

State of Connecticut



Mental Health Needs Assessment and Resource Inventory

Summary Report

State of Connecticut
Mental Health Transformation State Incentive Grant
Grant # SM54456-02

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I. Introduction

This Summary Report reflects Connecticut's most ambitious effort to date to assess the scope of mental health services the state provides to its citizens and to identify areas of need. The information in this report was gleaned from reviewing more than 165 existing state reports, surveys, and other documents, conducting new surveys and studies, and assessing expenditures related to mental health services provided by 14 state agencies and the Judicial Branch. It is important to keep in mind that the report presents only a snapshot of these assets and needs, as it is impossible to capture in a fixed document the organic nature of a public mental health system subject to funding, policy, and other decisions at various levels of government.

The Mental Health Needs Assessment and Resource Inventory came about as part of a federal grant awarded to Connecticut and six other states to help jump-start a fundamental overhaul in the way Americans view, deliver, and receive mental health care. The overhaul has its roots in a Presidential commission on mental health that was established in 2002 to study the condition of the mental health care delivery system across the nation.

In 2003, the New Freedom Commission on Mental Health released its groundbreaking report to the President. The report 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.

A transformed mental health system, according to the New Freedom Commission, is one in which the following six goals are met:

- 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.

To help achieve these overarching goals, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in 2005 awarded the seven states, including Connecticut, a Mental Health Transformation State Incentive Grant (MHT SIG). SAMHSA requires that the grant money be used to assess the states' 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 enables Connecticut to continue moving toward a recovery- and resilience-oriented system for its citizens, one which restores or develops a positive and meaningful sense of one's identity apart from one's condition. The state's work toward this goal began in earnest in 2000, when the Governor appointed a Blue Ribbon Commission on Mental Health to explore concerns about the provision of mental health services in Connecticut. Representatives of public and private mental health service providers came together for the first time with people who use those services, their family members, and a wide array of other stakeholders to examine the state's mental health system.

The initiative was responsible for several significant steps forward in articulating and implementing a recovery- and resilience-oriented system of mental health care. Two years after the Blue Ribbon Commission's work, for example, the word *recovery* formally made its way into Connecticut policies when the Commissioner of the Department of Mental Health and Addiction Services (DMHAS) issued Policy Statement #83. It states that "the concept of recovery shall be the guiding principle and operational framework for the system of care provided by the partnership of state and private agencies and services operated by individuals in recovery that comprise the Department's healthcare system. Services within this system shall identify and build upon each recovering individual's strengths and areas of health in addressing his or her *needs*."

Today, with guidance from Connecticut Governor Jodi Rell, 14 state agencies and the Judicial Branch are using the MHT SIG grant to build on these previous efforts and work as never before to achieve seismic shifts in attitudes and practices around mental health care in the state.

As part of the MHT SIG process, SAMHSA required the state to draft a Comprehensive Mental Health Plan, which Connecticut submitted to the federal agency in September 2006. SAMHSA also requested that the state conduct a comprehensive inventory of its mental health resources and assess its mental health needs. This report summarizes the most salient findings about Connecticut's existing mental health resources and the strengths and identified needs of its mental health system.

To guide its transformation process, Connecticut formed an Oversight Committee comprising individuals in recovery, family organizations, leaders from 14 state agencies and the Judicial Branch, advocacy groups, hospitals, and private nonprofit organizations. Six Transformation Work Groups were formed; they are consistent with and named for each of the six New Freedom Commission goals. Connecticut also recognized that workforce development and training are critical to transforming the state's mental health system and formed a seventh work group, the Workforce Transformation Work Group, to address that topic.

The main purpose of this summary of the Needs Assessment and Resource Inventory is to inform the work of the Oversight Committee, the seven core Transformation Work Groups, and the state's newly formed Consumer/Youth/Family Advisory Council. Members of these groups can use the report to identify additional data and information they will need as they move forward in their work to achieve the New Freedom Commission goals, as expressed through recommendations listed in the state's Comprehensive Mental Health Plan.

This document is an important resource for all who are committed to Connecticut's transformation effort. The information in this report may be a catalyst for new ideas as Connecticut continues toward its vision for its mental health system: 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.

II. Methodology

Several comments about methodology need to be made. First, the information in this report has been compiled from multiple sources over an extended period. The summarized findings about the state's mental health resources and about the strengths and identified needs of its mental health system emerged from the following sources:

- an extensive review of more than 165 existing reports related to Connecticut's mental health system from state agencies, commissions, and interagency task forces;
- surveys, interviews, and document reviews of 14 state agencies and the Judicial Branch;
- interviews with a sample of Connecticut households;
- a probabilistic population estimation (PPE) of overlap between state agency service recipients;
- an assessment of provider and consumer perspectives on the current service system;
- a survey of parents and of providers of children and family services related to MHT SIG recommendations;
- an assessment of workforce development needs; and
- a thorough inventory of resources that details the mental health expenditures of each state agency that signed the MHT SIG Memorandum of Agreement.

Much of the data gleaned from the first bulleted item above – the more than 165 existing reports from state agencies, commissions, and interagency task forces – are historical in nature and may not represent current realities. MHT SIG staff limited the review of state literature to reports issued since 2000 to keep the focus on recent efforts. But many things have changed or begun to change since then. When possible, findings were updated with more recent data. It is important to view the Needs Assessment and Resource Inventory as a “living” document that will continue to be informed and expanded throughout the transformation process.

Second, the information in this report is organized and presented in relation to each of the six New Freedom Commission goals. There are areas of overlap among the goals, of course, but efforts were made to reduce redundancy. When this was not possible, information was cross-referenced across multiple goals.

Finally, while the information in this report is aggregated at the state level, the materials were compiled from distinct state agencies, divisions, and departments. Information at a more detailed level from these entities may be available to further assist the transformation groups. There is a note of caution, however: Because the entities do not necessarily use common data elements, it may not be possible to answer all questions at all levels of detail or to definitively compare the data across the board.

The most significant findings generated by the multiple instruments and methods used to compile the data are described in the following section under two main headings. The first heading (III.A.) addresses the findings from the Resource Inventory. The second heading (III.B.) presents the findings of the Needs Assessment, organized according to the six New Freedom Commission goals.

III. Needs Assessment and Resource Inventory

As part of the MHT SIG, SAMHSA required Connecticut to conduct a thorough Resource Inventory and a comprehensive Needs Assessment that detail the existing mental health assets and needs in the state. The information was collected from the following 15 state agencies, divisions, and departments, which were signatories to the MHT SIG Memorandum of Agreement:

Commission on Aging (CoA), the agency that advocates on behalf of elderly people and which monitors the impact of current and proposed initiatives;

Connecticut Insurance Department (CID), the agency responsible for administering and enforcing the state's insurance laws and which licenses insurers, health care centers, and provider networks;

Department of Children and Families (DCF), the agency that provides behavioral health services for children and youth and which administers child protective services;

Department of Corrections (DOC), the agency that oversees the supervision of offenders and efforts to reintegrate released offenders into the community;

Department of Higher Education (DHE), the statewide coordinating and planning authority, as overseen by the Board of Governors for Higher Education, for Connecticut's public and independent colleges and universities;

Department of Information Technology (DOIT), the agency that leads state entities in the effective use of technology;

Department of Labor (DOL), the agency that protects and promotes the interests of workers in the state;

Department of Mental Health and Addiction Services (DMHAS), the state mental health authority and single state agency that administers the public behavioral health system of care for adults;

Department of Mental Retardation (DMR), the agency responsible for providing services across the life span to people with mental retardation;

Department of Public Health (DPH), the agency responsible for public health policy and advocacy and which provides a network of health services;

Department of Social Services (DSS), the agency that provides services to elderly people, people with disabilities, families, and individuals, and that administers the Medicaid program in Connecticut;

Department of Veteran Affairs (DVA), the agency that provides health, social, and rehabilitative services to veterans;

Office of Policy and Management (OPM), Connecticut's budget agency, which provides information and analysis to the Governor and assists state agencies in implementing policy decisions;

State Department of Education (SDE), the agency that promotes a public educational system that supports all learners in reaching their full potential; and

Court Support Services Division of the Judicial Branch (CSSD), the division that oversees intake, assessment, and supervision services for court-involved youth and adults.

III.A. Resource Inventory

To understand the scope of Connecticut's existing mental health resources, fiscal representatives from the 15 state entities collected 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.

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To compile the Resource Inventory in a consistent format and to identify and eliminate duplicated information, MHT SIG staff worked with the National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc.

For SFY 2005, state government behavioral health-related expenditures totaled \$1.68 billion. That figure includes expenditures for services related to behavioral health, mental health, substance abuse, and co-occurring mental health and substance abuse conditions paid for by the following 12 agencies: CSSD/Judicial, DCF, DMHAS, DMR, DOC, DOIT, DOL, DPH, DSS, DVA, OPM, and SDE. The \$1.68 billion in expenditures supported a variety of prevention, education, and direct services, including inpatient and other 24-hour care, to 962,760 persons of all ages.

For a more precise estimate of mental health expenditures, it is necessary to subtract out the cost of providing substance abuse education to school children under the Safe and Drug Free Schools Program. Removing that program from the calculation reduces expenditures by \$3.2 million and the number of people served by 573,000. Net expenditures, then, totaled \$1.67 billion, and the number of persons served statewide totaled 389,760.

That client count, however, may be higher than the actual number of persons served because of the inclusion of duplicated data. For example, a client who has multiple episodes of care or who receives care from more than one state entity may be counted more than once. So the number of clients served may be less than 389,760. All attempts have been made to reduce duplicated counts, but because the parameters of data collection vary among state entities, duplication likely exists.

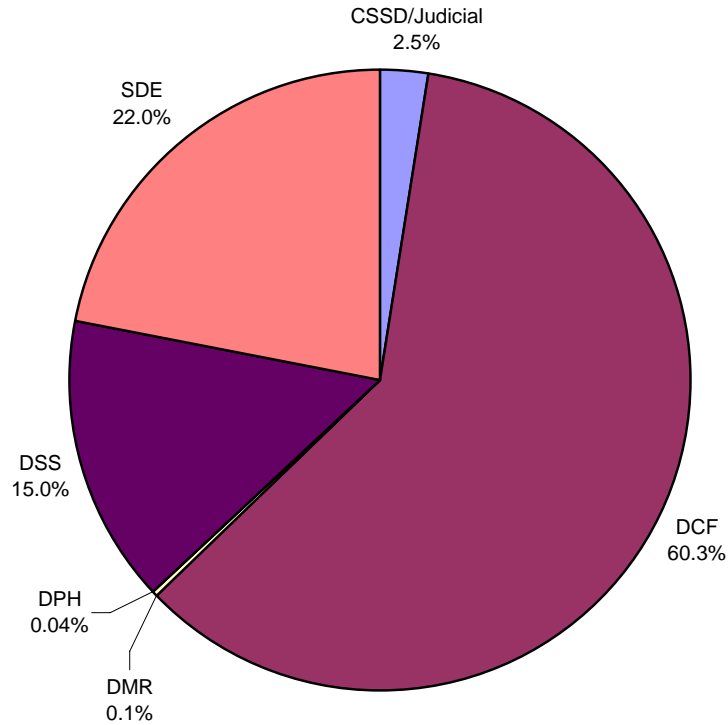
Dividing the \$1.67 billion in expenditures by the 389,760 individuals served yields an annual per capita behavioral health-related expenditure of \$4,300. Subtracting out duplicated client data would yield a higher per capita spending figure.

The following charts display the expenditures of the \$1.67 billion across service types and indicate that:

- DCF, DSS, and SDE account for virtually all expenditures for children's services (Figure 1);
- DMHAS and DSS account for the majority of expenditures for adult services (Figure 2);
- Inpatient and other 24-hour care (such as services received in a crisis stabilization unit, skilled nursing facility, residential treatment center, therapeutic group home, halfway house, etc.) consume 54% of the total \$1.67 billion (Figure 3);
- Administrative costs total 4%, leaving the majority of funds available to purchase direct services (Figure 3); and
- DMHAS, DCF, and DSS expenditures for all age groups combined account for 84% of the total (Figure 4).

Figure 1. FY'05 Connecticut Mental Health and Substance Abuse Expenditures by State Agency: Children Under Age 18*

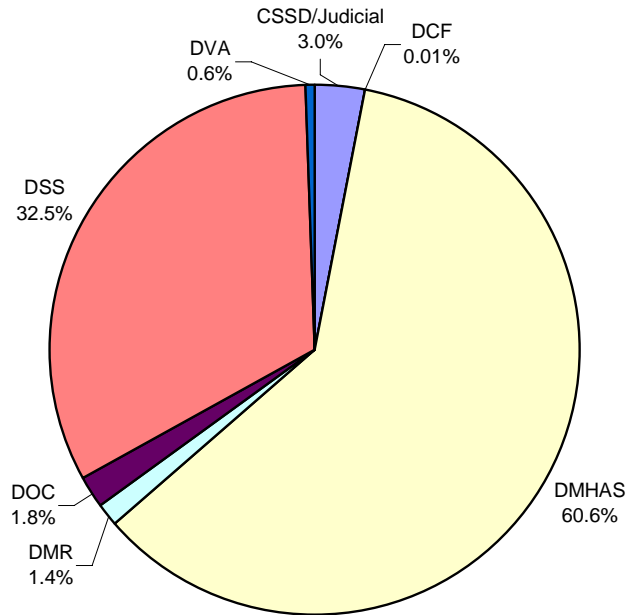
Total Expenditures = \$683.3 Million



* Some state agencies children's counts start at age 16 or 17 years old. Figure excludes agency expenditures not identified by age.

Figure 2. FY'05 Connecticut Mental Health and Substance Abuse Expenditures by State Agency: Adults Age 18 and Over*

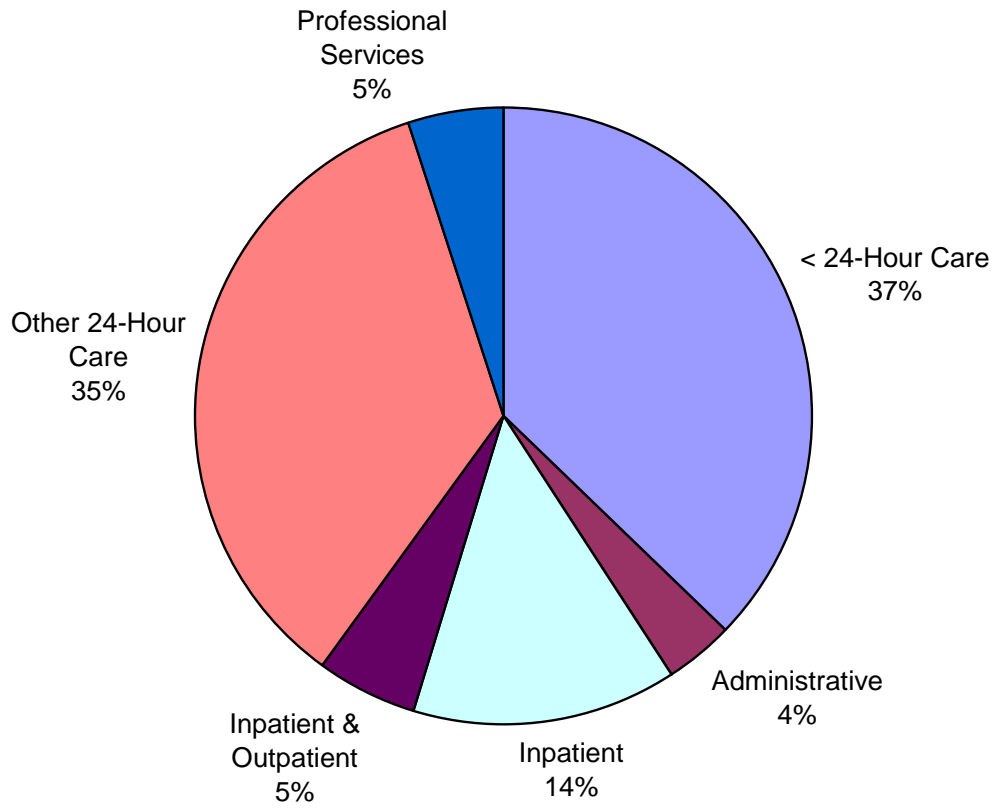
Total Expenditures = \$964.2 Million



* Some state agencies children's counts start at age 16 or 17 years old. Figure excludes agency expenditures not identified by age.

Figure 3. FY'05 Connecticut Mental Health and Substance Abuse Expenses by Service Category*

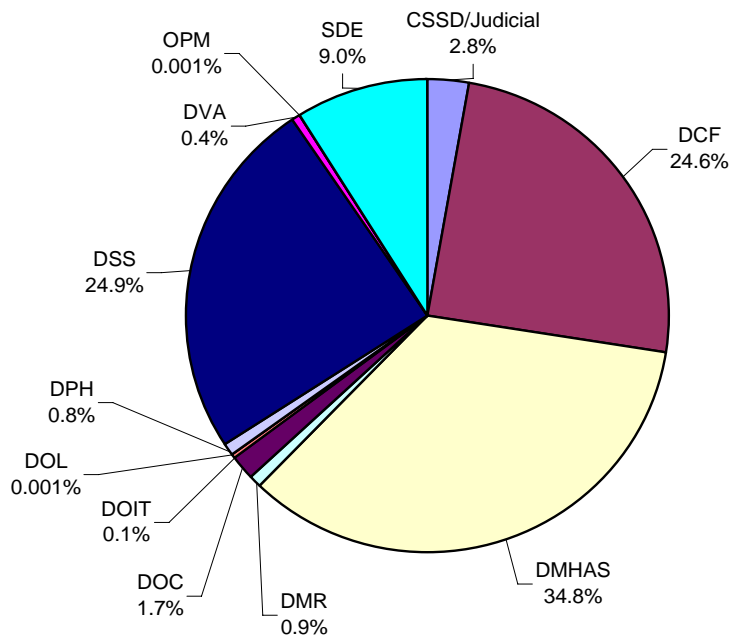
Total Expenditures = \$1.68 Billion



* The category "Inpatient & Outpatient" reflects data that were unable to be identified separately.

Figure 4. FY'05 Connecticut Mental Health and Substance Abuse Expenditures by State Government Agency

Total Expenditures = \$1.68 Billion



III.B. Needs Assessment

The Needs Assessment essentially is a look at the mental health landscape in Connecticut and involves identifying the services, activities, and programs that exist and that are lacking for the state's citizens. The Needs Assessment was conceptualized as spanning three levels or groups: individuals and families receiving care; mental health providers and agencies; and general citizens of Connecticut.

One component of the assessment involved reviewing all available reports since 2000 from state agencies, commissions, and interagency task forces, and other stakeholders. More than 165 such documents were reviewed. They contained 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. This information was categorized into 34 topic areas that coincided with the subgoals and priorities outlined in the New Freedom Commission report.

In addition, several other tools and instruments were used to help identify where the needs exist in Connecticut's mental health system. For the different groups, the following special efforts were undertaken (with the findings described Section IV):

- **Individuals and families receiving care.** DCF conducted a Mental Health Transformation Survey, which solicited information and views from parents and providers on how to improve the state's mental health infrastructure. Also, MHT SIG staff relied on an innovative measure, called Elements of a Recovery Facilitating System (ERFS), to better understand the needs and perspectives of adult service recipients.
- **Mental health providers and agencies.** DMHAS issued its Agency Recovery Self-Assessment to providers statewide and received 114 completed surveys.
- **General citizens.** The University of Connecticut's Center for Survey Research and Analysis surveyed Connecticut citizens to better understand where people turn for help with mental health concerns and collected 557 responses.

Data from each level were collated and analyzed according to the six New Freedom Commission goals and their accompanying themes, described in Table 1 below.

Table 1. President’s New Freedom Commission Goals Defined

NFC 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; Consumer and family involvement 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 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 that 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

IV. Major Findings from Additional Studies

MHT SIG staff undertook several collection and analytic activities to gather additional information for the Needs Assessment. What follows are descriptions of each of six additional surveys, evaluations, or instruments, along with the important findings.

IV.A Probabilistic Population Estimation

The Probabilistic Population Estimation (PPE) is a statistical procedure that helps to identify overlap among populations. The MHT SIG staff wanted to know how many clients who receive mental health services from DMHAS also receive other services that are publicly funded, such as services through Medicaid. (In estimating the number of people who are represented in data sets, the PPE uses no unique personal identifiers.) The staff collected data sets from the following sources: DMHAS, DCF, the Department of Correction (DOC), State Administered General Assistance (SAGA), Temporary Assistance to Needy Families (TANF), the Department of Mental Retardation (DMR), and the Department of Social Services, which oversees the Medicaid program in Connecticut (DSS-Medicaid). Bristol Observatories performed the PPE procedures.

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The Yale Program for Recovery and Community Health (PRCH) evaluation team provided further analysis.

The data sets involved adults only, and separate comparisons were made between DHMAS and each of the six entities. Comparisons among all the entities were not made.

The PPE findings for 2004 and 2005 are presented in Table 2. The area of greatest overlap was with the Medicaid program: 43% of DMHAS clients also received Medicaid benefits in 2005. That year, DMHAS clients received services from other state departments at rates ranging from 1% to 13%. The overlaps highlight the need for a more integrated and coordinated service-delivery system.

Table 2. Probabilistic Population Estimation Results

	2004			2005		
	N	% Caseload Overlap		N	% Caseload Overlap	
		% of MH	% of Data set		% of MH	% of Data set
Data sets*						
TANF	1,386	3%	5%	1,311	3%	5%
SAGA-Medical	5,319	13%	11%	5,599	13%	10%
Abuse/Neglect Perpetrators (DCF)	1,647	4%	5%	1,525	4%	6%
DOC	2,898	7%	10%	3,235	7%	12%
Arrests	4,227	10%	6%	*	*	*
Probation	2,284	6%	8%	2,388	6%	8%
DMR	621	2%	5%	629	1%	5%
DSS-Medicaid	18,070	44%	7%	18,505	43%	7%

* data not available for year 2005 at the time of this report

In looking at more detailed information, the PPE analyses also show that from 2004 to 2005 there was an increase in the number of DMHAS clients who also were likely to be receiving services from DOC. When the PPE information is broken down further by age categories, the largest gain in percentage overlap between DMHAS and any of the agencies studied occurred with DOC. The percentage of DMHAS clients ages 30 to 39 who also used DOC services rose from 8% in 2004 to 12% in 2005. This finding suggests an increasing rate of incarceration for DMHAS clients in their 30s. One interpretation might be that there has been some improvement in identifying individuals with mental health needs while in DOC custody, and thus individuals are becoming linked at a higher rate to mental health services upon release.

Furthermore, in 2004, 17% of DMHAS clients ages 18 to 29 were highly likely to be identified in the arrest data set. Taken together, the arrest and DOC findings suggest an increased need for greater jail-diversion and prevention efforts during the early adult years and for early identification and coordination of mental health services for inmates while they are in prison and upon release.

IV.B 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 the following: 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 members; any efforts to seek help, including from whom and the degree of satisfaction with the help received; barriers to receiving help; and recommendations for transforming the mental health system. The University of Connecticut’s Center for Survey Research and Analysis administered the survey. No identifying information was collected from respondents.

The final survey of 557 citizens includes a sample of the general population and an oversample 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.

Table 3 suggests that the survey sample succeeded in approximating the demographic distribution of Hispanics and in overrepresenting residents who described themselves as Black/African American or Other, when compared to reports of the demographic distribution within the state.¹ There was, however, an underrepresentation of men (30%).

Table 3. Demographic Profile of Respondents

Demographic	N	%	Demographic	N	%
Gender			Geographic Residence		
Male	165	30%	Urban	171	31%
Female	392	70%	Suburban	254	46%
Age			Rural	132	24%
18-29 years	67	13%	Educational Level		
30-39 years	86	16%	Grade school or less	18	3%
40-49 years	112	21%	Some high school	23	4%
50-59 years	126	23%	High school	134	24%
60-69 years	71	13%	Some college	162	29%
70-79 years	49	9%	College graduate	123	22%
80 years and older	27	5%	Postgraduate	93	17%
Race/Ethnicity			Refused	4	1%
White/Caucasian	408	73%	Work Status		
Black/Afr. American	75	14%	Full-time	289	52%
Other	67	12%	Part-time	82	15%
Don’t know	1	0	Not working	183	33%
Refused	6	1%	Refused	3	1%

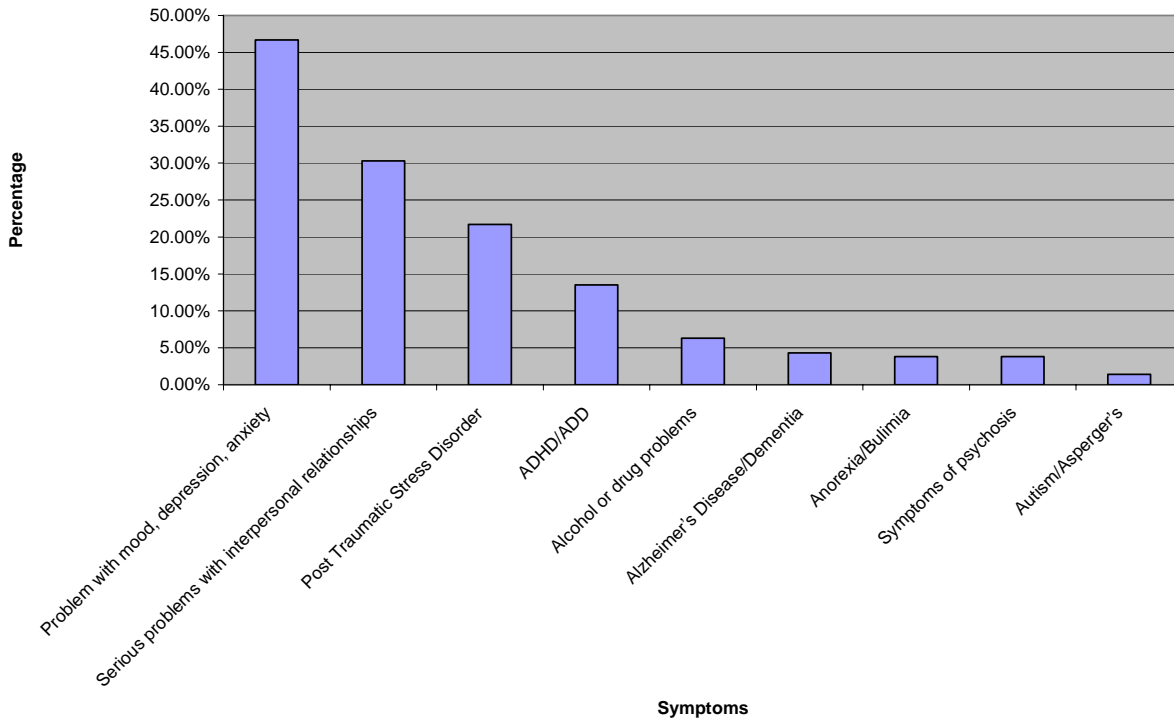
¹ <http://quickfacts.census.gov/qfd/states/09000.html>- According to the 2005 census, Connecticut citizens were reported to be 84.9% Caucasian; 10.9% Hispanic origin; 10.2% Black; 5% Other.

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Hispanic origin			Income		
Yes	57	10%	Less than \$20,000	67	13%
No	498	89%	\$20,000 to \$39,000	88	18%
Refused	2	0	\$40,000 to \$74,000	125	25%
			More than \$75,000	181	36%
			Refused / Don't know	39	8%

Results from the survey revealed that 63% of the respondents reported experiencing mental health symptoms in at least one diagnostic category. As described in Figure 5, respondents reported rates of mood and anxiety disorders (47.2%) and posttraumatic stress disorders (PTSD, 21.8%) that were higher than expected, based on national norms. These rates are worthy of further exploration.

Figure 5: Respondents Endorsed Psychiatric Symptoms

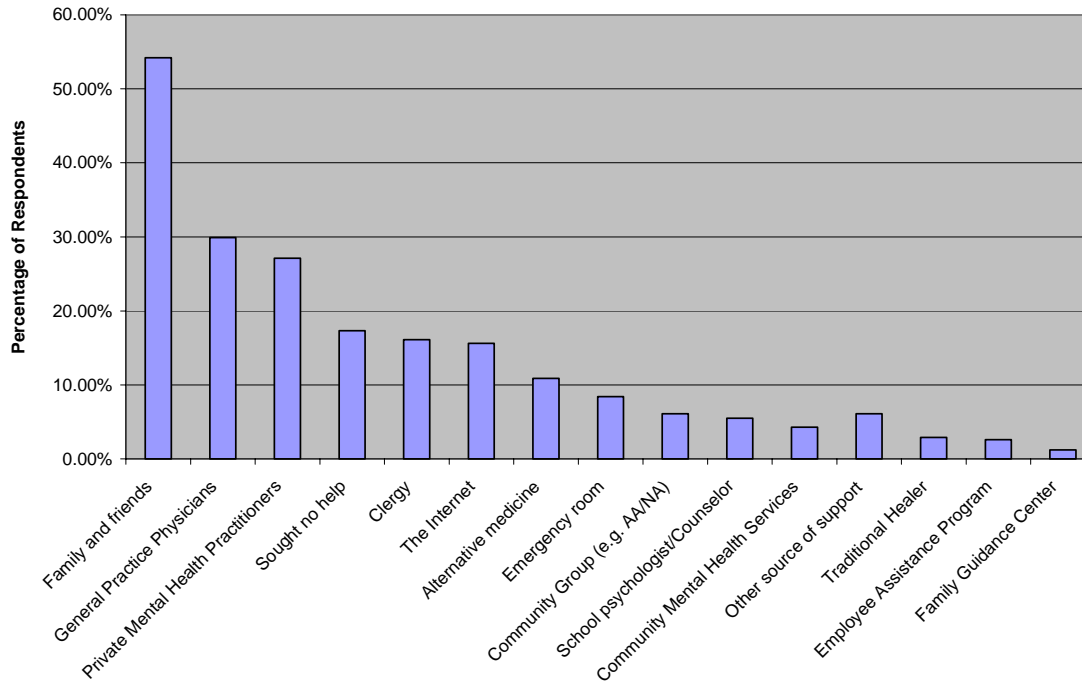


Respondents were asked about their efforts to seek help, including from whom and the degree of satisfaction with the help they received. As Figure 6 shows, the most striking finding in relation to help-seeking is that almost one of five respondents (17.8%) who reported experiencing psychiatric symptoms sought no help whatsoever. Furthermore, the majority of people who did seek help turned not to mental health professionals but to family and friends (54.2%) and general practice physicians (29.9%). Private mental health practitioners were sought by 27% of

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respondents. Clergy (16.1%) and the Internet (15.6%) were ranked next highest. Finally, emergency rooms/hospitals, school-based health care providers, community mental health centers, and self-help groups each were endorsed by less than 10% of respondents.

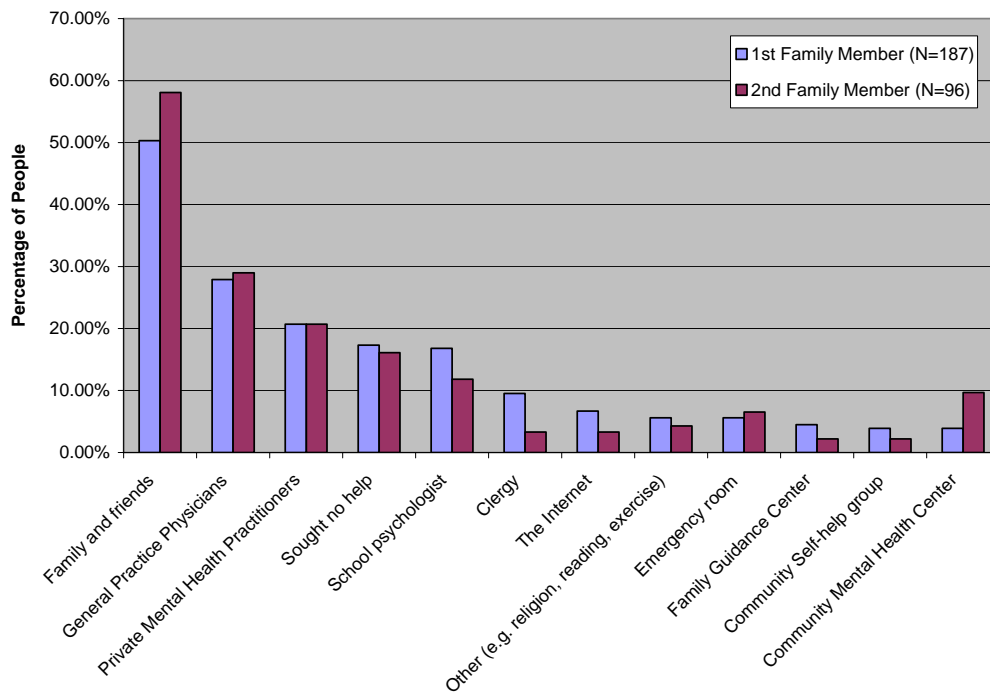
Figure 6: Where Respondents Turned for Help
N=349



Respondents also were asked to identify up to two additional household members and to provide information about these members' experience of symptoms and help-seeking behaviors. Household members were reported to have lower rates of psychiatric symptoms than the respondents themselves. For example, respondents reported experiencing mood or anxiety disorder symptoms at a rate of 47%, as compared to 32% and 22.6% on average for each of the two household members. Overall, respondents reported that 38.5% of household members experienced symptoms in at least one diagnostic category.

Diagnostic and help-seeking patterns were slightly different for the household members, which included children and youth, than for the respondents. For example, 25% of household members were identified as having attention deficit disorders, compared with 13.7% of respondents. Also, people in the family-member group were less likely than respondents to endorse private mental health practitioners and the Internet and more likely to endorse school-based health care providers, family guidance centers, and community mental health centers, as depicted in Figure 7.

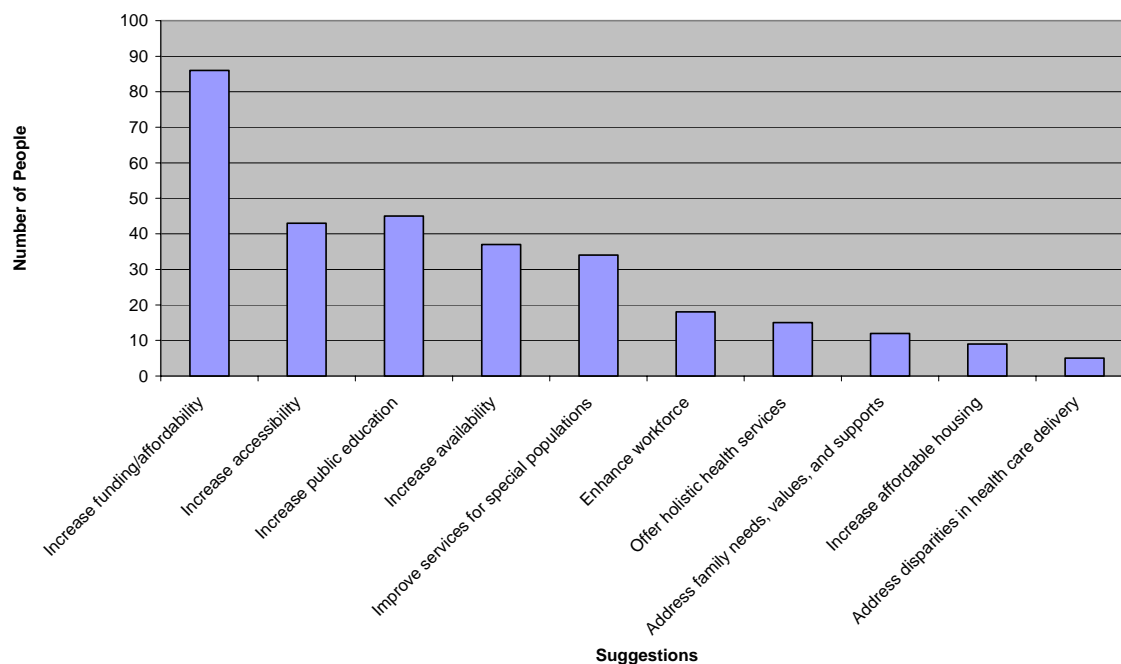
Figure 7: Where Family Members Turned for Help



Primary sources of help for mental health concerns for both respondents and family members were family, friends, general practice physicians, and private mental health practitioners. These arenas lie outside of the traditional scope of public-sector mental health and suggest valuable avenues for community education addressing stigma and for integration of primary health care and mental health care. The Internet and clergy are additional sources of support for some citizens, while school-based providers and family guidance centers also are used for some children and youth. A large number of people, however, seek no help for mental health concerns. Public information campaigns and informational Web sites may help to educate people about possible reasons for seeking help and where treatment is available in Connecticut.

Finally, the Citizens Survey also included the open-ended question: “Do you have any ideas about how to improve mental health services in the state of Connecticut?” Nearly half of respondents offered one or more suggestions or opinions, as Figure 8 shows.

Figure 8: Summary of Major Suggestions
N=252



Almost one third of the suggestions for improving mental health services involved increasing funding for services and making them more affordable for people in need. Respondents identified as problems health insurance coverage that is inadequate, too costly, or absent, and the vast disparities in the way mental health and physical health services are covered by insurance. Suggestions included providing mental health services at a lower cost or free of charge to people in need, enacting universal health and mental health coverage, lowering the costs of psychotherapy, and increasing public spending to improve mental health resources.

The next most frequently cited set of suggestions focused on the accessibility of mental health care. Respondents mentioned as problems long waiting lists and the “red tape” that makes access to services difficult, the lack of services and facilities in rural areas, and the lack of transportation to services. Many respondents identified the need for greater public education, including the need to widely disseminate information about available services and the benefits of seeking help. Other public-education suggestions included increasing people’s understanding of mental illnesses and reducing the stigma associated with mental health problems.

For other respondents, concerns included the lack of availability of services and the need to provide a broader range of services. These respondents identified gaps in available services that include home-based help, discharge planning and follow-up, housing and residential programs, rehabilitation services, free medications, support groups, outpatient services, affordable psychotherapy, drug rehab, and short-term crisis programs and settings. Respondents also

mentioned workforce issues, including the need to pay mental health workers a higher wage, the need for additional training of paraprofessionals and professionals, and the need for improved hospital staffing in Veterans Administration (VA) and state psychiatric hospitals. Some respondents also recommended working more closely with and educating primary care physicians on mental health issues and medications.

Another group of suggestions revolved around offering holistic or alternative and complementary services. Suggestions were to increase the availability of these and other services, including or related to acupuncture, meditation, spirituality, journaling, recreational activities, and diet. Some respondents supported efforts to increase self-esteem among people with mental health disorders and help them build a sense of belonging, and to improve social opportunities for isolated people, elders, and people discharged from state hospitals and other institutions. Some respondents also suggested paying greater attention to family and family values, the need by families for respite, and the need to assist people through “natural” supports, which include relatives, friends, and other resources available in their own communities.

Respondents identified special populations that warrant more attention in the mental health system. The most frequently mentioned concern was the lack of services for children and youth. Respondents cited a variety of children’s issues, including the lack of prevention services; the need for early and accurate assessments, diagnoses, and intervention; the need for more positive activities for youth; the lack of qualified and trained professionals such as child psychiatrists, social workers, and psychologists; the complexity of referral processes; the excess of red tape; and the need for residential programs for youth in their home communities. Other areas of need cited for youth involve the lack of emergency placements and the long waits in emergency rooms. Services for the elderly and for people with prolonged and severe mental illness, including those discharged from state hospitals, were mentioned as needs. Respondents also discussed addressing the disparities that exist in health care. They recommended making more therapists available for women, increasing community outreach to Hispanics, and increasing therapy targeted to Hispanic women.

IV.C. 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. The assessment was provided to the directors of DMHAS–funded and –contracted service agencies. One hundred fourteen completed surveys were received.

Results from the DMHAS Agency Recovery Self-Assessment reveal that on a scale from one to five (1 = lowest, 5 = highest) providers scored themselves lowest on the participation of people in recovery and family members in all aspects of services, despite providers’ own understanding of the importance of this principle, as depicted in Table 4.

Also in Table 4, it is interesting to note that “recovery orientation” and “cultural competency,” two areas in which the state has made considerable efforts to improve over the past several years, are among the lowest-rated items. This finding does not necessarily suggest that the efforts are

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not working, but in fact may reflect a predictable lapse in the time it takes to implement system-wide change. Or it may reflect an increase in expectations in these areas due to recent efforts to promote awareness of their importance.

The agencies rated themselves highest on the principles of “self-determination and client rights” and “person-centered recovery planning,” which are two recommendations from the New Freedom Commission report.

Principle	Score
Self-determination and client rights	4.47
Person-centered planning	4.45
Access and engagement	4.32
Continuity of care	4.12
Housing and work	4.09
Community integration	4.03
Peer supports & self-help	4.02
Quality improvement	3.86
Prevention & early intervention	3.78
Cultural competency	3.77
Recovery orientation	3.71
Participation of people in recovery & families	2.77

IV.D. Elements of a Recovery Facilitating System

Yale University has developed a tool that helps differentiate a recovery-oriented mental health system from a traditional mental health system, 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 service providers as they shift their orientation toward recovery in line with mental health transformation goals and public policies.

The ERFS tool asks individuals in recovery to rate their local service provider 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 local service provider assessment will be designed and used during subsequent years of the MHT SIG. The preliminary findings are based on a small statewide sample (N=29).

The data obtained from the sample suggest that people in recovery may view their local service provider more favorably than do providers and consumer-providers. Table 5 shows that the local

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service providers received very good or outstanding ratings in the areas of “encouraging growth,” “supporting strengths” and “satisfying basic needs.” The local service providers received the lowest rankings in the areas of “community-centered,” “rights and citizenship,” “connections to others in recovery,” and “culturally informed and respects diversity.” Again, this does not mean that current efforts in these areas are not working but may in fact, reflect an increase in expectations due to an increased awareness of their importance.

Table 5. Elements of a Recovery Facilitating System: Highest- and Lowest-Ranking Items

Highest-Ranking ERFS	% ranking average, very good, or outstanding performance
Encouraging growth	89%
Supporting strengths	89%
Satisfying basic needs	89%
Seeing a services user as a whole person/holistically	82%
Positive partnership with providers	82%
Supporting involvement in preferred activities and social roles	71%
Lowest-Ranking ERFS	% ranking below average or failing
Person in recovery directs recovery process	47%
Consumers direct and shape system of care	41%
Wellness lifestyle	41%
Relationship and sense of belonging	29%
Self-managed care	29%
Community-centered	23%
Rights and citizenship	23%
Connections to others in recovery	23%
Culturally informed and respects diversity	23%

IV.E. 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, or infrastructure, 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, 6 = lowest priority).

Table 6 contains the average priority ratings given to each of the New Freedom Commission goals for the sample as a whole (N=28), as well as for parents and providers separately. The lower the score, the higher the goal rated in importance.

The New Freedom Commission goal receiving the highest average priority rating was Goal 2 (“Mental Health Care is Consumer and Family Driven”). The goal receiving the lowest average priority rating was Goal 6 (“Technology is used to Access Mental Health Care and Information”). Parents rated Goal 2 as their highest priority and assigned it a significantly higher

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priority than did providers. Providers rated Goal 4 (“Early Mental Health Screening, Assessment, and Referral to Services are Common Practice”) as their highest priority and assigned it a significantly higher priority than did parents.

New Freedom Commission Goal	Average Rankings		
	Total Sample	Parents	Providers
	Score	Score	Score
1. Americans Understand that Mental Health is Essential to Overall Health	3.11	2.55	3.17
2. Mental Health Care is Consumer and Family Driven	2.44	1.64	3.67
3. Disparities in Mental Health Services are Eliminated	2.74	2.73	2.83
4. Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	2.62	3.30	2.08
5. Excellent Mental Health Care is Delivered and Research is Accelerated	3.46	3.80	3.08
6. Technology is Used to Access Mental Health Care and Information	5.50	6.00	5.08

Some respondents, instead of rating each goal according to the Likert scale, ranked the six New Freedom Commission goals in order of priority. Table 7 presents the priority rankings for parents and providers. As Table 7 shows, parents rated New Freedom Commission Goals 1 (“Mental Health Care is Essential to Overall Health”) and 2 (“Mental Health Care is Consumer and Family Driven”) as the top priorities. Providers rated Goal 1 as the top priority.

The two groups differed in their priority rating of Goal 2, with 46% of parents and only 8% of providers indicating that it was a top priority. Parents and providers also differed significantly in their ratings of Goal 4 (“Early Mental Health Screening, Assessment and Referral to Services are Common Practice”), with none of the parents and 33% of providers considering this goal as a top priority. The lowest-ranked priority for both groups was Goal 6 (“Technology is used to Access Mental Health Care and Information”).

These findings suggest that parents and providers agree that an important element of a transformed system of mental health care includes care that is directed by people in recovery and their families. Other important elements are reducing stigma and improving general attitudes toward mental health, and early mental health assessment and intervention, according to parents and providers.

Table 7. Percentage of Respondents Ranking Highest Priority to New Freedom Commission Goals

New Freedom Commission Goal	Percentage Ranking #1 Priority		
	Total Sample	Parents	Providers
1. Mental Health is Essential to Overall Health	37%	46%	42%
2. Mental Health Care is Consumer and Family Driven	37%	46%	8%
3. Disparities in Mental Health Services are Eliminated	26%	36%	25%
4. Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	15%	0%	33%
5. Excellent Mental Health Care is Delivered and Research is Accelerated	9%	0%	17%
6. Technology is Used to Access Mental Health Care and Information	5%	0%	8%

In addition to ranking and prioritizing the New Freedom Commission goals, respondents of the DCF Mental Health Transformation Survey were asked to answer questions related to each goal. The questions, followed by some responses, are presented here.

Goal 1: What recommendations do you suggest occur to better integrate mental health and physical health care and reduce stigma?

Respondents encouraged mental health providers and administrators to focus on minor mental health problems as well as more severe difficulties; help disseminate 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 care providers.

Goal 2: How can Connecticut’s mental health system better ensure that it is family driven?

Responses included asking families what they need and listening to the answers; basing performance outcomes on the ability to meet family needs; making sure families are present for all care-related discussions; reaching out to families not typically heard from; coaching parents and siblings on involvement in a child’s plan of care; expanding peer and family support at all levels of planning, implementation, and service provision; decreasing hurdles for family members to access support (for example, offering convenient hours of operation and family-friendly applications and paperwork); increasing home supports and child care; educating providers about family members’ experiences; having funding “follow” the client; launching extensive training programs around principles and practices of family- and consumer-driven care; hiring family members at all levels within the mental health system; and increasing the visibility and public awareness of family-support advocacy organizations such as the National Alliance on Mental Illness (NAMI).

Goal 3: What infrastructure ideas do you have to make the mental health system more culturally competent and eliminate disparities?

Survey respondents offered the following suggestions: make sure all families have comparable access to mental health services; provide services and documents in a client's primary language; make services available across all geographic regions, including rural areas; include juvenile justice representatives in community collaboratives; mandate training and practices that are culturally competent, or that respond to clients' ethnic, racial, and cultural backgrounds and that are gender-appropriate and trauma-informed; develop stringent standards for cultural competency and consumer involvement; educate police and court personnel about mental illness; require sensitivity training of all staff; encourage universities and colleges to enroll and support qualified candidates from diverse cultural, ethnic, and racial backgrounds; and develop cultural centers in communities.

Goal 4: What suggestion do you have to support early mental health screenings, assessment, and interventions?

Suggestions included asking teachers to report on students' mental health; increasing awareness of mental health issues by personnel who interact with people using services; improving communication about available services; making testing and assessment easier to obtain; requiring early screenings for mental health and development; educating physicians, nurses, and school personnel on the warning signs of mental health disorders and offering early identification and assessment; treating the entire family, not just the child who is receiving services; shortening the time from assessment to treatment; working with insurance companies to reimburse wellness visits and early interventions; increasing mental health programs for young children; funding more elaborate screening and assessment processes; and providing resources for preschool screenings.

Goal 5: How can the quality of mental health care in Connecticut be improved?

Recommendations were to enforce practice standards; improve accountability (by linking contracts to demonstration of quality of care, for example); address service-access issues; provide funding for new research on models of treatment; seek more positive media awareness; close gaps in communication; increase the number of educational degree programs that are related to mental and behavioral health; listen to the people who use services; maintain appropriate educational requirements; minimize paperwork required for authorizations; encourage licensed clinicians to form individual or group practices that may have a more sustainable workforce; encourage professionals to be a part of consumer-driven activities; provide ongoing education to professionals about new research; develop data-collection methods that accurately reflect needs, interventions, and progress; include parents in decision making; raise the pay scale for providers of mental health services; recruit more child psychiatrists; and increase compensation for mental health services from Medicaid.

Goal 6: Please prioritize the following three ways to use technology to support the Mental Health System transformation (1 = highest priority, 3 = lowest priority):

- 52% of respondents 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.*

This might include resource information about topics of interest and other things a resource center or library might provide.

- 26% of respondents rated as the highest priority: *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, aids to prescribing medications.*
- 22% of respondents rated as the highest priority: *Automated tools to help all providers and others, such as state agencies, know about the various services a child has already received in order to plan a child's care.*

Other comments pertaining to Goal 6 focused on issues of confidentiality of services and records, client rights, and suggestions for creating electronic medical-alert bracelets or electronic medical-record cards for clients.

IV.F. Workforce Focus Groups and Planning Meetings

The knowledge and preparedness of the mental health workforce around a recovery- and resilience-oriented system of care was not identified by the New Freedom Commission as a major goal. Yet Connecticut considered this issue important to address as the state seeks to transform its mental health system. In its application to SAMHSA, Connecticut proposed creating a Workforce Transformation Work Group as one of the seven work groups investigating an aspect of transformation. The Workforce Transformation Work Group is led by Michael Hoge, Ph.D., of Yale University and The Annapolis Coalition on the Behavioral Health Workforce.

The workforce work group sought to assess a) the knowledge and training of the current workforce; b) the capacity and needs of the workforce for transformation to a fully recovery- and resilience-oriented system of care; and c) perceptions of staffing needs by multiple stakeholders.

Research and state agency reports have informed the Workforce Transformation Work Group's efforts. In addition, the work group convened 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.

Finally, to ensure that the special workforce needs of children, youth, and families were addressed, the work group held 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 SAMHSA administrator, gave a keynote presentation.

The findings from the meetings and the focus groups were organized into three major categories: training and education, recruitment, and retention. The findings for each category are described below.

Training & Education Findings

Training Methods address how training is done. Participants in the MHT SIG process recommended that multi-faceted, ongoing, strengths-based, experiential training be provided onsite across all organizational levels. Other suggestions were to include persons in recovery as trainers; increase partnerships with higher education institutions, businesses, and employers; offer multiple training modalities, including Web-based and team models; offer multidisciplinary, consolidated training through one Web portal; provide group and individual supervision; and set up a one-stop Web site to link people to recovery services statewide.

Training Content/Focus is the “what” of education and training. Participants recommended the following as high-priority content areas for training: leadership development; cultural competency; supervision, peer, person-centered, and natural supports and recovery; co-occurring mental health and substance use 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.

Training Sites are the locations in which education and training occur. One key recommendation urged that cross-agency training be provided for agencies that serve clients who use services from multiple agencies. Other recommendations included increasing technology transfer; increasing the relevance of graduate education to current practice; improving coordination and collaboration among educational institutions and delivery systems; partnering with labor unions; and providing clinical consultation to juvenile and adult courts.

Student and Teacher Characteristics refer to students (staff, consumers of mental health services, families, etc.) and teachers (trainers, instructors). Key recommendations included increasing paraprofessional training; increasing the number of persons in recovery as staff; increasing the pool of bilingual, culturally competent licensed staff; offering family supports; developing a training academy to credential mental health staff; providing career tracks for all staff, including persons in recovery; increasing staff knowledge and skills about mental health needs, services, and treatment across the life span and for veterans and clients with co-occurring disorders; and providing training in gender-responsive, trauma-informed and forensic services, eating disorders, pervasive developmental disorders (PDD) and autism spectrum disorders, and sexual abuse victims and perpetrators. Another recommendation was to increase the pools of staff who are certified in prevention efforts and staff who are able to assist hearing-impaired clients.

Sustained Adoption refers to attainment, maintenance, and sustenance of changes that result from recovery- and resilience-oriented education and training. Recommendations included increasing organizational support for learning new practices; offering incentives and sanctions related to change; providing continuous, integrated, onsite training and development; providing across-level training for front-line staff, supervisors, leaders, and persons in recovery; assessing training effectiveness and cost-effectiveness; developing state and nonprofit cost-sharing partnerships; offering ongoing and time-unlimited on-the-job supports for persons in recovery in

the workforce; linking behavioral health clinics with primary care offices and clinics; increasing course offerings for state employees and private nonprofit employees; requiring leaders to spend time with consumers and front-line staff to understand workforce and customer concerns; and implementing a unified system for knowledge transfer about team leadership and supervision.

Existing Resources: Focus-group participants and interviewees noted that valuable resources exist which can be used in transforming the workforce. Some public and private resources include institutions of higher education; DMHAS's Education and Training Division and its Office of Prevention Training; the state Office of Multicultural Affairs (OMA) and its Project for Addiction Cultural Competence Training (PACCT); the state Department of Administrative Services (DAS) Learning Center; and the Connecticut Training & Development Network. Also, resources include organizations such as Connecticut Community of Addiction Recovery (CCAR); Connecticut Association for Addiction Professionals (CAAP); Drug and Alcohol Recovery Counselor program (DARC); Yale Program for Recovery and Community Health (PRCH); New England School of Addiction Studies; Connecticut Community Providers Association (CCPA); National Alliance on Mental Illness of Connecticut (NAMI-CT); Advocacy Unlimited (AU); Focus on Recovery–United (FOR-U); and the MERGE Mental Health Certificate Program.

Recruitment Findings

Participants broadly agreed that a workforce shortage, in terms of demand and supply, exists in the behavioral health field and that it is likely to worsen. Discussions of recruitment issues with representatives of the behavioral health disciplines in Connecticut reveal that a host of cross-cutting themes resonates throughout the field. The following is a synthesis of the themes, as cited by a variety of professional groups in the behavioral health field.

Salary & Benefits. A need to reduce the disparity between public- and private-sector salaries was identified. The disparity makes it difficult for private providers to attract staff. Salary and benefit increases are needed to support the high cost of living associated with attracting a quality workforce and to more accurately approach the salaries of young professionals starting out in other fields.

Training. Suggestions made by participants included using more online training and distance-learning opportunities; educating and training potential employees with the workforce skills and competencies needed and required; developing a rapid certification program for mental health and substance abuse staff; providing training to people who are interested but have no expertise in behavioral health; providing training in clinical supervision; developing “apprenticeships” for students, consumers, and family members; and training mentors to work with people who have behavioral health needs across the life span.

Incentives & Financial Support. Participants agreed that funds are needed to help encourage students to consider a behavioral health profession. Areas to explore include providing greater financial assistance to students entering the field; providing competitive sign-on bonuses; providing incentive programs and reviewing compensation programs for entry-level and experienced clinicians; providing part-time and other flexible working hours; and exploring ways to help nonprofit organizations contain or pay for health care costs.

Collaboration with Colleges/Universities & Other Entities. The professional groups suggested presenting the behavioral health field as a career option at high schools; enhancing graduate

school recruitment of bilingual and bicultural staff; expanding graduate-level curriculums in evidence-based programs; providing executive-type behavioral health education for people interested in returning to school; streamlining the internship process; and forming partnerships with job-placement and professional groups.

Advertising/Hiring Process. One suggestion was to develop alternative job positions and career paths, such as internships and practicums, to encourage the entry of less-experienced or noncertified clinicians into employment in mental health agencies. Participants also recommended using the services of a national advertising firm to develop an effective media campaign; holding behavioral health job fairs; supporting advertising campaigns that defeat stigma associated with persons who experience behavioral health disorders; developing online interviews for recruitment; streamlining Connecticut’s hiring process; and partnering with “outside” organizations to develop the existing and future workforce.

Specialty Focus Areas. Specific areas of clinical expertise also were identified as lacking in the field and as benefiting from recruitment efforts. These areas include the need for culturally and linguistically competent staff; hiring staff with a strong recovery and strengths-based orientation; hiring staff with a holistic approach to treatment; hiring people in recovery and family members at all levels in the system; recruiting a sufficient number of staff trained to identify and treat individuals across the life span; and hiring staff who are trained in best practices for co-occurring mental health and substance use disorders.

Existing Resources. Participants agreed that it is important to tap into well-established resources that could be expanded with additional funding. Examples include establishing and expanding relationships between providers and graduate schools and tapping into the resources these institutions have to offer; connecting with Comprehensive Clinical Evaluation Programs (CCEPs) around the establishment of their curriculum in evidence-based family treatment models; and using professionals in the field to help with recruitment initiatives and with developing and implementing trainings.

Retention Findings

The professional groups interviewed by the Workforce Transformation Work Group identified several needs and recommendations related to workforce retention. They also listed workforce-related resources that the state potentially could draw on in addressing the retention issues facing the behavioral health workforce.

Salary & Benefits. Participants suggested increasing awareness of available tuition, work-shop, and certification reimbursement and loan repayment options; eliminating the disparity in salary between public- and private-sector providers, and offering salaries that are more competitive in general; and providing salary increases with the attainment of educational degrees or completion of training.

Job Characteristics. The following recommendations were distilled from interviewing the professional groups: define a “core curriculum” for every job level; ensure that clinical supervision is a part of every agency; reduce staff caseloads in order to enhance the level of care and reduce employee “burnout”; streamline paperwork demands; and conduct an audit of the skill levels of the current workforce.

Work Environment. Suggestions by participants included: offering part-time and other flexible working hours; forming state-funded mentoring programs that link people who do the work with people who want to learn to do the work; and increasing the amount and quality of clinical supervision. Another suggestion was to offer additional DMHAS-sponsored trainings in an array of behavioral health-related areas across the life span, including co-occurring disorders, assessment and diagnosis, best practices, recovery, clinical supervision, stigma, prevention, early intervention, health promotion, wellness, and relapse prevention.

Rewards. Participants identified the importance of developing career paths for clinicians to advance within agencies while being recognized financially for continuing to do clinical work. Other rewards suggested to assist in retention included increasing the use of internal promotions and developing workplace incentives for mentoring (for example, time off or increased vacation in return for mentoring services).

Existing Resources. Participants offered several ideas for augmenting resources within the state. They include having state agencies trade training resources with each other through memorandums of understanding; making better use of inhouse expertise; integrating training and operations to foster recovery-oriented and evidence-based practices; building on the telemedicine pilot program conducted in the State Mental Health Authority (SMHA) by the state Office of Multicultural Affairs (OMA); promoting the Certified Psychiatric Rehabilitation Practitioner (CPRP) credential; improving existing mentoring programs; and examining ways to better use the resources offered by a host of groups, programs, and agencies, such as the United States Psychiatric Rehabilitation Association (USPRS), the Recovery Institute, Focus on Recovery, Regional Mental Health Boards, and DMHAS, to name a few.

V. Overall findings

To best advance the transformation effort, MHT SIG staff organized the findings from the collection and analytic activities described in the previous section, and all other information gathered in connection with Connecticut's mental health resources and needs, according to the six major goals of the New Freedom Commission.

The most noteworthy of the findings of the Mental Health Needs Assessment and Resource Inventory are summarized below. It is hoped that the findings may be a catalyst for new ideas and creative, innovative, and resourceful approaches in Connecticut's continued progress toward transforming its mental health system.

Each goal is introduced by some important accompanying principles endorsed by the New Freedom Commission.

V.A. Goal 1: Mental Health is Essential to Overall Health

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, Americans 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.

The Needs Assessment shows that there is evidence that state agencies and divisions embrace values of recovery and resilience and believe that citizens of Connecticut should have equal access to effective mental health care. Yet barriers exist that impede effective mental health care delivery to citizens. These barriers include a gridlocked system of care; the stigma associated with seeking care; a lack of education about recovery- and resilience-oriented mental health; fragmented data systems that do not allow for effective communication across state agencies and among providers; and funding that has not kept pace with increases in operating expenses. Commonly identified needs include increasing collaboration between primary health care providers and behavioral health care providers; conducting public-awareness campaigns around mental health; improving collaboration among state and local agencies, departments, and collaboratives; linking data systems to better coordinate care; and offering more explicit plans for increased consumer and family involvement in all aspects of service planning, delivery, and evaluation.

V.B. Goal 2: Mental Health Care is Consumer and Family Driven

This New Freedom Commission goal includes transformation objectives that focus on the people who use mental health services. According to the commission's 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.

In Connecticut, state agencies and divisions vary in the extent to which mental health services are driven by consumers and families. Most departments, however, recognize the importance of involving people in recovery and their families in care decisions. Many departments are advocating the use of individualized plans of recovery and resilience. Barriers to establishing a mental health care system that is driven by consumers and family members include the following: few policies and procedures are in place to ensure consumer and family involvement; existing community resources are underutilized; adequate and affordable housing is lacking, particularly for special populations such as people transitioning from more restricted settings, people with co-occurring mental health and substance use disorders, young adults, and the elderly; and limited transportation options are available to support people as they seek services and supports. Additional identified needs center on addressing employment barriers and promoting the hiring of persons in recovery; providing more youth-oriented, community-based supports and family-centered practices; establishing technical assistance and training for person-centered planning and working with special populations; and continued financing for recovery and resilience initiatives.

V.C. Goal 3: Disparities in Mental Health are Eliminated

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, culture, language, gender, sexual orientation, physical abilities, immigration, age, and place of residence.

Each state agency and division in Connecticut has articulated a goal to provide services in a culturally competent manner. Yet in order to create a statewide health care system in which disparities in mental health are eliminated, several areas of need warrant attention. These areas include developing more services and programs that are gender- and ethnically specific, trauma-focused, and linguistically and culturally appropriate. In addition, existing services can be enhanced by offering additional training on how to provide trauma-informed and gender-sensitive care; establishing policies, procedures, and standards for delivering culturally appropriate care; assessing service strengths and gaps for diverse populations; and exploring ways of determining the extent to which staff diversity matches the diversity of the people using services.

V.D. Goal 4: Early Mental Health Screening, Assessment, and Referral are Common Practices

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. In a transformed system, 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.

Connecticut offers several programs and initiatives in connection with the early identification of behavioral health concerns. The state works to promote mental health, prevent substance abuse, involve the schools, and encourage the use of screening tools, as documented in the Resource Inventory. Yet to fully attain New Freedom Commission Goal 4, the MHT SIG process identified several areas of need. There is the need for policies related to early identification and assessments of mental health conditions across all age groups and environments, and particularly for people who are elderly, in nursing homes, in adult or juvenile justice systems, in shelters, or in primary care settings. Other areas of need include offering supports for families, friends, and other caregivers; working more closely with school systems; enhancing services for young people who are transitioning into adult service systems; providing integrated treatment for persons with co-occurring mental health and substance use disorders; and increasing access to primary health care providers across the system.

V.E. Goal 5: Excellent Mental Health Care is Delivered and Research is Accelerated

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. 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.

In Connecticut, the majority of agencies providing services articulated the need to ensure that care and practices are grounded in the best available research. Yet resources are disproportionately allocated to inpatient and other 24-hour care, such as services received in a skilled nursing facility, residential treatment center, therapeutic group home, halfway house, supervised apartment, crisis stabilization unit, etc. To ensure the delivery of excellent mental health care, more resources need to be made available or existing resources reallocated to alleviate service gridlock and promote recovery- and resilience-oriented care throughout the system. The development of standards around the coordination of inpatient and outpatient care would help in this effort. To achieve New Freedom Commission Goal 5, several other areas must be addressed. They include more outreach services for older adults; a better coordinated transportation program; additional community-based crisis and emergency services; training across disciplines in early identification and screening of mental health conditions; the establishment of infrastructure and standards for clinical supervision; better coordination across all state departments and agencies; development of a common set of process, intermediate, and outcome measures; the collection of cost-effectiveness data; establishment of recovery- and resilience-oriented performance measures; use of a valid and reliable needs and risk assessment tool; and creation of methods of pooling or blending funding streams to be able to fund more evidence-based and recovery- and resilience-oriented practices.

V.F. Goal 6. Technology is Used to Access Mental Health Care and Information

A transformed mental health system 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.

In Connecticut, information and data about services, clients, and the agencies and practitioners who provide the services are contained in several large data systems which are discrete to each state agency. No single agency appears to have an electronic health record as the basis for the full range of interactions with consumers. Connecticut can improve its current system by undertaking several initiatives, including setting policies and standards around the development of electronic medical records; launching public awareness campaigns on how to access statewide information; enhancing telemedicine capacities; establishing common data fields across departments and developing interstate database-comparability capabilities; using universal utilization management; developing automatic reporting tools; and enhancing the availability of technology and equipment in many facilities and for use by people of all ages.

VI. Discussion

The Mental Health Needs Assessment and Resource Inventory contains the seeds of many ideas and suggestions for transforming Connecticut's mental health system. Organizing the ideas around the most prominent themes to emerge from the Needs Assessment process may be helpful. Four recurring themes stem from the results of the various surveys, questionnaires and

other special efforts undertaken to assess Connecticut's mental health needs. The four major themes are:

- shifting toward a mental health system that is oriented toward recovery and resilience for all Connecticut citizens;
- shifting toward a mental health system that is driven by consumers, youth, and families;
- using technology to increase access to mental health care and the availability of information; and
- developing the behavioral health workforce to help effect and sustain Connecticut's transformation effort.

The themes are presented below, accompanied by bulleted items that describe some of the challenges associated with each theme.

Recovery and resilience for all citizens

As with many states, only a relatively small segment of Connecticut's population accesses public mental health care and typically as a last resort. As a result, the publicly funded system of care has invested its resources heavily in "high-end" services such as hospitalizations or other residential treatments and crisis response and intensive outpatient care, leaving few resources to fund less intensive and less costly services. Transformation to a recovery and resiliency orientation places a proactive emphasis on community-based care, provision of in vivo services, reliance on natural rather than institutional supports, and a focus on enabling youth, families, and adults to manage their own conditions while leading meaningful lives in the communities of their choice. The Needs Assessment process also revealed that too many Connecticut citizens with psychiatric symptoms seek no help for those symptoms. The findings and trends suggest that greater public education about mental illness is needed to help reduce the stigma that surrounds seeking help and remove barriers to timely access.

- More than a dozen state agencies and departments are represented in Connecticut's transformation initiative. Yet three agencies, DMHAS, DSS, and DCF, absorb 84% of total public mental health expenditures for all age groups. The Needs Assessment process identified the need for a more integrated and coordinated service delivery system and a closer collaboration between the public and private mental health sectors to facilitate the movement of individuals from one system to another.
- The publicly funded mental health system is perceived to be one where people turn only as last resort, rather than one that offers a broad range of information, education, services, and supports when people first begin to have mental health concerns or questions. Shifting from the former to the latter will require conducting an effective community education campaign and developing services that are less intensive than crisis or 24-hour care, such as early-intervention services. It also will require providing funding and reimbursement for these services and otherwise lowering barriers to access to care.
- Existing resources can be maximized by continuing to redirect funds from acute, institution-based, and crisis-oriented services to proactive community-based care that promotes identification, early intervention, and the secondary prevention of disability. Connecticut can

reduce its reliance on institutions such as prisons, hospitals, and residential treatment by expanding community-based alternatives, creating safe and affordable housing options, and providing care in community settings. The effectiveness and impact of services also can be increased, and costs decreased, through better collaboration among state agencies and the pooling of resources in joint ventures based on a comprehensive understanding of the person's or family's life as a whole.

- Many barriers to accessing mental health services lie outside of the traditional purview of mental health. For example many people, especially those living outside of major cities, have no means of transportation to access services and supports that might prevent a need for crisis stabilization or other intensive and costly measures. Other examples of systemic barriers include a lack of mental health screening and education offered as part of routine primary health care and the lack of responsiveness of existing services to people from various cultural backgrounds. Addressing these and other systemic barriers presents opportunities for increasing timely access to mental health care.

A system that is driven by consumers, youth, and families

Increasing the involvement of children, youth, and adults with mental illness and their families in various aspects of the system remains a formidable challenge not only in Connecticut but in most states. Achieving success will require developing and adopting new and more effective strategies. Most important, it will require greater participation by consumers and families. A consumer- and family-driven system is not possible without people in recovery and their families having active, substantive, and central roles throughout all aspects of system redesign, evaluation, and service delivery.

- It is imperative to develop and adopt policies and procedures throughout the mental health system of care and its component parts that require and promote consumer and family involvement. Examples of such policies range from requiring a majority of a private nonprofit agency's board of directors to comprise consumers and families to changing visiting hours on an inpatient unit to accommodate the schedules of family members who work during the day. Additional examples can be found in *Practice Guidelines for Recovery-Oriented Behavioral Health Care*, produced by DMHAS.
- Collaboration with consumer, youth, family, and advocacy organizations will help to determine ways in which consumers and families would like to be involved and ways in which they will view their involvement to be meaningful and substantive. These goals will be furthered by reaching out to people with mental illnesses who are inside and outside the publicly funded system of care and eliciting their views. Consumers and families also are critical to developing a framework of opportunities and supports for their active involvement in meaningful ways at all levels and throughout all aspects of the system, from driving their own care plan to helping to determine the future of the system as a whole.

Using technology to increase access to care

The Needs Assessment process noted the disconnection between the administrative and clinical databases of the various state agencies and the need for an integrated management information system across state agencies. The Connecticut General Assembly has funded an Internet-based single point of entry and information site related to mental health, called Network of Care. Its offerings are to include a directory of services and providers available at all levels of

government; information about the latest mental health diagnoses and treatments; links to national and state advocacy organizations; summary information on federal and state mental health law, including private insurance coverage; and an optional, secure personal folder for users to manage their own care and assistance portfolios. This initiative will be integrated with the overall transformation agenda and promises to provide a useful platform for additional developments in using technology to disseminate information to the public and to service recipients. The initiative, however, does not address the need for integrated data collection and data sharing across state agencies.

- The rollout of the Network of Care Web site should be carried out in conjunction with existing help-lines, clearinghouses, information hubs, and other sources people turn to when seeking information and help. A broad public education campaign can serve the dual purpose of announcing the Network of Care rollout and educating citizens about the realities of mental illness and possibilities of recovery and resilience.
- No single state agency appears to have an electronic health record that could be used as the basis for the full range of interactions with a service recipient. If electronic health records were in place, it then may be possible to use them across the relevant state agencies to begin laying the groundwork for the integration of the management information systems. Policies and standards related to the use of electronic medical records would need to be developed, and the considerable resources required to bring all publicly funded health care into compatible “paperless” electronic systems would need to be amassed.
- Combining existing efforts to integrate data across state agencies would help to overcome the current fragmentation of the state service systems. Such efforts should include establishing common data fields across departments and developing interstate database comparability capabilities; using universal utilization management; developing a common set of recovery- and resilience-oriented process, intermediate, and outcome measures; collecting disparity and cost-effectiveness data; developing standardized performance and quality improvement measures; and developing automatic reporting tools.
- Further developing the state’s telemedicine capacities would enable more people to access mental health services. Efforts to enhance the availability of needed technology and equipment throughout facilities across the state and to persons of all ages and from all cultural backgrounds also are recommended. Finally, focused efforts need to be made to adapt this technology for use by people with disabilities. People with special needs will have to be shown how to access and use the new resources, including the Network of Care and other Internet-based resources for people in recovery.

A behavioral health workforce that supports transformation

A fourth major theme lies in the workforce development area. To contribute effectively to the transformation of Connecticut’s mental health system, workforce development efforts must place particular emphasis on the provision of services and supports that enable children, youth, adults, and families to establish and enhance meaningful lives in their communities irrespective of their mental health conditions.

- Because the Needs Assessment process revealed that many Connecticut citizens receive mental health services from people outside of the behavioral health profession, it is wise to target trainings to nonbehavioral health professions such as school personnel, nurses, and

primary care physicians to increase their mental health awareness and offerings of effective interventions.

- Most current education and training efforts lack a focus on promoting resiliency and recovery, which is central to the transformation agenda. Failing to address this shortcoming will contribute little to bringing about substantive reform in the mental health system. All efforts and initiatives to be undertaken in the area of workforce development will want to ensure that the approaches used, the material to be covered, and the skills to be developed are not only based on the best available evidence and practices but also are grounded in a recovery and resilience framework and oriented to promote a meaningful life in the community for all Connecticut citizens who are to be served.
- Current efforts do not pay adequate attention to the issues of health care disparities and the need for culturally responsive care. It is essential that workforce development efforts promote culturally and linguistically appropriate and responsive services, ranging from the development of ethnically, developmentally, or gender-specific services to ensuring the cultural competence of practitioners who may serve people from diverse backgrounds. As with recovery and resilience, cultural competence cannot be simply an add-on to the existing system but must permeate, inform, and influence the provision of all services and supports offered — across the life span, across ethnic, cultural, and linguistic divisions, across genders. Cultural competence also involves being attentive and responsive to the possibility of a history of trauma that might be contributing to the person’s current difficulties. A central strategy for addressing cultural competency is to base the provision of services and supports on person- and family-driven recovery and resilience planning, a process which should be a primary focus of training and technical assistance efforts and which will eventually replace treatment, service, and care plans. Workforce developments efforts focused on recruitment and retention should have as a primary aim the achievement of a workforce whose diversity matches that of the population being served.
- Previous reports have noted the gradual disappearance of supervision across clinical and rehabilitative programs over the previous two decades and the need to reestablish and reinvigorate this central oversight and mentoring function to ensure quality of care. These reports also have noted that supervision is not typically a “billable” service, and that it has disappeared largely due to fiscal pressures. Efforts to reestablish an infrastructure and standards for supervision and mentoring will take this issue into account and offer an alternative strategy for ensuring that staff and supervisors have the time needed to review the quality of the services and supports being provided. In addition, the nature, scope, and content of the supervision and mentoring should be consistent with the nature, scope, and content on which staff members are being trained, as described above. That is, supervision will be strengths-based, culturally responsive, and oriented to promoting resilience and recovery as opposed to being focused solely on diagnosis or functional impairments.

It is hoped that this Summary Report will inform the work of the Oversight Committee, its subcommittees and the work groups involved in transforming Connecticut’s mental health system and help the members of these groups identify additional data and information they may need as they continue their work. Beyond that, this document is available as a resource to all who have a stake in the state’s progress toward 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.