Mental Health Transformation Workgroup Recommendations

The following recommendations of the Transformation Workgroups have been consolidated and grouped according to categories used in the needs assessment, resource inventory and evaluation processes.

A: Policies: Federal, state and community laws, codes agreement, protocols, policies, procedures, memoranda of understanding.
A. 1. Engage and involve consumers/families in all aspects of planning (e.g., strategic, program, etc.), delivering and evaluating State agency and provider organization services as a condition of continued funding/participation. (2.1, 2.7, 2.9)*
A. 2. Expand and strengthen existing bodies (e.g., Protection & Advocacy) or, create an interagency entity, to monitor and enforce compliance with all state and federal laws regarding patients' rights. (2.19, 2.20, 2.21, 2.22, 2.23)
A. 3. Improve access, accountability and the sharing of information by developing and/or coordinating policies, regulations, standards, etc.; and streamlining funding related to recovery-oriented services such as housing, employment and treatment. (2.11, 6.1)
A. 4. Provide timely access to appropriate services within the continuum of care as an alternative to incarceration, nursing home placement, and to ease emergency department gridlock. (2.24, 5.1, 5.2, 5.6)
A. 5. Prevent or minimize further criminal justice involvement by creating systemic and policy changes to identify and divert children and youth involved in the juvenile and criminal justice systems into evidence-based prevention and intervention programs. (5.3)
B. Practices/Services: Activities, programs, actions, interventions, strategies.
B. 1. Prevent unnecessary institutionalization by increasing service supported housing resources for persons with psychiatric illness leaving institutional settings and youth transitioning from youth status. (2.18, 5.7)
B. 2. Review, develop, pilot and implement mental health screening, assessment, and intervention protocols and standards that are comprehensive, strength-based, culturally competent, and consumer and goal-centered within a vast array of service settings.(2.2, 4.1)
B. 3. Fulfill the continuum of care and enhance quality improvement initiatives by (2.8, 2.10): **B. 3. a.** employing self-identified persons in recovery and family members in the service system; **B. 3. b.** supporting peer employment roles that allow opportunities to accumulate experience and education needed to advance along a career path; **B. 3. c.** developing peer and family-operated programs to deliver mental health services.
B. 4. Co-locate developmentally-informed mental health professionals and resource coordinators and fund consultation-liaison arrangements to improve access to mental health prevention, screening, referral, consultation, and intervention services within early care, school, and primary care settings/systems.(4.2)

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C. Workforce/Training: Individuals/groups who work with or impact persons who are mentally ill (e.g., policy makers, school teachers, police and probation officers, therapists) and/or education, training, skills development that will enhance care.
C. 1. Expand upon the Suicide Prevention Guidelines issued by the Department of Education in 2004 by encouraging local school districts to disseminate and adopt suicide prevention and anti-stigma modules as part of comprehensive school health curricula. (1.3)
C. 2. Develop and implement core competency curricula that address (3.5, 7.5, 7.8): **C. 2. a.** age and developmental stages; **C. 2. b.** culture, race and health disparities; **C. 2. c.** supervision in accord with a common set of standards.
C. 3. Develop a culturally and linguistically diverse workforce by offering (3.6, 3.7 part 3, 7.4): **C. 3. a.** loan forgiveness programs to providers in rural communities and designated Health Professional Shortage Areas; **C. 3. b**. leadership development opportunities; scholarships, training stipends, and other incentives.
C. 4. Develop curricula to implement broad-based training opportunities for the public on (4.5, 6.6): **C. 4. a.** Suicide; **C. 4. b.** Stigma; **C. 4. c.** The availability of mental health services/resources, the use of technology to access information and coordinate mental health care.
C. 5. Create a *Connecticut Behavioral Health Workforce Collaborative* charged with planning, coordinating, and implementing interventions to strengthen the workforce such as "Centers for Excellence" serving as regional resources in behavioral health practices. (7.1, 7.9)
C. 6. Create and implement a web-based training system for the specialty workforce, other health and human service personnel, persons in recovery, children, youth, and families.(7.7)
C. 7. Train the mental health workforce and other health and human service personnel in (1.3, 1.4, 2.17, 3.3, 4.5, 7.6): **C. 7. a.** recovery-oriented services; **C. 7. b.** mental illness and co-occurring disorders; **C. 7. c.** racism prevention; **C. 7. d.** employment **C. 7. e.** housing; **C. 7. f.** suicide; **C. 7. g.** stigma.
D. Organization/Collaboration: Persons, organizations, or systems working together to address common goals and objectives (e.g., task force, association, interagency, boards, councils, providers, agencies, systems of care, partnerships, advisory committees, facilitated process, structure).
D. 1. Convene a high level (Governor endorsed and appointed) statewide MH Anti Stigma Task Force to conduct an annual policy review and propose a set of

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policy recommendations that if enacted serve to reduce stigma and eliminate barriers to employment, housing and overall community integration. (1.1)
D. 2. Increase levels of interagency coordination by leveraging community-based employment resources, identifying and disseminating best practices across all systems (DMR, DCF, BRS, DMHAS, DOL), and building transition protocols between key agencies. (2.14)
D. 3. Make decent, safe, affordable housing units available statewide by developing a statewide resource list and collaborating with existing advocacy efforts. (2.16)
D. 4. Establish a State Office of Multicultural Affairs and allocate at least one FTE in each state agency to promote quality assurance; develop, train, oversee, and coordinate cultural competence initiatives across State agencies and State funded service providers. (3.1, 3.2)
D. 5. Establish a model and conduct a public information campaign about the availability of a coordinated interagency collaboration that builds upon the existing system of care that is comprehensive, coordinated and consumer-driven and flexible. (4.3)
D. 6. Create a state-wide center for the identification, promotion and implementation of evidence-based and "effective" practices for mental health services across the lifespan. (5.4)
E. Data: Information from reliable sources and systems that is organized and useful- includes references to studies, quality assurance, process and outcome indicators.
E. 1. Develop, implement and provide incentives to programs to adopt a recovery-oriented performance measures system, including a universal consumer satisfaction survey (for children and adults), that is consumer and family informed and that provides feedback to consumers/families and programs on programs' performance and outcomes. (2.5, 6.5)
E. 2. Develop an integrated information system across agencies, the judicial branch, their providers and payors that establishes a uniform data collection system and uses common variables and data definitions to facilitate identification, monitoring and elimination of behavioral health disparities. (3.4, 6.2)
E. 3. Develop a Consumer/Family/ Provider–friendly resource information system including a web site that increases access to, and information on a range of recovery-oriented services, and appropriate behavioral, physical health and social service resources. (2.12, 6.4)
E. 4. Create and implement a single portable Electronic Medical Records/Electronic Health Records EMR/EHR including advanced directives and the ability to obtain/coordinate consumer/family/provider input. (6.3)
E. 5. Increase accountability through the measurement and tracking of employment outcomes. (2.15)
F. Financing: Allocation of resources to support system efforts and initiatives.
F. 1. Design and pilot a flexible funding system in order to implement a consumer-driven (self-directed) service delivery system for adults with mental illnesses and children with serious emotional disturbances using lessons learned and models employed from national pilots (SAMHSA-funded) and the Department

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of Mental Retardation (DMR). (2.3, 2.6)
F. 2. Ensure the availability, accessibility and quality of behavioral healthcare in rural and remote geographical areas, and among populations for whom barriers impede access to care by utilizing and expanding current reimbursements for innovative technologies such as telemedicine mobile health vans, interpreters, and non-traditional services such as outreach provided by community health workers. (3.7 parts 1&2)
F. 3. Increase timely access to service by maximizing Medicaid funding, identifying and addressing regulatory changes and waivers necessary to overcome policy barriers, leveraging federal matching reimbursement dollars, coordinating and aligning funding streams, and developing a reimbursement mechanism for prevention, screening, assessment, consultation, and treatment. (4.4, 5.5)
G. Consumer/family involvement: Involvement of persons in recovery/consumers/service users and family members in any level of service development.
G. 1. Establish and promote a statewide consumer advocacy movement. (2.4)
G. 2. Increase the number and percentage of persons in recovery and family members at all levels of the public and private behavioral health workforce. (7.2)
I. Other: Other (not related to funding).
I. 1 Develop, implement, and evaluate multi-faceted awareness campaigns to (2.3, 2.16, 2.25, 7.3): **I. 1. a.** Promote awareness of mental health rights and responsibilities. **I. 1. b.** Increase recruitment of behavioral health workers by implementing a multi media campaign that highlights career and job opportunities in behavioral health; **I. 1. c.** Promote the positive role of employment in recovery, assist consumers in advancing in their careers, and increase the visibility of employment opportunities.
J. All Relevant Funding: Federal or local grants, contracts, allocations, or other funding sources.
J. 1. Charge existing suicide prevention networks and advisory boards with identifying state/federal funds currently available for suicide prevention activities and implementing and evaluating a statewide suicide prevention campaign based on the strategies and recommendations from the State's Comprehensive Suicide Prevention Plan developed in 2005 by the Inter-Agency Suicide Prevention Network. (1.2)

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