluation into a revised emergency placement system to help in detecting and treating early any mental health problems of children removed from home because of neglect or abuse.

In 2006, the CT BHP continues to enact recommendations of the Blue Ribbon Commission. Three projects are particularly significant: 1) blending state general funds and Medicaid dollars to create a more seamless service delivery system; 2) further expanding community-based services by increasing use of Medicaid’s Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) and considering use of the Rehabilitation Option; and 3) providing enhanced rates of reimbursement to Enhanced Care Clinics that meet higher standards for timely access, delivery of evidence-based treatments, culturally responsive care, integration with primary care and other practice improvements.

The needs assessment and resource inventory data offers much support for these and other initiatives. The report highlights the need to: work with insurance companies to reimburse early interventions and wellness visits; fund more elaborate screening and assessment processes; work with and educate primary care physicians on mental health issues and medications; educate and train primary care physicians, nurses and school personnel on mental health assessment and other issues; make mental health assessments a standard practice in schools and primary care; improve collaboration between mental health and physical health providers; establish policies related to early identification and assessments across all age groups and environments; work more closely with school systems; integrate treatment for people with co-occurring mental health and substance abuse disorders; and increase access to primary health care providers across the system.

Recommendation: *Increase timely access to services by maximizing Medicaid funding, identifying and addressing regulatory changes and waivers necessary to overcome policy barriers, leveraging federal matching reimbursement dollars, coordinating and aligning funding streams and developing a reimbursement mechanism for prevention, screening, assessment, consultation and treatment.*

Potential strategies that support achievement of this goal include:

- Establish a work group of state agencies to leverage federal matching reimbursement dollars and coordinate and align funding streams.
- Identify and address regulatory changes and waivers necessary to overcome policy barriers.
- Identify and address challenges to sustainability by institutionalizing contracting procedures and fee/reimbursement structures for eligible services.
- Disseminate information to providers, referral networks, parents and natural supports through public information campaigns about the availability of reimbursable services for mental health individuals in recovery.

Potential GPRA Outcome Measures to be used in the evaluation process include:

- Maximization of Medicaid funding
- Evidence of leveraging of federal matching reimbursement dollars
- Increased amount of federally matched reimbursement dollars
- Evidence of a reimbursement mechanism for prevention, screening, assessment, consultation and treatment

Section 5: New Freedom Commission Goal 5

Goal #5

Excellent Mental Health Care Is Delivered and Research Is Accelerated.

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

The development of new methods, models and techniques proven by research to be effective often results in advances in medical and mental health treatment. These methods, models and techniques are referred to as evidence-based practices. Examples of evidence-based practices in the mental health field include multi-systemic therapy, cognitive therapy, dialectical behavioral therapy and assertive community treatment. Providers must receive appropriate training and agencies or systems need to support evidence-based practices in order to achieve positive results. For those reasons and more, it often takes years for evidence-based treatment advances to become available in local settings.

Some new methods, models and techniques show initial positive results but lack the benefit of lengthy research that would prove their effectiveness. These are called emerging best practices. Some examples include programs that divert offenders from jail into other settings, and programs that help people make the transition from incarceration to community living. Emerging best practices also include trauma-specific services and systems of care for children and their families.

In Connecticut, DMHAS, DCF, DOC and the Judicial Branch’s Court Support Services Division (CSSD) are a few of the state entities that offer and strive to implement evidence-based and emerging practices within treatment settings. Some examples are documented in two recently published state reports, the Connecticut Juvenile Justice Strategic Plan and the Jail and Prison Overcrowding Report.

The state’s first strategic plan for juvenile justice in Connecticut, released in August of 2006, supports and builds on several of the goals set forth in New Freedom Commission report. The juvenile justice strategic plan, a collaboration among the Judicial Branch, DCF, parents, advocates and public and private agencies, supports initiatives around increased family involvement, the elimination of mental health disparities, and the unique challenges facing adolescents as young as 14 years old who are incarcerated in adult prisons. These youngsters do not have access to developmentally appropriate treatment or to multi-systemic therapy and other evidenced-based practices that are available in juvenile justice settings.

Among the many action strategies in the *Connecticut Juvenile Justice Strategic Plan: Building Toward a Better Future* is the commitment to review and be guided by best practices when developing and designing programs. The report also urges that “Services be

grounded in research and promising practices that are trauma-informed, culturally and linguistically competent and gender-responsive.”

A second report, from the Prison and Jail Overcrowding Commission, makes recommendations around addressing the needs of people aged 14 and older who are involved with or at risk for becoming involved with DOC. Some recommendations in the commission’s 2006 annual report specifically address the large number of inmates who have mental health or substance abuse issues or both. The report urges the continued use and expansion of programs that divert eligible adult offenders from jail. It recommends providing alternatives to jail, and helping offenders with the transition from incarceration to community living. It also suggests incorporating evidence-based or preferred practices for treatment, moving toward a recovery-oriented system and using buprenorphine to treat opiate dependence. The Governor’s current budget provides funding for some of the recommendations.

The recommendations have the potential to help a significant number of adults and young people. In 2004, more than half (55 percent) of the 16,864 juveniles referred to the Juvenile Court showed signs of a mental health disorder. DOC reported a total prison population of 19,212 that year; a recent legislative report estimates that about 12 percent of those involved in the criminal justice system need mental health treatment. Also in 2004, about one quarter of the total supervised adult population of 53,974 was identified with mental health needs.

The material contained in the Connecticut Juvenile Justice Strategic Plan and the Jail and Prison Overcrowding Report echoes the findings of the needs assessment. Departments identified the need for enhancing clinical consultations in the courts, expanding jail diversion and community re-entry services and increasing access to programs that provide alternatives to incarceration.

In the area of policy, identified needs included establishing policies for early identification of mental illness and for assessing and evaluating offenders in the juvenile and adult justice systems.

Service and practice needs identified in the needs assessment include prevention and intervention efforts that target youth in communities, schools and detention centers. There also were calls for increasing clinical resources, developing programs and processes in the juvenile justice system for assessing young people and improving continuity of care.

Most agencies providing services underscored in the needs assessment the need to provide evidenced-based care. Some agencies currently import evidence-based technology through staff development and training, while others affiliate with universities and other training centers.

Recommendation: *Prevent or minimize further criminal justice involvement by creating systemic and policy changes to identify and divert children and youth involved in the*

juvenile and criminal justice systems into evidence-based prevention and intervention programs.

Potential strategies that support achievement of this goal include:

- Create an interagency task force to address identifying and diverting children and youth involved in the juvenile and criminal justice systems. Ensure collaboration among justice-serving agencies (CSSD, DCF, DOC, SDE and local education authorities) and seek comments from individuals in recovery and families.
- Review and put into place recommendations from existing studies of children and youth involved in the juvenile justice system. Pay special attention to those recommendations that identify systemic barriers to using existing screening and assessment data and to sharing data across agencies.
- Promote the continued adoption of evidence-based practices and early interventions among state entities that serve children and youth involved in the juvenile and criminal justice systems. Especially promote efforts that are geared toward reducing racial and ethnic disparities or those that are gender sensitive or specific.
- Promote the continued adoption and dissemination of early intervention and diversion strategies, such as community-based juvenile review boards. These boards provide alternatives to punitive measures and increase access to community-based services for children and youth in the juvenile justice system.
- Blend funds among agencies to better serve children and youth and ensure a continuum of care. Promote interagency collaboration with an emphasis on young people who are making the transition to the adult system of care.
- Review and implement as appropriate the recommendations of the DCF/CSSD juvenile justice strategic plan. Consider especially recommendations that address access to resources, best practices, legal and ethical issues and data sharing among state agencies that serve youth and children involved in the juvenile justice system.

Potential GPRA Outcome Measures to be used in the evaluation process include:

- Increased number of evidence-based prevention and intervention programs in the state
- Number of individuals at-risk for criminal justice system involvement
- Increased number of at-risk individuals who were diverted into evidence-based programs
- Increased number of policies, procedures and protocols related to criminal justice diversion
- Increased number of juvenile justice diversion resources available
- Increased proportion of at-risk individuals who were diverted into evidence-based programs
- Increased number of trainings offered in evidence-based prevention and intervention programs
- Increased number of staff trained in diversion techniques

Section 6: New Freedom Commission Goal 6

Goal #6

Technology Is Used to Access Mental Health Care and Information.

6.1 Use health technology and telehealth to improve access to and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

6.2 Develop and implement integrated electronic health record and personal health information systems.

A transformed mental health system in Connecticut will empower individuals in recovery and families because it will be grounded in advanced communication and information technology. Individuals in recovery and families will be able to communicate regularly with the professionals and personnel who deliver treatment and support services and who are accountable for helping people to achieve the goals outlined in their plans of care. Individuals in recovery and families will have ready access to information about illnesses, effective treatments and available community services.

Ensuring easy access to information will help foster continuous, caring relationships between individuals in recovery and mental health providers. Technology can strengthen these relationships by electronically linking multiple service systems, allowing individuals in recovery to update and manage their own care records, and providing easier access to more complete medical histories. Providers will be able to deliver care that is more coordinated and responsive, and grounded in the best practices and research. Making the most of technology is essential if the state is to achieve its overarching transformation goal: To empower individuals in recovery, their families and providers to use the best and latest information as they create and use services that are recovery- and resilience-oriented.

Currently in Connecticut, there is no single locus of information about resources, programs, services and supports. Individuals in recovery, family members and young people need to know where services are located throughout the state. They also need to know what to expect as they use services or undergo treatments. Technology is essential to providing these vital roadmaps.

Connecticut lawmakers have recognized the critical need to put technology to better use in the mental health field. Section 83 of Public Act 05-280 requires the DMHAS commissioner to “initiate the development, implementation, promotion and maintenance of a single resource web site to provide timely access to mental health care information and assistance for children, adolescents and adults.” The law requires that the web site include a directory of services and providers available at all levels of government. The web site must have information about the latest mental health diagnoses and treatments; links to national and state advocacy organizations; and summary information on federal and state mental health law, including private insurance coverage. Finally, the law says the web site must offer an optional, secure personal folder for users to manage their own care and assistance portfolios.

The New Freedom Commission has endorsed Network of Care as a means of achieving Goal #6. Many states already use the product. Among other things, the Network of Care web site offers a resource library; state-specific provider listings searchable by name, type of service, location, availability of bilingual staff and other criteria; links to national, state and local resources; a component that tracks relevant federal and state legislation and enables users to e-mail their legislator; and a secure personal folder where users can store information about medical history, medication, providers, advance directives and literature. Users can grant family, friends and providers limited or full access to the folder for a limited or indefinite time. The Network of Care web site is available in multiple languages and it can be accessed by users who are visually impaired.

Common responses and themes around Goal #6 found in the needs assessment and resource inventory data include the need for: public awareness campaigns on how to access statewide information; the development of telemedicine capacities; the development of web-based information targeting young adults; and the expansion of electronic libraries and other resource information outlets that exist in Connecticut.

DCF asked its affiliated providers and parents in its Mental Health Transformation Survey to single out the best ways to use technology to support mental health transformation. More than half of the respondents, 52.2 percent, rated as the highest priority, “automated information and tools that parents can access to learn about a child’s mental health issues and available resources.”

Recommendation: *Develop a consumer-, family- and provider-friendly resource information system including a web site that increases access to and information about a range of recovery-oriented services and appropriate behavioral, physical health and social service resources.*

Potential strategies that support the achievement of the goal include:

- Develop a new web site or expand an existing one to make it current, easy to navigate and available in multiple languages. The web site will contain materials that are appropriate for the ages and reading levels of children, adults and older adults. It will permit searches based on questions and have the potential for users to rate programs and services.
- Establish an oversight/governance committee to determine the content of the web site and review the web site links. The oversight committee will work with other web site development committees in the state. The oversight committee will determine issues related to the web site such as advertising, public awareness and locations for access (for example, clubhouses, shelters and libraries).
- Expand web-based resources used by telephone information systems that provide information to people who may not have access to the Internet.
- Launch advertising and marketing campaigns to enhance awareness.
- Launch several trainings to teach people in recovery and providers how to navigate the web site.

Potential GPRA Outcome Measures to be used in the evaluation process include:

- Evidence of a resource information system
- Evidence of a web site that contains information on a range of recovery-oriented services and appropriate behavioral, physical health and social service resources
- Increased number of hits on the web site
- Increased number of agencies listed on the web site
- Increased number of resources available on the resource list

Section 7: Connecticut Goal 7

Goal #7

Transform and Develop Connecticut's Workforce

In gathering information about the state of mental health care in America, the New Freedom Commission found evidence of diverse and substantial concerns about the behavioral health workforce. The New Freedom Commission wrote in its 2003 final report:

“The Commission heard consistent testimony from individuals in recovery, families, advocates, and public and private providers about the “workforce crisis” in mental health care. Today not only is there a shortage of providers, but those providers who are available are not trained in evidence-based and other innovative practices. This lack of education, training, or supervision leads to a workforce that is ill-equipped to use the latest breakthroughs in modern medicine.”

As this excerpt suggests, the New Freedom Commission recognized that the education, training, recruitment and retention of mental health leaders, professionals and personnel were essential elements of sustainable reform and a critical vehicle for transforming current systems of mental health care.

There are many reasons to believe that Connecticut is facing a workforce crisis of the kind described to the New Freedom Commission. Provider agencies report major difficulties in recruiting and retaining qualified employees, particularly in the private non-profit sector. There is a critical shortage of personnel trained and skilled in caring for special populations such as children, youth, young adults and elderly people. Today's mental health practitioners are far less diverse in their cultures and languages than the people they serve, raising concerns about the ability of the existing workforce to provide culturally relevant services. Higher education institutions and continuing education systems have had difficulty keeping pace with rapid changes in health care delivery. There is particular concern that recovery- and resilience-oriented approaches to care, and approaches in which providers and individuals in recovery share decision making, are not adequately taught in our training systems.

In applying for the MHT SIG, Connecticut identified workforce planning as an issue we wanted to pursue as we developed our Comprehensive Mental Health Plan. Specifically, we sought to assess the knowledge and training of our workforce, its capacity and its needs for

transformation to a recovery-oriented system of care. We also wanted to learn more about how various stakeholders perceive the needs surrounding workforce issues. To address these issues, we created a Workforce Transformation Work Group as one of seven work groups that have conducted planning as part of the MHT SIG.

(We should note that discussions about Connecticut's workforce were pervasive within the six other planning work groups, as well. These work groups also offered several workforce-related recommendations, many of which focused on training.)

The Workforce Transformation Work Group adopted a broad definition of "workforce." The definition included, of course, those people who are specifically trained and employed to provide mental health care. It also included other health and human services providers, state employees and individuals in recovery and family members. Individuals in recovery and family members have an enormous and too often unrecognized role in caring for themselves and others. People in recovery and parents of children with emotional health concerns contributed greatly to our planning efforts, particularly during a daylong retreat when work group members, staff and participants discussed special workforce concerns involving children, youth and families.

The work group divided its assessment of workforce needs into three areas: training and education, recruitment and retention. In discussing training and education, members explored issues such as training methods, content, student and teacher characteristics, sites, existing resources and how to ensure that new practices and attitudes remain in place over time.

Many recommendations were made in connection with training methods. Members suggested that multi-faceted, ongoing, strengths-based experiential training be provided on-site across all organizational levels. Other recommendations included: having people in recovery serve as trainers; increasing partnerships with higher education institutions, businesses and employers; and presenting training through multiple modalities, including web-based and team-training modules. Still other recommendations urged that training be multi-disciplinary, consolidated through one portal, and that it include group and individual supervision and a one-stop web site to link people to recovery services statewide.

In the area of training content, work group members gave highest priority to the following areas: leadership development; cultural competency; co-occurring disorders; evidence-based practices; psychiatric rehabilitation; assessment and treatment of young children and young adults with behavioral health needs; parenting skills; life span needs; forensic services; and pharmacology. Members also encouraged training in the areas of supervision, peer, person-centered and natural supports and recovery.

For students and teachers in the mental health field, recommendations were to: increase paraprofessional training; increase certified staff in prevention services; rely more on people in recovery to help train the workforce; and increase the number of bilingual, culturally-competent, licensed staff. Also, to: offer family supports; develop a training academy to credential mental health staff; offer career tracks for all staff, including people

in recovery; and increase staff knowledge and skills about mental health needs, services and treatment across the life span and for veterans and clients with co-occurring substance abuse and mental health disorders. Furthermore, according to the responses, training must be gender-responsive and trauma-informed. The workforce should be trained in forensic services, eating disorders, pervasive developmental disorders and autism spectrum disorders. Practitioners must be able to help sexual abuse victims and perpetrators and hearing-impaired clients, according to the work group recommendations.

Finally, the recommendations called for: offering training across state agencies that serve common populations; increasing technology transfer; increasing the relevance of graduate education to current practice; improving coordination and collaboration among educational institutions and the delivery system; partnering with unions; and providing clinical consultation to juvenile and adult courts.

Work group members gave a great deal of thought to how to systemically sustain the changes that result from education and training. Some suggestions included increasing organizational support for learning new practices and providing incentives and sanctions related to change. Other recommendations were to: provide continuous, integrated on-site training and development; provide across-level training for front-line staff, supervisors, leaders and people in recovery; assess training effectiveness and cost-effectiveness; develop state and non-profit cost-sharing partnerships; offer ongoing on-the-job supports for people in recovery in the workforce; link behavioral health clinics with primary care; increase course offerings for state and private non-profit employees; require leaders to spend time with their staff and individuals in recovery in order to understand workforce and customer concerns; and adopt a unified system for transferring knowledge about team leadership and supervision.

The work group conducted focus groups and interviews with individuals. Both sets of participants noted that valuable resources already exist to help transform the workforce. Among the resources are institutions of higher education; DMHAS's Education and Training Division, Prevention Division and Office of Multicultural Affairs; Department of Administrative Services Learning Center; Connecticut Council of Addiction Recovery; Connecticut Association of Addiction Professionals; Drug Abuse Rehabilitation Counselor Program; PRCH; New England School of Addiction Studies; Connecticut Community Provider Association; National Alliance for the Mentally Ill-Connecticut; Advocacy Unlimited; Focus on Recovery-United; Project for Addiction Cultural Competence Training; Connecticut Training and Development Network; and the MERGE Mental Health Certificate Program.

Transforming the staffing structures, composition and proficiencies of the behavioral health workforce is fundamental to the greater task of transforming Connecticut's mental health system. The recommendation below represents a starting point for addressing this critical agenda. A sustained effort to recruit, retain, train, supervise and support Connecticut's behavioral health workforce must be foremost among the state's priorities as it strives to improve access to compassionate and effective care.

Recommendation: *Train the mental health workforce and other health and human services personnel.*

Potential strategies that support achievement of this goal include:

- Develop and implement trainings in recovery-oriented services
- Develop and implement trainings on mental illness and co-occurring disorders
- Develop and implement employment trainings
- Develop and implement trainings on housing
- Develop and implement trainings on suicide prevention
- Develop and implement trainings on stigma reduction

Potential GPRA Outcome Measures to be used in the evaluation process include:

- Increased number and type of trainings developed
- Increased number and type of trainings implemented across state, across audiences
- Enhanced ratings of training satisfaction
- Increased number of individuals trained
- Increased knowledge in training areas

Section 8: Connecticut Goal

Goal #8

Protect and Enhance the Rights of Persons with Mental Illness.

After reviewing the data collected in the needs assessment and resource inventory process and our priority goals for transforming Connecticut’s mental health system we recognized the need to more sufficiently reflect the state’s commitment to the protection and enhancement of the rights of people with mental illness in our transformation efforts. In this section, we address recommendation 2.5 of the New Freedom Commission report, “Protect and enhance the rights of people with mental illnesses.”

As previously described, six of Connecticut’s work groups focused on one of six specific goals of the New Freedom Commission report. The work group that addressed the commission’s Goal #2 (*mental health care is consumer and family driven*) spent considerable time discussing the rights of people with mental illness. Here is an excerpt from the work group’s report:

“Under sub-goal 2.5 of the New Freedom Commission’s report are a number of objectives that speak to the rights and protections of persons with a psychiatric disability and children with serious emotional disturbances. Among these are: fully integrating individuals in recovery into their communities under (the 1999 U.S. Supreme Court ruling known as) *Olmstead*, (which stated that people with disabilities have the right to seek treatment in the least restrictive settings); eliminating conditions under which parents must forfeit parental rights so that their children with serious emotional disturbances can receive adequate mental health treatment; eliminating discrimination based on past assignment of a psychiatric diagnosis or mental health

treatment; and reducing the use of seclusion and restraint in mental health treatment settings.”

In 2003, after a *Hartford Courant* newspaper article brought to light the grim realities of using physical and chemical restraint for people with psychiatric disorders, SAMHSA’s administrator, Charles Curie, declared, "Seclusion and restraint should no longer be recognized as a treatment option at all, but rather as a treatment failure." SAMHSA set forth a vision and plan for reducing and ultimately eliminating seclusion and restraint from treatment settings for mental health and addiction disorders. The federal Centers for Medicare and Medicaid Services (CMS) also established standards for the use of seclusion and restraint in Medicaid- and Medicare-participating hospitals and psychiatric residential treatment facilities for people under age 21. Both sets of standards:

- prohibit the use of seclusion and restraint as coercion or discipline;
- exclude their use except to ensure safety in emergency situations (and then only using approved methods);
- require debriefing and reporting of any deaths with staff and individuals in recovery; and
- require staff education and training.

Connecticut and the rest of the nation since have examined their practices in the use of seclusion and restraint. Staff training and the adoption of revised protocols have cut back on the practices in Connecticut. Despite the success in lowering the overall number of hours that people in institutions spend in restraints, the discussion group expressed concern about whether the downward trends applied uniformly to all institutions in the state. Work group members noted that training exists for mental health personnel on how to de-escalate situations that can lead to the use of restraint. This training must be repeated to assure that continuous reinforcement of alternatives is part of a lasting institutional change, the work group members said.

The discussion also focused intensely on consumer-directed illness management. Self-management programs have been developed in recent years, with the most widely accepted being Mary Ellen Copeland’s Wellness Recovery Action Planning (WRAP). WRAP enables individuals in recovery to identify resources that will help with recovery, then create their own plan. Individuals in recovery generally are encouraged to develop a crisis plan that describes their treatment wishes during mental health emergencies. A WRAP is similar to an advance directive in that both provide a post-crisis plan for getting back on the road to recovery. Confusion exists as to the differences among advance directives, WRAP and person-centered planning. More training will help individuals in recovery distinguish among these mechanisms for conveying their personal treatment preferences in order to take full charge of their recovery. The discussion group also recommended that Connecticut establish a statewide advance-directives registry within the Secretary of the State’s office in collaboration with DMHAS and other relevant agencies.

As individuals in recovery become more involved in recovery planning and advance directives, they increasingly are using grievance processes and otherwise exercising their

rights. The discussion group recognized a need for advocacy assistance beyond what is reflected in or generated by individuals in recovery complaints. A more coordinated approach is needed to understand and uphold the rights of people with psychiatric disabilities, especially as new laws, including Public Act 06-195, expand the rules of health care decision-making in the state.

The discussion group also examined broader issues involving general knowledge of rights and protections, and compliance with the federal Americans with Disabilities Act (ADA). Currently in Connecticut, many people who have mental health disorders and their families, employers and health care professionals are not aware of ADA protections. Nor are many citizens aware of concepts of recovery, self-directed care or the importance of advance directives for mental health emergencies. People also lack knowledge about the Office of Protection and Advocacy for People with Disabilities (OPA) and other state agencies that provide information or help, the group said.

OPA provides legal assistance and advocacy services to disabled citizens in the state. In addition, an OPA-published booklet titled “Your Rights in a Psychiatric Facility” clearly describes a person’s rights associated with important topics such as medications, seclusion and restraint and filing a request to leave a facility. The booklet also provides instructions on how to file a grievance.

Another resource available to individuals in recovery/people in recovery is the Connecticut Legal Rights Project (CLRP), an independent agency that advocates for people with low incomes who have a psychiatric disability. Like OPA, CLRP offers legal and advocacy services.

The discussion group made the following recommendations:

1. Require all state agencies and any entity or individual contracting with the state or applying for licensure to provide mental health services to inform the people they serve of their rights regarding psychiatric disabilities.
2. Enforce full compliance with the ADA for all agencies in Connecticut.
3. Expand and strengthen the state OPA’s role in promoting empowerment and involvement of individuals in recovery.
4. Create an interagency of DMHAS, DCF, DOC the DPH and Commission on Aging (CoA), called the Joint Division of Community Education and Recovery Affairs, to better coordinate activities related to the rights and protections of people with psychiatric disabilities.
5. Promote the awareness and use of advance directives so that people with mental health disorders are better informed and able to communicate their preferred treatment choices.
6. Adopt a policy across all state agencies of a goal of zero-use of restraints as coercion or discipline in institutional settings.
7. Promote awareness of mental health rights and responsibilities through a coordinated and comprehensive media campaign.

Specific strategies under the first recommendation to require all state agencies and entities contracting with the state to inform the people they serve of their rights regarding psychiatric disabilities include:

- distributing copies of a handbook that contains a description of the rights of individuals in recovery and an agency's obligations to individuals in recovery under state and federal law;
- displaying posters describing individuals in recovery' rights under state and federal law; and
- developing a rights education plan for individuals in recovery, employees and community members that includes: a schedule for and description of how individuals in recovery will be informed of rights upon admission to a program and periodically thereafter; a description of training that will be provided to new and existing staff on an ongoing basis; and a schedule and description of trainings that will be provided to individuals in recovery and their supporters, along with a curriculum samples and other materials.

The work group devoted most of one meeting to discussing expanding and strengthening OPA's role in promoting empowerment, possibly through the use of more volunteer advocates. One strategy calls for posting notice of volunteer and paid positions in mental health facilities, social clubs and community newspapers. Another promotes seeking mental health individuals in recovery to fill vacancies on OPA's board of directors. Other suggested strategies include: hiring more individuals in recovery as staff in professional and para-professional positions; increasing the kinds and availability of advocacy services, including in the areas of advance directives, conservatorship and recovery and planning; and increasing publicity about OPA and its mission.

In a recommendation echoed in other discussion groups, the rights and protections discussion group urged the formation of an interagency committee to review current state agencies' mission statements, goals and strategic plans. This body, meeting regularly, would disseminate brochures and other literature and identify gaps and overlaps in protection and rights activities. It would develop ways to improve the state's system of rights and protections for individuals in recovery in an ongoing review of needs and applied solutions.

Finally, the discussion group recommended undertaking a media campaign to provide education about the rights of people with mental health concerns and their families, guardians and conservators. The media campaign also could educate citizens about advance directives, care and treatment planning options, grievance procedures and accessing advocacy services. Suggestions include hiring an advertising or media consultant and convening media work groups across the state whose members include an interagency rights specialist, media personnel, individuals in recovery and mental health advocates.

The work group, with guidance from the Oversight Committee, will reconvene to identify and more fully develop a plan to address how Connecticut will continue to protect and enhance the rights of people with mental illnesses.

Connecticut’s eight priority goals are listed in Table 8. Together they make up the state’s proposed Comprehensive Mental Health Plan. Table 8 also lists the associated strategies to achieve each goal, key stakeholder groups involved or affected, the time frame in which the recommendation will be implemented and the potential GPRA indicators to be used to evaluate outcomes.

Table 8: Elements of Connecticut’s Comprehensive Mental Health Plan

Goal	Recommendation	Potential Strategies/Actions	Stakeholders	Time line	Potential GPRA Outcome Measures
1	C. 1. Expand upon the suicide prevention guidelines issued by the Department of Education in 2004 by encouraging local school districts to disseminate and adopt suicide prevention and anti-stigma modules as part of comprehensive school health curricula.	<p>Implement suicide prevention and anti-stigma curricula in school health settings that:</p> <ul style="list-style-type: none"> include information about mental health, mental illness, risk factors and resources; are flexible- allowing modifications that address special needs of pre-schoolers, and elementary, middle and high school students; and consider cultural differences of families and communities in matters of mental health, mental illness, death and suicide. 	<ul style="list-style-type: none"> Children/Families State Department of Education Department of Children and Families Department of Public Health Local school districts 	Year 2	<ul style="list-style-type: none"> Increased number of schools that receive suicide prevention guidelines Increased number of schools that receive anti-stigma modules Increased number of people/schools/school districts receiving training in modules Increased number of schools/ school districts that adopt the modules
2	E. 1. Develop, implement and provide incentives to programs to adopt a recovery-oriented performance measures system, including a universal satisfaction survey (for children and adults), that is informed by individuals in recovery and their family and that provides feedback to individuals in recovery/families and programs on programs’ performance and outcomes.	<ul style="list-style-type: none"> Establish measures for a universal satisfaction survey using the Practice Guidelines for Recovery-Oriented Behavioral Health Care, associated principles of resiliency and the ERFS tool Individuals in recovery and professionals modify/adapt ERFS tool to reflect concerns relative to the age and stage of life of the person receiving services Capture non-identifiable demographic information on the universal satisfaction survey and use it as an adjunct to other data to assist in identifying and eliminating health disparities Engage consumer- and family-run businesses or organizations in designing and administering the surveys 	<ul style="list-style-type: none"> Individuals in recovery/Families Department of Children and Families Department of Mental Health and Addiction Services Court Support Services Division of the Judicial Branch Department of Mental Retardation Department of Veteran Affairs Commission on Aging Providers 	Year 2	<ul style="list-style-type: none"> Evidence of incentives to programs to adopt a recovery-oriented performance measure system that includes a universal satisfaction survey Increased number of agencies that use the recovery-oriented performance measurement system Evidence of the provision of feedback to individuals in recovery and families on program performance and outcomes Evidence of the provision of feedback to programs on programs performance and outcomes
3	E. 2. Develop an integrated information system across	<ul style="list-style-type: none"> Engage agencies in the analysis of their data to assess system-wide parity in access to services, and make 	<ul style="list-style-type: none"> Individuals in recovery/Families State Agencies 	Year 2	<ul style="list-style-type: none"> Evidence of an integrated information system across agencies, the judicial branch,

	agencies, the judicial branch, their providers and payers that establishes a uniform data collection system and uses common variables and data definitions to facilitate identification, monitoring and elimination of behavioral health disparities.	<p>needed adjustments to improve quality and outcomes and engagement and retention practices</p> <ul style="list-style-type: none"> • Establish and enforce, uniform standards for data collection to improve service quality related to mental health disparities • Create a statewide report that identifies current and projected trends related to behavioral health disparities 	<ul style="list-style-type: none"> • Providers 		<p>providers, and payers</p> <ul style="list-style-type: none"> • Evidence of a uniform data collection system • Increased number of agencies that are linked with the information system • Increased number of cross departmental/ cross agencies policies developed in relation to an integrated information system
4	F. 3. Increase timely access to services by maximizing Medicaid funding, identifying and addressing regulatory changes and waivers necessary to overcome policy barriers, leveraging federal matching reimbursement dollars, coordinating and aligning funding streams, and developing a reimbursement mechanism for prevention, screening, assessment, consultation, and treatment.	<ul style="list-style-type: none"> • Establish a work group of state agencies to leverage federal matching reimbursement dollars and coordinate and align funding streams • Identify and address regulatory changes and waivers to overcome policy barriers • Institutionalize contracting procedures and fee/reimbursement structures for eligible services • Conduct public information campaigns about the availability of reimbursable services for mental health individuals in recovery to providers, referral networks, parents and natural supports 	<ul style="list-style-type: none"> • Individuals in recovery/Families • Department of Social Services • Department of Insurance • Department of Children and Families • Department of Mental Health and Addiction Services • Department of Veteran Affairs • Office of Policy and Management • Commission of Aging • Providers 	Year 2	<ul style="list-style-type: none"> • Evidence of maximization of Medicaid funding • Evidence of leveraging of federal matching reimbursement dollars • Increased amount of federally matched reimbursement dollars • Evidence of a reimbursement mechanism for prevention, screening, assessment, consultation, and treatment
5	A. 5. Prevent or minimize further criminal justice involvement by creating systemic and policy changes to identify and divert children and youth involved in the juvenile and criminal justice systems into evidence-based prevention and intervention programs.	<ul style="list-style-type: none"> • Create an interagency task force to address identifying and diverting children and youth involved in the juvenile and criminal justice systems • Review and implement recommendations (specifically those that identify systemic barriers to using existing screening and assessment data and sharing data across agencies) from existing studies of children and youth involved in the juvenile justice system • State entities that serve children and youth involved in the juvenile and criminal justice systems continue to adopt evidence-based practices and early interventions that eliminate 	<ul style="list-style-type: none"> • Children/Families • Court Support Services Division of the Judicial Branch • Department of Children and Families • Department of Mental Health and Addiction Services • Legislators 	Year 2	<ul style="list-style-type: none"> • Increased number of evidence-based prevention and intervention programs in state • Number of at-risk individuals for criminal justice system • Increased number of at-risk individuals who were diverted into evidence-based programs • Increased number of policies, procedures, protocols related to CJ diversion • Increased number of juvenile justice diversion resources available • Increased proportion of

		<p>racial, ethnic and gender disparities</p> <ul style="list-style-type: none"> • Continue to adopt and disseminate early intervention and diversion strategies, such as community-based juvenile review boards • Blend funds among agencies to ensure a continuum of care and better serve children and youth • Promote interagency collaboration with an emphasis on young people who are making the transition to the adult system of care • Review and implement recommendations of the DCF/CSSD juvenile justice strategic plan that address access to resources, best practices, legal and ethical issues and data sharing among state agencies that serve youth and children involved in the juvenile justice system 			<p>at-risk individuals who were diverted into evidence-based programs</p> <ul style="list-style-type: none"> • Increased number of trainings offered in evidence-based prevention and intervention programs • Increased number of staff trained in diversion techniques
6	E. 3. Develop a consumer/family/provider-friendly resource information system including a web site that increases access to, and information on a range of recovery-oriented services, and appropriate behavioral, physical health and social service resources.	<ul style="list-style-type: none"> • Develop a new, searchable web site or expand an existing one to contain materials tailored for children, adults and older adults and with the potential for users to rate programs and services • Establish an oversight/governance committee to determine and periodically review the content of the web site and links • Expand web-based resources used by telephone information systems that provide information to people who may not have access to the Internet • Advertise and market the web site • Teach people in recovery and providers how to navigate the web site 	<ul style="list-style-type: none"> • Individuals in recovery/Families • State Agencies • Providers 	Year 2	<ul style="list-style-type: none"> • Evidence of a resource information system • Evidence of a web site that contains information on a range of recovery-oriented services and appropriate behavioral, physical health and social service resources • Increased number of hits on the web site • Increased number of agencies listed on the web site • Increased number of resources available on the resource list
7	C. 7. Train the mental health workforce and other health and human service personnel.	<p>Develop and implement trainings in:</p> <ul style="list-style-type: none"> • recovery-oriented services • mental illness and co-occurring disorders • employment 	<ul style="list-style-type: none"> • Individuals in recovery/Families • State Agencies • Providers 	Year 2	<ul style="list-style-type: none"> • Increased number/type of trainings developed • Increased number/type of trainings implemented across state, across audiences • Enhanced ratings of

		<ul style="list-style-type: none"> • housing • suicide prevention • stigma reduction 			<p>training satisfaction</p> <ul style="list-style-type: none"> • Increased number of individuals trained • Increased knowledge in training areas
8	Protect and enhance the rights of persons with mental illness.	To be developed.	<ul style="list-style-type: none"> • Individuals in recovery/Families • State Agencies • Providers • Advocacy Groups • Legislators 		<ul style="list-style-type: none"> • To be determined

In summary, we intend to begin the next phase of the transformation process with the following eight initial areas of focus:

- Prevent suicide and increase mental health awareness through health education in schools.
- Give individuals and families a voice regarding mental health services through a universal feedback tool.
- Identify and eliminate mental health disparities through standardized data collection.
- Expand access to prevention, screening, early intervention and treatment by maximizing state and federal dollars.
- Prevent youth from becoming involved in or having repeated involvement in the juvenile justice system through the use of evidence-based practices.
- Provide Connecticut citizens with a first of its kind comprehensive mental health website to improve access to mental health information and resources.
- Expand and enhance mental health training throughout Connecticut’s workforce.
- Protect and enhance the rights of persons with mental illness.

Section 9: Governance and Organizational Structure

SAMHSA has asked us to describe how our transformation effort will complement other mental health planning initiatives and sources of funding as Connecticut begins to adopt elements of the Comprehensive Mental Health Plan. Specifically SAMHSA has asked us to describe:

- how the stakeholders represented in transformation will work together to move the comprehensive plan forward; and
- how we will integrate the Mental Health Block Grant Planning and Advisory Council into our overall governance structure.

The governance and organizational structure developed during the first year of the MHT SIG and illustrated in Table 2 will continue throughout the remaining years of the grant. The structure may be modified as needed.

During the previous year, the transformation staff has coordinated with block grant staff in various ways. Block grant council members represent individuals in recovery and family members, providers, advocacy organizations and state agency employees. Council members have actively served on various transformation work groups. For example, the chairman of the block grant's Adult Planning Council is a member of the Mental Health Transformation Oversight Committee.

Furthermore, transformation staff members regularly have attended planning council meetings to make presentations and provide updates on the transformation efforts, and they attended the 2006 Annual Block Grant meeting. Transformation efforts were identified and incorporated into the Block Grant application recently submitted to the federal government for 2007 mental health funding.

We expect the levels of coordination and collaboration between transformation and block grant personnel only to increase as the state begins to implement the recommendations in the Comprehensive Mental Health Plan.

Next Steps

Soon after the state submits this plan to SAMHSA for approval, we will hold Town Hall meetings to share the plan with Connecticut citizens and seek additional information and feedback. A Town Hall event will occur "live" at one site. Through the use of videoconferencing technology, we will hold meetings simultaneously in at least one location in each of four other regions throughout the state. The live presentation will be projected on a screen at the remote sites, with the audio portion delivered through telephone lines. Members of the audience at any of the remote Town Hall sites may interact with the presenter.

We also will broadcast the Town Hall meeting over the World Wide Web. People will be able to "attend" the presentation by accessing it through the Internet as the event occurs. Video and audio portions will be available and people may submit e-mails to the presenter. The meeting will be archived on the web, and viewers may e-mail additional comments or questions through the archived version. We hope the use of this technology will encourage participation from people who otherwise would not attend because of time, distance or transportation hurdles.

We would like more individuals in recovery, family members and youth to participate in the effort to transform our mental health system. In particular, we plan to engage Connecticut's young people in the process by seeking their thoughts at already established youth groups and forums and offering meetings at times that do not conflict with school obligations. Meaningful participation of individuals in recovery, young people and families is central to our transformation effort and we will continue to welcome all those interested.

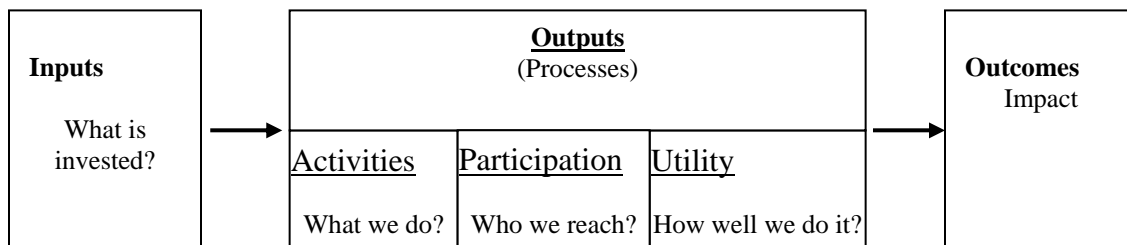
As we continue planning, we will reconvene the seven transformation work groups and ask them to further identify and refine strategies around the priority recommendations. We will ask them for specific ways to implement the strategies. Their work will yield plans with

information about funding levels and funding sources available or needed, detailed implementation steps, timelines, the names of the people and agencies whose participation will be needed and outcome measures. We will review, revise and validate the data collected in the Needs Assessment and Resource Inventory process in an ongoing way as we support the implementation and funding of the transformation initiatives.

The four subcommittees of the Oversight Committee will help and advise the work groups. The full Oversight Committee will monitor progress and report to the Office of the Governor, who remains in charge of the transformation effort. Just as the MHT SIG represents a continuous, multi-year effort, so will the evaluation process be a continuous, multi-year effort. The first year of evaluation will focus on inputs, activities, outputs and utilities. In subsequent years, evaluations will focus on implementation and the impacts of the changes to the way mental health services are delivered in Connecticut. Stakeholders, departments, individuals in recovery, family members and all participants in the transformation effort will be involved in evaluation activities.

A logic model will serve as the basis for an evaluation plan. It will require us to collect and review accurate, objective and timely data on an ongoing basis to ensure that transformation activities are adopted as planned and achieve the intended results. Periodic review of these data will allow for mid-course revisions. In this way, our approach can be flexible and responsive, and make the most efficient use of resources over time.

Figure 3: Logic model components



A logic model (Figure 3) is a representation of program inputs, outputs and expected outcomes, based on a program theory of change. Inputs refer to things such as staff, volunteers, time, money, materials, equipment, technology and partners that are invested in mental health transformation. Outputs include the *activities* conducted, the *people* who are targeted and an assessment of the *utility*, or usefulness, of the activities. *Activities* include workshops and meetings held, assessments, development of products and reports, media work and publicity, recruitment of participants and training. *Participation* refers to the people who are reached by the transformation efforts. They include individuals in recovery, family members, community members, providers and other key stakeholders. *Utility* refers to an assessment of how well the activities were conducted. Outcomes refer to short- and medium-term results and the long-term impact of the MHT SIG activities.

Upon federal approval of the Comprehensive Mental Health Plan, the evaluation team will articulate the anticipated activities and participation for Year 2 and beyond. The evaluation

plan in Years 2 through 5 includes process and outcome variables; it will be guided by the activities outlined in the Comprehensive Mental Health Plan. To evaluate progress toward the goals, the evaluation team will use timelines and checklists that contain targeted activities and dates, evaluation instruments to help departments with quarterly reporting requirements and annual reports.

We will develop, measure and evaluate performance goals on a quarterly basis as GPRA requires. GPRA data will be collected for the seven indicators that SAMHSA has provided. The quarterly reports will capture a program's success in achieving performance goals. The reports will outline performance goals for the following year, address unmet goals and describe the use and assess the effectiveness of achieving performance goals (linked to indicators and outcomes). The reports also will include a summary of findings that stem from evaluations of the programs.

The eight recommendations we describe in this plan represent only the beginning steps to a transformed mental health services delivery system in Connecticut. As we in the state begin to translate the eight goals into action, we are mindful that more than three dozen priority recommendations from the transformation work groups' efforts remain. We expect to turn our attention to them in the coming months and years. We also expect that areas of need or priority may change as the new vision for Connecticut's mental health system unfolds. Transformation, if successful, does not represent a finite process but one that is flexible, responsive and evolutionary. The opportunity presented by the MHT SIG has been transforming in itself. At no other time has such a large and diverse group of people with a stake in our mental health system come together to discuss a need as critical and exhilarating as transformation.

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APPENDIX 1: Impact and feasibility Rating Form

Recommendations	Feasibility							Impact							1: Specific Action?		2: Achieved at no cost?		3: Dynamic System or Process?		4: Sustainable?		
	Low ← → High							Low ← → High							Y	N	Y	N	Y	N	Y	N	
	1	2	3	4	5	6	7	1	2	3	4	5	6	7	Y	N	Y	N	Y	N	Y	N	
B. 3. Fulfill the continuum of care and enhance quality improvement initiatives by (2.8, 2.10): B. 3. a. employing self-identified persons in recovery and family members in the service system;																							
B. 3. b. supporting peer employment roles that allow opportunities to accumulate experience and education needed to advance along a career path;																							
B. 3. c. developing peer and family-operated programs to deliver mental health services.																							
B. 4. Co-locate developmentally-informed mental health professionals and resource coordinators and fund consultation-liaison arrangements to improve access to mental health prevention, screening, referral, consultation, and intervention services within early care, school, and primary care settings/systems. (4.2)																							
C. 1. Expand upon the Suicide Prevention Guidelines issued by the Department of Education in 2004 by encouraging local school districts to disseminate and adopt suicide prevention and anti-stigma modules as part of comprehensive school health curricula. (1.3)																							
C. 2. Develop and implement core competency curricula that address (3.5, 7.5, 7.8): C. 2. a. age and developmental stages;																							
C. 2. b. culture, race and health disparities;																							
C. 2. c. supervision in accord with a common set of standards.																							
C. 3. Develop a culturally and linguistically diverse workforce by offering (3.6, 3.7 part 3, 7.4): C. 3. a. loan forgiveness programs to providers in rural communities and designated Health Professional Shortage Areas;																							
C. 3. b. leadership development opportunities; scholarships, training stipends, and other incentives.																							

Recommendations	Feasibility							Impact							1: Specific Action?		2: Achieved at no cost?		3: Dynamic System or Process?		4: Sustainable?		
	Low ← → High							Low ← → High							Y	N	Y	N	Y	N	Y	N	
	1	2	3	4	5	6	7	1	2	3	4	5	6	7	Y	N	Y	N	Y	N	Y	N	
C. 4. Develop curricula to implement broad-based training opportunities for the public on (4.5, 6.6): C. 4. a. Suicide;																							
C. 4. b. Stigma;																							
C. 4. c. The availability of mental health services/resources, the use of technology to access information and coordinate mental health care.																							
C. 5. Create a <i>Connecticut Behavioral Health Workforce Collaborative</i> charged with planning, coordinating, and implementing interventions to strengthen the workforce such as “Centers for Excellence” serving as regional resources in behavioral health practices. (7.1, 7.9)																							
C. 6. Create and implement a web-based training system for the specialty workforce, other health and human service personnel, persons in recovery, children, youth, and families. (7.7)																							
C. 7. Train the mental health workforce and other health and human service personnel in (1.3, 1.4, 2.17, 3.3, 4.5, 7.6): C. 7. a. recovery-oriented services;																							
C. 7. b. mental illness and co-occurring disorders;																							
C. 7. c. racism prevention;																							
C. 7. d. employment;																							
C. 7. e. housing;																							
C. 7. f. suicide;																							
C. 7. g. stigma.																							
D. 1. Convene a high level (Governor endorsed and appointed) statewide MH Anti Stigma Task Force to conduct an annual policy review and propose a set of policy recommendations that if enacted serve to reduce stigma and eliminate barriers to employment, housing and overall community integration. (1.1)																							

Recommendations	Feasibility							Impact							1: Specific Action?		2: Achieved at no cost?		3: Dynamic System or Process?		4: Sustainable?	
	Low ← → High							Low ← → High							Y	N	Y	N	Y	N	Y	N
	1	2	3	4	5	6	7	1	2	3	4	5	6	7	Y	N	Y	N	Y	N	Y	N
D. 2. Increase levels of interagency coordination by leveraging community-based employment resources, identifying and disseminating best practices across all systems (DMR, DCF, BRS, DMHAS, DOL), and building transition protocols between key agencies. (2.14)																						
D. 3. Make decent, safe, affordable housing units available statewide by developing a statewide resource list and collaborating with existing advocacy efforts. (2.16)																						
D. 4. Establish a State Office of Multicultural Affairs and allocate at least one FTE in each state agency to promote quality assurance; develop, train, oversee, and coordinate cultural competence initiatives across State agencies and State funded service providers. (3.1, 3.2)																						
D. 5. Establish a model and conduct a public information campaign about the availability of a coordinated interagency collaboration that builds upon the existing system of care that is comprehensive, coordinated and consumer-driven and flexible. (4.3)																						
D. 6. Create a state-wide center for the identification, promotion and implementation of evidence-based and “effective” practices for mental health services across the lifespan. (5.4)																						
E. 1. Develop, implement and provide incentives to programs to adopt a recovery-oriented performance measures system, including a universal consumer satisfaction survey (for children and adults), that is consumer and family informed and that provides feedback to consumers/families and programs on programs’ performance and outcomes. (2.5, 6.5)																						
E. 2. Develop an integrated information system across agencies, the judicial branch, their providers and payors that establishes a uniform data collection system and uses common variables and data definitions to facilitate identification, monitoring and elimination of behavioral health disparities. (3.4, 6.2)																						

Recommendations	Feasibility							Impact							1: Specific Action?		2: Achieved at no cost?		3: Dynamic System or Process?		4: Sustainable?			
	Low ← → High							Low ← → High							Y	N	Y	N	Y	N	Y	N		
	1	2	3	4	5	6	7	1	2	3	4	5	6	7										
E. 3. Develop a Consumer/Family/Provider–friendly resource information system including a web site that increases access to, and information on a range of recovery-oriented services, and appropriate behavioral, physical health and social service resources. (2.12, 6.4)																								
E. 4. Create and implement a single portable Electronic Medical Records/Electronic Health Records EMR/EHR including advanced directives and the ability to obtain/coordinate consumer/family/provider input. (6.3)																								
E. 5. Increase accountability through the measurement and tracking of employment outcomes. (2.15)																								
F. 1. Design and pilot a flexible funding system in order to implement a consumer-driven (self-directed) service delivery system for adults with mental illnesses and children with serious emotional disturbances using lessons learned and models employed from national pilots (SAMHSA-funded) and the Department of Mental Retardation (DMR). (2.3, 2.6)																								
F. 2. Ensure the availability, accessibility and quality of behavioral healthcare in rural and remote geographical areas, and among populations for whom barriers impede access to care, by providing reimbursements for innovative technologies such as telemedicine mobile health vans, interpreters, and non-traditional services such as outreach provided by community health workers. (3.7 parts 1&2)																								
F. 3. Increase timely access to service by maximizing Medicaid funding, identifying and addressing regulatory changes and waivers necessary to overcome policy barriers, leveraging federal matching reimbursement dollars, coordinating and aligning funding streams, and developing a reimbursement mechanism for prevention, screening, assessment, consultation, and treatment. (4.4, 5.5)																								

Recommendations	Feasibility							Impact							1: Specific Action?		2: Achieved at no cost?		3: Dynamic System or Process?		4: Sustainable?			
	Low ← → High							Low ← → High							Y	N	Y	N	Y	N	Y	N		
	1	2	3	4	5	6	7	1	2	3	4	5	6	7										
G. 1. Establish and promote a statewide consumer advocacy movement. (2.4)																								
G. 2. Increase the number and percentage of persons in recovery and family members at all levels of the public and private behavioral health workforce. (7.2)																								
I. 1 Develop, implement, and evaluate multi-faceted awareness campaigns to (2.3, 2.16, 2.25, 7.3): I. 1. a. Promote awareness of mental health rights and responsibilities.																								
I. 1. b. Increase recruitment of behavioral health workers by implementing a multi media campaign that highlights career and job opportunities in behavioral health;																								
I. 1. c. Promote the positive role of employment in recovery, assist consumers in advancing in their careers, and increase the visibility of employment opportunities.																								
J. 1. Charge existing suicide prevention networks and advisory boards with identifying state/federal funds currently available for suicide prevention activities and implementing and evaluating a statewide suicide prevention campaign based on the strategies and recommendations from the State’s Comprehensive Suicide Prevention Plan developed in 2005 by the Inter-Agency Suicide Prevention Network. (1.2)																								

Name of Oversight Committee member responsible for the completion of this form: _____

Total number of Stakeholders providing input to support the completion of this form: _____

Please provide us with some detail regarding your agency’s stakeholder group by checking which of the following constituencies were included:

State agency employees _____ Consumers/Family/Youth _____ Private sector agencies/programs _____ Advocacy Groups _____