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## Chairman's Preface

This report to Governor John Rowland is responsive to his Executive Order # 17A. In that order he clearly outlined the challenge and the goals of the Commission. We hope this report will enable the Governor, and those who are concerned about mental health in Connecticut, to review the past and present state of our mental health services and to view the Commission's recommendations as a timely opportunity. These recommendations are the result of the creative, dedicated work of several hundred citizens (professional experts, advocates, persons in recovery and family members) who are committed to sustaining their efforts in the service of the goals outlined in Governor Rowland's Executive Order.

The Blue Ribbon Commission suggests the creation of a Mental Health Policy Council designed to work with the Executive Branch as it begins implementing the Commission's recommendations in a practical and sustained manner. The current crisis of gridlock in state hospitals and in the emergency rooms and inpatient units of our general hospitals and the need for more community options in order that children and adults may receive appropriate services in the least restrictive environment, needs immediate attention. This issue is described in Secretary Ryan's letter of June 14, 2000. In calling for a behavioral health summit meeting on June 26, 2000, he refers to the "...myriad of issues related to the mental health crisis in the state and its impact on consumers, families, and providers." These are issues for which the Executive Branch, under the leadership of the Governor, will find eager collaborators in the Blue Ribbon Commission, its four Expert Panels and those who actively participated in the six public hearings. At the same time the longer-term issues and recommendations can be addressed in a systematic manner over time.

## Psychiatric Disabilities in Real Life

The following vignettes were adapted from statements made by people who testified at public hearings held throughout Connecticut on the Governor's Blue Ribbon Commission on Mental Health:

- ❑ *A seventy-year-old woman wonders what will become of her 40-year-old son when she dies. The son has paranoid schizophrenia and has lived with her all his life.*
- ❑ *A father with tears in his eyes speaks of having exhausted his home equity by borrowing to pay for his daughter's mental health treatment after the family's insurance benefits ran out.*
- ❑ *A mother asks why she has had to wait for months to have her 7-year-old daughter evaluated by a mental health specialist.*
- ❑ *A woman describes her experience with mental illness. She says: "I know first hand the isolation, the terror, and the lack of sensitivity that are experienced by many people with psychiatric disabilities."*
- ❑ *A man with co-occurring mental illness and substance abuse goes to jail after being charged with domestic violence for threatening his mother. She describes her failed attempts to get help for him.*
- ❑ *A mother of a suicidal child with bipolar disorder reports having to send her child to California to obtain care due to a lack of Connecticut treatment facilities.*
- ❑ *A distraught mother recounts that her son with a psychiatric disability has been robbed repeatedly and on one occasion, severely physically assaulted because of where he is forced to live.*
- ❑ *Within 24 hours after being arrested for a minor offense an eighteen-year-old young man with a psychiatric disability is found dead in his jail cell.*
- ❑ *An adult suffering from complex medical problems and severe depression is placed in a nursing home for lack of a more appropriate facility.*
- ❑ *A 45-year-old woman with bipolar disorder is admitted to a homeless shelter following her discharge from a hospital for treatment of her psychiatric disability.*

## REPORT SUMMARY

### **Introduction**

Recognizing mental health as a serious concern to the well being and prosperity of Connecticut residents, Governor John G. Rowland established the Blue Ribbon Commission on Mental Health in January 2000. His order mandated the Commission to examine the mental health system and to recommend how it might be improved. As the Commission conducted its study, particular emphasis was placed on exploring ways that academic, private and state agencies could collaborate to improve the range of services needed by people with mental illness throughout their life cycle. Strategies for promoting mental health and preventing mental illness were investigated, as well as strategies for supporting people who have mental illnesses and those who are in recovery.

### **The Blue Ribbon Commission**

The Blue Ribbon Commission consisted of fifty members, with fifteen members serving on the Steering Committee. Panels of experts were assembled to address four perspectives:

- ❑ Advocacy and consumer perspectives
- ❑ Management of services
- ❑ Prevention
- ❑ Treatment and intervention.

The members of the Commission and of each expert panel were chosen so that both the issues of concern to children and their families and the issues of concern to adults were represented. In addition, members were chosen to represent diverse areas of expertise relating to mental health. During six public hearings held across the state, about 600 people attended and 200 of them presented testimony.

### **Challenges Facing Connecticut**

The issues that emerged from the work of the Commission and from the public testimony point to a critical concern about access to mental health services, as a component of health care. The crisis in access to this form of health care spans the public and private systems. Although Connecticut was recognized as having one of the country's best community mental health systems for adults a decade ago (Torrey, 1990), there are signs that many people who need services are not getting access to appropriate care.

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Similarly, the child mental health system, while having made important gains in the last several years, is inadequate to meet current needs. For every person in Connecticut who receives mental health care, at least one other person who needs services is not receiving them. From the perspective of children, families and adults who cannot obtain needed access to this form of health care, the crisis is real and immediate. This theme was echoed repeatedly by citizens who testified at the six public hearings held by the Commission.

Signs of the crisis in access to appropriate services and other significant problems have been brought to the attention of the Blue Ribbon Commission, including the following:

- ❑ In Connecticut, during a single year, there are an estimated 600,000 adults with mental illness (including 135,000 with serious mental illness) and 85,000 children with serious emotional disturbance, yet it is estimated that only about half receive any form of public or privately funded treatment.
- ❑ Spending on publicly funded community-based services has not kept pace with the influx of new client groups entering the system.
- ❑ Cost cutting efforts by private sector managed care companies are reducing access to services and forcing people to seek care in the public system.
- ❑ The closure of two major state hospitals during the past four years has placed demands on the community system beyond its capacity to respond effectively.
- ❑ Absence of appropriate community services has caused gridlock in hospital beds making it difficult to discharge those no longer in need of hospitalization and equally difficult to admit people who need acute inpatient psychiatric care. Gridlock also exists between acute, intermediate length-of-stay and long-term care inpatient units within state hospitals. This prevents the transfer of patients already in these facilities to the appropriate level of inpatient care.
- ❑ A growing number of Connecticut general hospitals have cut back and are considering further reductions in their psychiatric services, because they are no longer able to afford the financial drain of supporting such services.
- ❑ Criminal justice officials and operators of nursing homes and shelters for the homeless report increasing numbers of people with psychiatric disabilities entering their facilities.
- ❑ Advocates for the homeless estimate that about 6,000 people with mental disabilities are living in Connecticut shelters.
- ❑ Advocates for children's mental health services point to a disproportionately high percentage of spending on inpatient and

residential care, due to insufficient outpatient alternatives. Meanwhile, 350 children needing mental health treatment have been placed in out-of-state residential facilities because the services they require do not exist in Connecticut.

- ❑ Stigma is a major barrier to people accessing care and interferes with people in recovery.
- ❑ There are widely circulated reports of children being held for days in general hospital emergency departments because of a lack of appropriate community alternatives.
- ❑ Educational systems at every level are not adequately integrated into the children's mental health delivery system.
- ❑ Programs designed to promote mental health and prevent mental illness are not generally funded or available.
- ❑ Consumers and family members are not involved as equal partners in decision-making regarding services they receive and what services are provided.
- ❑ Although some gains have been made, much more needs to be done to strengthen the cultural responsiveness of mental health services.

Taken together, these factors signal the need to thoroughly examine mental health care in Connecticut in order to promote mental health, strengthen prevention efforts, and improve mental health treatment and support for people throughout the life cycle. All of these factors point to an emerging crisis in the State that must be addressed as a major health care priority.

## **Vision for the Future**

Connecticut's response to these issues must be built on both a shared vision and principles that guide development of the public and private mental health services for children, families and adults. Under these principles, Connecticut must ensure that:

- ❑ A full continuum of care and supports is developed and maintained that provides people adequate choice of services and providers.
- ❑ Access to appropriate care is timely and easy to obtain.
- ❑ People who use services are treated with dignity and respect and their legal rights are protected.
- ❑ Best practices and the latest scientific knowledge guide service delivery.
- ❑ Services are culturally responsive and sensitive to the needs of diverse groups and individuals.
- ❑ Services and programs support early intervention and prevention.
- ❑ Care for Connecticut citizens is provided within the state's borders.
- ❑ Funding and reimbursement for mental health services are adequate to support quality care.

- ❑ Mental health services are designed to promote recovery and self-sufficiency and improve quality of life, health and well being.
- ❑ Service delivery decision-making is made at a local level, with consumers and family members as equal partners in these discussions.
- ❑ The stigma associated with psychiatric disabilities and the use of mental health services is reduced.
- ❑ Local school systems are full partners in community-based mental health collaboratives for children with severe emotional disturbances.

## **Recommendations**

The recommendations of the Blue Ribbon Commission centered on six issues specified by the Governor's order:

1. How the mental health, child welfare and criminal justice service systems can work together more effectively.
2. How the state can maximize the collaboration of state agencies and the academic and private communities with expertise in the area of mental health.
3. Potential applications of new knowledge in the area of prevention and earlier identification of mental illness.
4. The treatment approaches that need to be emphasized and more effectively used as the state incorporates increased community-based treatment.
5. The major successes and challenges of the public mental health system from both the national and Connecticut perspectives.
6. The perspective of the advocacy and consumer community as to what is in the best interest of consumers and their families.

Based on study and analysis of the existing service system, the Blue Ribbon Commission has developed several priority recommendations. In addition, the Commission has identified two mechanisms for implementing these recommendations. The Commission's priority recommendations were adapted from the work of the Commission, its Steering Committee, the Expert Panels, and from input garnered during public hearings. In addition, more detailed recommendations were made by the Expert Panels and are incorporated herein by reference.

**Recommendation: Address gridlock in care delivery for children and adults.**

*Timeframe: Immediate action required.*

*Addresses Governor's Area of Emphasis Items # 4 and 5.*

Immediate steps must be taken to ensure that inpatient care is accessible when needed, both for children and adults. To do this, the system must develop a full continuum of community-based services within each geographical area of the state. Community services must be enhanced without compromising the availability and quality of inpatient care.

*Issue:* This recommendation addresses several critical issues. Local community services are neither adequate nor accessible for children with severe emotional disturbance. Similarly, insufficient community services for adults result in increased demand for acute care (e.g., hospitalization) as clients with unresolved clinical needs continue to deteriorate. Patients already in hospitals, who could be discharged to less restrictive settings, have nowhere to go, resulting in system "gridlock." These problems have been exacerbated by cost-containment efforts related to managed care. Providers must struggle with the enormous financial drain of serving people without adequate reimbursement. Because of this, some providers have discontinued care for the most vulnerable populations. While the impact of managed care related cost cutbacks have been felt throughout the system, general hospital behavioral health programs have been particularly hard hit. Most importantly, people who need services encounter difficulties obtaining access to care, or the duration of treatment is cut short of that necessary to achieve positive outcomes. Some people, discharged prematurely from inpatient settings because they no longer qualify for care, end up in shelters for the homeless.

For further discussion of this topic see the Treatment and Intervention Expert Panel recommendations #1, #4, and #6.

**Recommendation: Adjust rates to ensure adequate support for mental health services.**

*Timeframe: Immediate action required.*

*Addresses Governor's Area of Emphasis Items # 4 and 5.*

State agencies, including Office of Policy and Management (OPM), Department of Social Services (DSS), Department of Children and Families (DCF) and Department of Mental Health and Addiction Services

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(DMHAS), should examine and adjust Medicaid and other payment rates for inpatient and community services to adequately support the cost of providing care.

*Issue:* In many cases, the reimbursement rates for inpatient and community-based services are unreasonably low. This reduces access to care for vulnerable populations, contributes to hospital gridlock, and increases homelessness and incarceration among youth and adults with emotional and mental disorders.

For further discussion of this topic see the Managing Services Expert Panel recommendation #1a.

**Recommendation: Enhance community services for children and for adults.**

*Timeframe: During next 6 to 18 months.*

*Addresses Governor's Area of Emphasis Items # 2, 3, 4 and 5.*

DMHAS and DCF, in collaboration with appropriate agencies and consumers, should assess existing community resources. After identifying areas where there are gaps in services, DMHAS and DCF should expand the community-based system to include a full range of services. Further, in collaboration with researchers and academic institutions, state agencies and providers should identify best care practices, and put them into effect.

*Issue:* In some parts of Connecticut, children with serious emotional disturbance are not well served, nor are adults with serious psychiatric disabilities. Long waiting lists, lack of existing services, and programs that do not follow best clinical practices hinder effective treatment. The community services that need to be in place include, but are not limited to, outpatient psychiatric evaluation and treatment, assertive community treatment (including outreach and engagement of homeless people with psychiatric disabilities), mobile crisis services, rehabilitative services, residential services, prevention and early intervention, and non-clinical supports.

For further discussion of this topic see the Managing Services Expert Panel recommendations #4, #5a and #5b and the Treatment and Intervention Expert Panel recommendations #1, #3, #4 and #5.

**Recommendation: Continue to develop locally based systems of care.**

*Timeframe: During next two years.*

*Addresses Governor's Area of Emphasis Items # 1, 2, 3, 4 and 5.*

Community services should be integrated as systems of care, and these systems should be managed locally. DCF and DMHAS must continue to support the development and enhancement of locally-based systems of care that include private and public providers and utilize lead agencies to coordinate planning, policy implementation, and service delivery within specific geographical areas.

*Issue:* When services are not locally managed the continuity of care and client treatment outcomes are adversely affected. This increases the cost of care, the likelihood that care will be disrupted, and risk of homelessness and criminal justice involvement. The DMHAS General Assistance Behavioral Health Program offers a model for adult care that should be considered as DMHAS expands its local systems of care.

For further discussion of this topic see the Managing Services Expert Panel recommendations #2a and #2b.

**Recommendation: Bring home children who have been placed in out-of-state residential facilities.**

*Timeframe: Zoning legislation should be developed during the next legislative session and other components over the next three years.*

*Addresses Governor's Area of Emphasis Items # 4 and 5.*

Out-of-state placements should be halted as soon as necessary services are developed in Connecticut. At that point, children who are placed out-of-state should be returned home to Connecticut. The services required to meet the needs of these children should be made available within the state.

Further, in order to make sure that there are available and appropriate services, including residential care, legislation should prevent municipalities from using zoning regulations to keep DMHAS or DCF service providers from operating within town borders. Although municipalities should not be permitted to prohibit the siting of community-based facilities, DMHAS and DCF should develop such facilities while ensuring that the needs and concerns of local communities and neighborhoods are recognized and taken into account.

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*Issue:* More than 350 children from Connecticut are currently placed in out-of-state residential facilities. The absence of specialized programs for youth with behavioral disorders has made it necessary to place adolescents out of state. When these adolescents finally return home, follow-up care has been made more difficult by the fact that most of them have no sustained connection to their communities. Programs for this population are difficult to establish because of high costs, neighborhood opposition, and the reluctance of providers to face this kind of opposition. Neighborhood opposition to the siting of residential and other treatment facilities also affects DMHAS clients.

For further discussion of this topic see the Advocacy and Consumer Perspectives Expert Panel recommendation #5.

**Recommendation: Ensure coordinated care for young adults who are transitioning from DCF to DMHAS supported services.**

*Timeframe: Ongoing.*

*Addresses Governor's Area of Emphasis Items # 1, 4 and 5.*

Adolescents need transitional services as they "age out" of the DCF system and enter into the service system of DMHAS. The existing programs for transitional youth and special populations that have been developed by DCF and DMHAS should be expanded. Collaborative programmatic and fiscal planning involving DCF, DMHAS and other state and private entities is needed to ensure access to services that were previously unavailable to this population. These services must focus on transitioning youth into adulthood, not only into the adult mental health system.

*Issue:* In the past, DCF and DMHAS have focused on different target populations. DCF has served children, including those with serious emotional disturbance, and DMHAS has served adults with serious and prolonged mental illness and adults with substance use disorders. Too often, young adults have become disconnected from needed mental health services when they are no longer served by DCF. Lack of timely services at this crucial developmental stage increases the risk that these young people will end up in jails, in psychiatric hospitals, on the streets, or idle at home.

For further discussion of this topic see the Managing Services Expert Panel recommendations #3 and the Treatment and Intervention Expert Panel recommendations #7.

**Recommendation: Enhance opportunities for recovery through consumer and family member involvement and empowerment.**

*Timeframe: Immediately begin work, develop DCF customer service office within one year, and complete other recommended components over next two years.*

*Addresses Governor's Area of Emphasis Item # 6.*

The state should quickly develop and implement a plan to make consumers and family members equal partners in the design and implementation of mental health policy and services. The plan should address the following areas:

- ❑ How to assist consumers and families in developing a better understanding of the mental health system.
- ❑ Provision of the necessary resources for effective self-advocacy and advocacy support, including a statewide network of coordinated consumer empowerment and advocacy services.
- ❑ Development of a comprehensive, enforceable universal bill of consumer rights.
- ❑ Development of a consumer-staffed customer relations office at DCF.

*Issue:* An effective and efficient mental health care system must consult with, respect, inform, and support its consumers and family members. Generally, consumers and family members have not been sufficiently involved in decisions about the delivery of mental health services. In addition, there is a need for more consumer/family-friendly information regarding treatment options, the consumer/family role in the development of treatment plans, and their rights when accessing and utilizing public services.

For further discussion of this topic see the Advocacy and Consumer Perspectives Expert Panel recommendations #1 and #2.

**Recommendation: Implement an ongoing community education campaign.**

*Timeframe: Begin development immediately and phase-in over long term.*

*Addresses Governor's Area of Emphasis Items # 2, 3 and 5.*

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State agencies should collaborate with consumers, families, local school systems and academic and private institutions to develop and promote an ongoing statewide education campaign that:

- ❑ Increases public understanding and awareness of psychiatric disabilities.
- ❑ Promotes early detection and treatment of mental health problems.
- ❑ Provides information about how to obtain treatment.
- ❑ Supports recovery from psychiatric disabilities.
- ❑ Collaborates with local school systems to ensure behavioral health education for students, kindergarten through 12<sup>th</sup> grade.

*Issue:* The well being of Connecticut residents would be served if people were better informed about mental health, psychiatric disabilities, and the negative consequences of stigma. By teaching children and adolescents about behavioral health, local school systems can promote the emotional well being of children and adolescents.

For further discussion of this topic see the Advocacy and Consumer Perspectives Expert Panel recommendations #3 and #4.

**Recommendation: Integrate primary prevention into the state system.**

*Timeframe: Over Time.*

*Addresses Governor's Area of Emphasis Items # 2 and 3.*

State government should support primary prevention programs designed to promote mental health, improve health outcomes, and generate net cost savings. State agencies should collaborate on the development of a comprehensive plan to promote mental health across the life cycle, based on state-of-the-art prevention research and practices. The plan should include:

- ❑ A prevention budget across departmental lines.
- ❑ Indicators and benchmarks to guide planning and measure program effectiveness.
- ❑ Prevention training and education targeted to the community-at-large, existing prevention providers, public elementary and secondary schools, and health systems involved in prevention efforts.

In addition, grants should be used to establish model prevention programs throughout the state. Where possible, the programs should build on the central role that certain institutions such as school systems and early childhood play in prevention and early identification.

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*Issue:* Current mental health prevention efforts are fragmented and not well funded or coordinated. Proven models with demonstrated efficacy are not being used in a systematic fashion. Much has been learned in the area of substance abuse prevention that can serve as the basis for development of effective mental illness prevention programs (especially for those disorders that are not caused primarily by biological and genetic factors).

For further discussion of this topic see the Prevention Expert Panel recommendations #1 and #2.

**Recommendation: Improve the cultural competence of mental health service delivery.**

*Timeframe: Over time.*

*Addresses Governor's Area of Emphasis Items # 2, 4, 5 and 6.*

State agencies involved in the delivery of mental health services should incorporate principles of cultural competency into their organizational structures and policies and into the design, development, purchase and implementation of such services. State agencies should engage in high-level interagency collaboration to develop and implement cultural competence clinical standards, outcome measures, policies and procedures. This enhancement should be based on proven models that draw on best practices in the area of cultural competence.

*Issue:* Cultural competence research indicates that cultural issues impact the mental health service delivery system in many ways, including level of client trust, access, engagement, retention, recidivism, cost effectiveness and quality of care. Connecticut must adopt new approaches for addressing the rich cultural diversity of persons who need mental health services.

For further discussion of this topic see the Managing Services Expert Panel recommendation #6 and the Treatment and Intervention Expert Panel recommendation #5.

**Recommendation: Address the programmatic and financial needs of the mental health system.**

*Timeframe: Begin planning immediately and continue on ongoing basis.*

*Addresses Governor's Area of Emphasis Items # 4 and 5.*

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DCF, DMHAS, Judicial Branch and other impacted agencies should develop multi-year plans containing specific programmatic and fiscal proposals to support and enhance the mental health system. Programmatic proposals should be based on assessment of needs of the children, adolescents and adults to be served. These plans should set priorities for each year. In addition, the plans should:

- ❑ Specify the type, service capacity, and number of proposed programs to be implemented during each year.
- ❑ Specify provider performance objectives.
- ❑ Create economies of scale and maximize the efficient use of resources.
- ❑ Support the integrity of the existing services.
- ❑ Integrate the management of multiple funding streams including Medicaid and state grant dollars by implementing the DCF and DMHAS carve-out proposals.

Concurrently, OPM, DSS, DCF and DMHAS should develop plans to:

- ❑ Maximize the use of optional Medicaid State Plan services, including rehabilitation services and targeted intensive case management services.
- ❑ Utilize Medicaid waivers to expand services to adults and children.
- ❑ Reinvest new Federal revenue into the mental health system for children and adults.
- ❑ Conduct an ongoing outreach initiative to enroll eligible individuals in Medicaid. This will ensure Federal reimbursement for services.

For further discussion of this topic see the Managing Services Expert Panel recommendation #1a-1c.

## **Mechanisms for Implementation**

The Blue Ribbon Commission recommends two mechanisms that should be acted upon in order to assure that the recommendations of the Blue Ribbon Commission will be implemented.

**Recommendation: Establish a permanent statewide Mental Health Policy Council that, in supporting the departments and agencies responsible for organizing, managing, and providing mental health services and through periodic reports to the Governor and legislature, would ensure the accessibility and quality of mental health services for Connecticut residents throughout the life cycle.**

***Timeframe: Immediately establish the council's steering committee in order to begin the process.***

***Addresses Governor's Area of Emphasis Items # 1 through 6.***

The Governor's Blue Ribbon Commission on Mental Health has been an effective tool as policymakers, state administrators, service providers, consumers, family members and advocates have explored ways to improve mental health policies and practices, and prevent mental illness. The Commission has recommended an array of changes that will require concerted effort and collaboration.

The Mental Health Policy Council should be comprised of consumers, family members, advocates, providers, community leaders, and representatives from state agencies and academic institutions and include subcommittees that focus on Advocacy, Prevention, Managing Services and Treatment/Intervention. The Council should perform the following functions:

- ❑ Report on implementation of the recommendations made by the Governor's Blue Ribbon Commission on Mental Health.
- ❑ Suggest areas for better coordination among state agencies.
- ❑ Use material gathered from regularly scheduled multidisciplinary case conferences as the basis of policy change.
- ❑ Support the participation and contributions of consumers, family members and advocates in the evolution of mental health policy.
- ❑ Promote the use of best practices in the areas of prevention, early identification, treatment and support for children and families and to support evidence-based treatment and support for adults with psychiatric disabilities.
- ❑ Focus public attention on mental health issues to devise means of promoting recovery from psychiatric disabilities and decreasing stigma.
- ❑ Preserve and protect the state's role as a safety net for poor, disabled and vulnerable citizens.
- ❑ Promote the use of culturally competent mental health services.
- ❑ Propose legislation to improve the service delivery system, reduce barriers to care, and enhance coordination and collaboration among state agencies and service providers.
- ❑ Coordinate its efforts with those of the Connecticut Alcohol and Drug Policy Council, the State Advisory Board of Mental Health and Addiction Services and DCF's Statewide Advisory Council.

For further discussion of this topic see the Prevention Expert Panel recommendation #3 and the Treatment and Intervention Expert Panel recommendation #1.

**Recommendation: Refine and elaborate existing areas of interagency collaboration and develop additional opportunities for collaboration.**

*Timeframe: Ongoing.*

*Addresses Governor's Area of Emphasis Items # 2, 4, 5 and 6.*

Unmet clinical training needs, service fragmentation and problems with the continuity of care have been barriers to effective service delivery. They reduce the likelihood of successful treatment outcomes. State agencies have been working to implement strategies to promote coordination of their efforts. Examples of such collaborations are listed in the appendix of the full report. As the two principal state agencies responsible for mental health services, DCF and DMHAS should continue to work in concert with:

- Advocates, family members and people with psychiatric disabilities to ensure that services are responsive to client needs, that the service delivery system is based on a recovery philosophy, and that the rights and dignity of people with psychiatric disabilities are preserved and defended.
- Universities, training institutions and research scientists to provide training and promote understanding of the underlying principles and assumptions that inform effective treatment of individuals with mental health problems across the life cycle. Identify best practices for the prevention and treatment of emotional and mental disorders and develop implementation standards that can be monitored and evaluated regularly to assess any improvement in the quality of care based on client outcomes.
- Public/private partners to develop and enhance local systems of care and improve access to services.
- The Judicial Branch to prevent incarceration of adolescents and adults with emotional and mental disorders when mental health treatment is the appropriate alternative.
- The Department of Correction to ensure that people with psychiatric disabilities being released from prisons and jails are adequately supported, supervised, and treated.
- The Department of Education, local school systems, and the Probate Courts to help identify and implement strategies for the prevention, detection and early treatment of mental illness.
- The Department of Public Health to identify opportunities for community education about mental illness as a public health problem, and to monitor the quality of mental health care.

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- The Department of Mental Retardation to ensure adequate access to psychiatric services for people with combined intellectual and functional impairments.
- The Department of Social Services to ensure that people with mental health and substance use disorders receive the most appropriate level of care, particularly individuals that are homeless. Additionally, to maximize federal revenue and to implement behavioral health managed care programs for Medicaid recipients as have been proposed in recent studies involving DSS, DCF, DMHAS and OPM. As the state's Medicaid authority, DSS has lead responsibility for ensuring that these proposals are developed and implemented consistent with state requirements and Medicaid regulations.
- OPM and the Legislature to refine and elaborate plans and to help develop Executive and Legislative Branch support.

In order to understand the context in which the Blue Ribbon Commission developed its recommendations it is important to review the work of the Commission's Expert Panels and to examine the current status of mental health in the United States and Connecticut. In the sections that follow, important trends and new developments in mental health are discussed as a means of providing this context. The Connecticut service system for children, families and adults is also described.

### **The Reports of the Expert Panels**

Each of the Expert Panels has compiled an extensive report, providing context, information, and recommendations relating to key issues relating to their particular perspective. These reports are included in the complete report of the Blue Ribbon Commission and summarized below.

#### **The Report of the Expert Panel on Advocacy and Consumer Perspectives**

The panel notes that the consumer movement has substantially influenced mental health policy to tailor services to consumer needs. Consumers are involved in all aspects of mental health services. The slogan "Nothing About Us, Without Us" personifies this effort. The advocacy movement has encouraged mental health systems to view recovery as a defining goal. Recovery-based outcomes, as defined by consumers and their families, are set as the measure of success. The advocacy movement is credited with helping to ensure that the system remains responsive to individual needs, flexible enough to accommodate new ideas, and committed to long-term solutions that promote recovery. Advocacy has promoted the vision that

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the broader community must become a community of recovery that affords equal opportunity for people in recovery and fosters health and wellness.

The report of the panel details current efforts in Connecticut to bring consumers' perspectives into policy discussions and into practice. It describes three types of advocacy as being essential:

- ❑ Self-advocacy - These programs build skills that enable people using mental health services and their families to be more effective advocates on their own behalf. They can include a) comprehensive information and referral systems and help lines; b) advocacy and empowerment training programs; c) effective grievance processes and assistance in using them.
- ❑ Advocacy assistance - These programs provide non-legal and legal advocates to assist people using mental health services in getting better access to appropriate care and in negotiating complex systems. Such advocates may also act as the primary advocates for people who are unable to advocate for themselves.
- ❑ Systems/legislative advocacy - Programs of this type address systemic barriers and recurring issues relevant to the timely delivery of clinically and culturally appropriate care.

After an extensive review and discussion of existing advocacy resources, the panel addresses the need for a better-informed community. Following this, the panel addresses three key issues:

- ❑ Involvement in system design and evaluation
- ❑ Enhancing and coordinating advocacy resources
- ❑ Enhancing public understanding.

### **The Report of the Expert Panel on Managing Services**

Despite attempts to improve the service delivery system, inadequate and fragmented funding presents barriers to comprehensive, community-based care for children and adults. Inadequate funding restricts access, discourages the development of new services, reduces quality and continuity of care, and compromises client outcomes. It also makes it difficult to recruit and retain competent staff to practice in a manner that will result in the best possible outcomes for those receiving services.

Funding fragmentation contributes to unnecessary administrative complexity and inefficiency at all levels of the system. For example, in the children's system, funding comes from five different state agencies. Because the management of service funding is not integrated and some funding sources do not reimburse some forms of care, children and adults

who need mental health care are sometimes denied access to the care they need. This can result in longer than necessary stays in inpatient settings or discharges to shelters or other inappropriate settings for lack of alternatives. The panel strongly urges that these barriers be eliminated.

Ensuring integrated and sufficient funding requires an understanding of the complexity of funding needs. As the service delivery system moves to a community-based system of care, the concept of a “continuum of care” for people with psychiatric disabilities is redefined. The continuum is now seen in broader terms, extending from the prevention of mental illness, to treatment, to the basic supports people need to live and thrive in their homes and communities. These basic supports include income supports, housing, employment, education, transportation, non-clinical community services, primary health care, and the help of both professionals and non-professionals such as family, friends and peers.

Sufficient resources must be directed to each aspect of the continuum to achieve a continuity of care. The challenge is in identifying sufficient resources to ensure a balanced distribution of resources at levels that meet consumer needs. Investment in a recovery-based continuum of care will ultimately result in reduced recidivism and decreased utilization of high-cost services, and in a more cost-effective use of state resources. It will also create the opportunity to employ collaborative approaches that cross the traditional boundaries of state agencies and to blend resources from different agencies and disparate funding streams.

Key issues addressed by the expert panel on managing services include:

- ❑ Sufficient funding
- ❑ Local management of services
- ❑ Development of services for young adults
- ❑ Ensuring accountability for services
- ❑ Supporting professional development.
- ❑ Cultural competence

### **The Report of the Expert Panel on Prevention**

Prevention is focused on both reducing vulnerability and enhancing wellness. Prevention is achieved by reducing risk factors that are known or suspected of causing illness while encouraging protective factors that are known to promote health. Mental health promotion involves taking actions in a deliberate and positive way to build mental health and counteract harmful circumstances before they can cause disorder or disability.

Prevention services help to blunt the onset and effects of problems. These services provide a serious stopgap to crisis. Prevention efforts work to reduce costs for health care and criminal justice systems, as well as reducing lost productivity. Studies have shown that prevention is a cost-effective and affordable investment. When using prevention comprehensively, policymakers can help to decrease violent behavior, aggression, hospital stays, long-term residential treatment, and suicide. They can promote better quality of life, resilient communities, and safety. The report of the expert panel on prevention explores the following topics in depth:

- ❑ The parameters of prevention
- ❑ Improving family life, learning and safety
- ❑ The values of primary prevention
- ❑ The importance of prevention and health promotion for Connecticut
- ❑ Best practice prevention programs
- ❑ Risk and protective factors
- ❑ Points of intervention.

Key issues are then addressed, including:

- ❑ Coordination of prevention efforts across state agencies
- ❑ Mental health as a way of life
- ❑ Best practices in prevention.

### **The Report of the Expert Panel on Treatment and Intervention**

Scientific advances have made mental illnesses eminently treatable. Humane, informed, and effective care is now expected. However, significant challenges remain. For example, major depression accounts for a larger share of the societal burden of lost productivity associated with illness than cancer. It also is known that existing treatments are more effective in bringing about recovery from depression than from many chronic physical illnesses. Yet many people neither seek nor receive appropriate treatment.

Connecticut faces many challenges: overcoming stigma; sustaining and enhancing an effective transition from an inpatient-based to a community-based system of care; having care distributed across both public and private sectors; finding ways to integrate disparate funding streams; overcoming the discrepancy between care that research suggests is “best” and care as typically delivered in the real world; addressing the increased prevalence of co-occurring mental illness and substance use; making treatment responsive to cultural, ethnic, and linguistic differences; expanding services to respond to the increasing number of elderly

individuals needing mental health treatment; providing specialized treatment for specific disorders; and delivering effective treatment services for children and adolescents.

The panel report examines treatment in depth, with separate sections devoted to mental health services for children and those for adults. After exploring the benefits and risks of separating into adult and child subgroups, the panel concluded that the developmental demands and transitions of childhood and adolescence warrant different treatment approaches.

Key issues that the expert panel on treatment and intervention addressed include:

- ❑ Treatment and policy
- ❑ System of care
- ❑ Quality of services
- ❑ Persons with psychiatric disabilities in the criminal justice system
- ❑ Gridlock in the delivery of acute care for children's services.

## **National Trends in Mental Health Service Systems**

Several chapters of the report of the Blue Ribbon Commission address the governor's request to survey the major successes and challenges of the mental health delivery system from both the national and Connecticut perspectives. Issues of national importance are summarized in this section, followed by a section about the mental health service delivery system in Connecticut.

**Mental health**--Mental health and mental illness are not considered to be polar opposites, rather they are viewed as points along a continuum. This is a changed perspective, even from that of the mid-twentieth century, when individuals with psychiatric disabilities were sent away to live in large, residential hospitals in bucolic settings. Many stayed for years, but treatments proved elusive. For long-term patients, recovery from mental illness was deemed unlikely. However, recent advances in clinical research and practice, in medications, and in effective use of interventions and support systems within the community have led to the understanding that treatment works. Success rates of treatment for mental illness range from 60 to 80 percent, even for serious disorders, including major depression, schizophrenia and bipolar disorder.

**The Surgeon General's Report**--In December 1999, the U.S. Surgeon General released a comprehensive report on mental health. In outlining a

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vision for mental health in this country, the Surgeon General's Report makes the following recommendations:

- ❑ Facilitate entry into treatment.
- ❑ Ensure the supply of mental health services and providers.
- ❑ Ensure delivery of state-of-the-art treatments.
- ❑ Tailor treatment to age, gender, race and culture.
- ❑ Overcome stigma.
- ❑ Improve public awareness of effective treatment.
- ❑ Reduce financial barriers to treatment.

By providing extensive information about mental health in this country, the Surgeon General's Report has been invaluable to the work of the Blue Ribbon Commission. Some of those findings are discussed in detail in the full report of the Commission.

The Surgeon General's report lists the following effects of mental illness:

- ❑ About one in five Americans experience a mental disorder during the course of a single year.
- ❑ Approximately 15 percent of those with a mental disorder in one year also have a co-occurring substance use disorder.
- ❑ Less than one third of those with a diagnosable mental disorder receives treatment in one year.

Knowledge about mental illness and mental health highlight the following:

- ❑ Mental health is essential to well being and prosperity.
- ❑ A range of effective treatments exists for most mental disorders and their efficacy is well documented.
- ❑ Some effective prevention strategies are being developed, but progress in prevention has been slow.
- ❑ There are gaps between optimally effective treatment and the treatments used in actual practice.
- ❑ Mental disorders and less severe mental health problems must be understood within a social and cultural context.
- ❑ The involvement of consumers and families has become an important force for positive change in service delivery and policy development.
- ❑ Renewed hope for recovery has helped consumers attain greater self-reliance and personal satisfaction and to become more fully involved in community life.

The costs of psychiatric disabilities are significant:

- ❑ In 1996, the cost of treatment and rehabilitation for psychiatric disabilities was \$69 billion; an additional \$13 billion was spent on substance use disorders.
- ❑ Approximately 47 percent of treatment costs come from private sources, primarily insurance and individual payments; 53 percent of treatment costs were from public sources, primarily state general fund appropriations and Medicaid and Medicare.
- ❑ In 1990, the indirect costs of psychiatric disabilities - financial losses resulting from reduced productivity, incarceration, or premature death - were estimated to be \$79 billion.

**The Olmstead Decision** -- In June of 1999, the U.S. Supreme Court issued a decision that upheld the validity of the Department of Justice regulations and specifically found that unnecessary segregation and institutionalization constitute discrimination under the Americans with Disabilities Act (ADA). The case involved the rights of two Georgia women, institutionalized for many years, to receive services in a community setting. The Court noted that Congress intended that the ADA be used to secure community living opportunities for persons with disabilities. The Olmstead decision makes it clear that public entities have a responsibility, within reason, to promote community integration in settings that enable individuals with disabilities to interact with non-disabled persons to the fullest extent possible.

**The Recovery Movement**--The concept of recovery from psychiatric disabilities is based on the evidence that many people who have access to the right combination of sustained and well-coordinated treatments and supports can learn to manage their illnesses. As recovery progresses, the individual becomes more independent and better adjusted to community life while simultaneously reducing reliance on the mental health system. Pioneering long-term studies following persons with serious psychiatric disabilities have documented recovery rates as high as 50-65 percent, twenty-five years after initial diagnosis (Harding et al, 1987).

In order to maximize the prospects for recovery for individuals with severe disorders, the National Alliance for the Mentally Ill (NAMI) has developed model legislation. This legislation contains eight critical components considered to be important to recovery:

- ❑ Increased consumer and family participation in services planning
- ❑ Equitable health care coverage
- ❑ Access to newer proven medications
- ❑ Programs for assertive community treatment

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- ❑ Work incentives for persons with psychiatric disabilities
- ❑ Reduction of life-threatening and harmful care such as restraints and seclusion
- ❑ Reduction of criminalization of persons with severe psychiatric disabilities
- ❑ Increased access to permanent, safe affordable housing with appropriate community-based services.

**Advocacy**--Across the country, consumers--people who use or have used services of the mental health system--have joined with family members and advocates to influence mental health policy. The nationwide campaign, "Nothing About Us, Without Us," sponsored by the National Alliance for the Mentally Ill, illustrates the role of advocacy groups in helping to shape the country's mental health agenda. The primary goals of the advocacy movement are to:

- ❑ Overcome stigma and prevent discrimination in policies and laws affecting persons with psychiatric disabilities
- ❑ Encourage self-help and a focus on personal dignity, consumer rights, and recovery
- ❑ Draw attention to the special needs associated with certain disorders or disabilities and promote research to improve treatment
- ❑ Ensure that treatment and support services are responsive to the needs of different age, gender, racial and cultural groups.

**Responding to cultural needs**--The Surgeon General states, "The U.S. mental health system has not been very responsive to the needs of racial and ethnic minorities." Responding to the needs of diverse racial, ethnic, and cultural groups represents a major challenge for the mental health system in America.

Experts in the field of cultural competence have shown that the outcomes of interventions vary when consumers from different racial, ethnic, or cultural groups are treated without regard to their particular cultural standards. Cultural competence must be a perspective that permeates every aspect of the development and operation of the mental health system. It cannot be viewed simply as a fragment or "special" area of focus.

**Co-occurring disorders**--In recent years there has been increasing documentation of the prevalence of persons with both a substance use disorder and mental illness. Several studies have found that about one-half of all persons with a serious psychiatric disabilities also had a substance use disorder during their lifetime. This has led to considerable research to find a model for treating individuals who need services for both mental illness and substance abuse. This is particularly important since recent

studies have suggested that the use of alcohol and illegal substances substantially increase the risk of violent behavior. Recently, treatment models are emerging to deal with the complexities of co-occurring disorders.

**The criminalization of mental illness**--Over the past decade, there has been concern about the increase in the proportion of inmates in jails and prisons who have mental disorders. Though often blamed on de-institutionalization and inadequate funding for community care, it also results from a combination of social factors including substance abuse, lack of adequate social support, medical complications, and the difficulty of maintaining long-term engagement in treatment. The presence of more people with psychiatric disabilities living in the community has resulted in an increase in the arrest and incarceration of some of these individuals, particularly those involved in minor offenses. As a result of all these factors, rates of serious mental disorder among the U.S. jail and prison population are considerably higher than in the general population. Several studies have concluded that 6 – 10 percent of incarcerated adults have a serious psychiatric disability, such as schizophrenia or bipolar disorder.

## **Mental Health Services in Connecticut**

During the past twenty years, mental health care in Connecticut has shown improvement. Advances have been made in rehabilitation and support systems for clients living in community settings, in the development of cognitive and behavioral therapies, and in new medications. In addition, continuity of care has been enhanced. There is continuing work to decrease fragmentation of services. Changes in the management, organization, and financing of services have facilitated these advances. More recently, a growing movement of consumers, families and advocates has changed the focus of public policy. Issues of fundamental importance that the advocacy movement has brought to the system include promoting consumer rights, emphasizing recovery as a goal, advocating for children's mental health services, and highlighting the burdens of stigma. Connecticut's new insurance parity law covers benefits for virtually all mental health and substance use disorders.

## **Mental Health Services for Children, Adolescents, and Their Families**

The Connecticut Department of Children and Families (DCF) has maintained statutory responsibility for children's mental health services for almost twenty-five years. DCF also has statutory responsibility for child welfare, substance abuse, juvenile justice, and prevention services. It is mandated to license, monitor, and evaluate certain services provided for

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children by private and community providers, such as outpatient mental health clinics, extended day treatment services, foster homes, group homes, emergency shelters, and residential treatment centers.

In 1974, Connecticut was the first state in the nation to legislate the structure for a consolidated agency for services for children and their families. The move to integrate children's service within a single agency rather than scatter them across separate agencies was based on several premises:

- ❑ The mental health needs of children were too often overlooked or given too little attention within the system for adults.
- ❑ The developmental needs of children require a specialized set of interventions that are distinct from those that are effective for adults.
- ❑ There is considerable overlap in the populations of children and adolescents who have experienced abuse or neglect, those who have significant emotional disabilities and those who have been involved in the juvenile justice system.
- ❑ The wide range of services needed by children and their families can best be met in an agency that works in partnerships with families and the community agencies which address the needs of children, including schools, advocacy groups, and private providers of care for children.

Connecticut has established a system for planning and monitoring children's services that draws on representatives from consumer groups and providers in all parts of the state. The State Advisory Council (SAC), appointed by the Governor to advise DCF, coordinates the efforts of five Regional Advisory Councils. The Children's Behavioral Health Advisory Council, which reports to the SAC, serves as the State Planning Council for Children's Mental Health. This group reviews services and strategies and assists in planning resource development. More than 51 percent of the members of the Planning Council are parents, foster parents, or adoptive parents of children with severe emotional disturbance. This subcommittee also advises on the implementation of Public Act 97-272, "An Act Concerning the Mental Health Mandate of DCF," that enables parents or guardians to use state-funded mental health resources for their child without having to relinquish guardianship. This planning process has been further expanded by Public Act 00-188, passed during the 2000 legislative session. This act established a Children's Behavioral Health Advisory Committee composed of members appointed by the State Advisory Council and members representing key state agencies who are appointed by the Governor.

The Blue Ribbon Commission acknowledges the importance of emphasizing the uniqueness of children and therefore supports the need for

a comprehensive and consolidated mental health system for children that coordinates mental health and substance abuse services with those of child welfare and juvenile justice.

**Structure of DCF and access to service**--The mental health division of DCF oversees and coordinates mental health program development and policy on a statewide basis. While DCF is responsible for overseeing an array of services for children, unless these services are Medicaid funded or provided to children in the custody of the state, they are not considered entitlements. Thus, the department must balance need with available appropriations, and looks to coordinating DCF-funded services with those provided through local school systems and private and public insurance.

**Community-based DCF funded services**--Child guidance clinics serve as the backbone of the community mental health system. There are 26 child guidance clinics in Connecticut. DCF dollars provide only partial payment for their services.

**Residential facilities**--The only state-administered psychiatric hospital for children in Connecticut is Riverview Hospital, in Middletown. It provides inpatient care to 98 children and youth. Additionally, Connecticut Children's Place, a 54-bed residential care facility for abused and neglected adolescents, provides extensive diagnostic evaluation and brief treatment services to children waiting alternative placement. High Meadows, with 42 beds, serves adolescents in need of emergency placement or short-term residential care, including psychiatric assessment and clinical treatment.

**DCF-funded private residential facilities**--For children in need of intensive residential treatment beyond the capacity of Connecticut Children's Place or High Meadows, DCF pays for residential treatment elsewhere. As of 1999, DCF had placed over 1,250 children in residential treatment.

**Systems of Care**--The blueprint for a community-based mental health delivery system for children who are seriously emotionally disturbed is based in P.A. 97-272, "an Act Concerning the Mental Health Mandate of DCF", passed by the legislature in 1997. The aim is to provide community-based care that meets the needs of children who are seriously disturbed while keeping them at home and in their communities. The System of Care model identifies an array of services and integrates these services into a broader system.

**Transitional services**--Two relatively new programs are now providing specialized supports for older adolescents. Both grew out of collaboration between DCF and DMHAS. The Special Populations project serves

adolescents who are "aging out" of DCF and who behave in ways that put themselves or the community at risk. This highly individualized program combines clinical intervention with services that are both appealing and highly motivating. It serves almost 50 youth. The Transitional Youth Program serves an additional 30 children.

**Youth Suicide Advisory Board** – This statutorily mandated board has as its mission, a coordinating and advisory role on the topic of youth suicide. DCF is responsible for the coordination and oversight of this vital group of concerned providers, state agencies and consumers.

**Other child mental health services**--The State Department of Social Services funds a range of inpatient and outpatient mental health services through the Medicaid program. The State Department of Education provides funding for 94 Youth Service Bureaus statewide. Other state agencies and private organizations such as general hospitals and freestanding psychiatric hospitals provide a range of mental health services. In addition, mental health services are provided by social workers and school psychologists in school-based and school-linked health centers throughout the state.

### **Adult Mental Health Services in Connecticut**

The Department of Mental Health and Addiction Services was established by the General Assembly in 1995, expanding the functions previously provided by the Department of Mental Health to include oversight for addiction services in Connecticut.

Providers of mental health services for adults in Connecticut include:

- DMHAS Funded and Operated Facilities
  - Fifteen Local Mental Health Authorities (LMHAs) covering the entire state, including six operated by DMHAS and nine run by DMHAS-funded private non-profit agencies, plus over ninety affiliated private non-profit community-based organizations. The LMHAs provide a broad range of services including outpatient, residential, vocational, emergency crisis, case management, psychosocial rehabilitation clubhouses and other specialized programs. (See Appendix A for listing of areas covered by LMHAs)
  - DMHAS-operated inpatient psychiatric hospitals, including Connecticut Valley Hospital in Middletown and Cedarcrest Hospital in Newington and two smaller DMHAS operated inpatient

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units sited at Greater Bridgeport Community Mental Health Center and at Connecticut Mental Health in New Haven.

- Services Provided by Other State Agencies, Private Organizations and Other Entities:
  - Inpatient and ambulatory psychiatric care provided by general hospitals and two private psychiatric hospitals.
  - Services provided by private mental health practitioners.
  - Involvement of the Probate Courts in assessing the need for psychiatric inpatient commitments, assignment of conservators, involuntary medication orders and in other mental health related legal proceedings.
  - Mental health services provided by the Department of Correction to inmates in Connecticut prisons.
  - Services provided to people with psychiatric disabilities through the state's Court Supported Services Division of the Judicial Branch.
  - Services offered through community outpatient clinics (e.g., Federally Qualified Health Centers), Health Maintenance Organizations, and primary care physicians.
  - Services operated by the Veteran's Administration, including 28 inpatient psychiatric beds in West Haven and outpatient services in West Haven and in Newington. Counseling services are also available in five Veteran's Centers around the state.
  - Pastoral counseling offered by religious organizations.
  - Volunteer-run peer support and self-help groups.

**Access to Services--** The majority of adults with mental illness served in the DMHAS system are those with severe and persistent forms of these disorders. However, it is important to note that not all people with severe psychiatric disabilities are served in the public sector, and that many people with mental disorders are not receiving any form of treatment.

It is also important to understand that the public system serves substantially higher numbers of persons of different racial, ethnic or cultural groups, including African Americans and those of Mixed Race/Other than are found in the general population. Although these individuals total only 11 percent of the Connecticut adult population, they constitute 42 percent of the inpatient use of DMHAS facilities and represent 25 percent of its community clients. Men are significantly more likely than women to be treated in DMHAS hospital settings, by a ratio of 2:1. During FY 99, approximately 16 percent of the adults receiving mental health services in DMHAS were also being treated for one or more substance use disorders.

### **The General Assistance Behavioral Health Program**

In June 1997, the General Assembly granted DMHAS authority to operate a managed behavioral health program for recipients of State Administered General Assistance. The model was designed to utilize the best technologies of private sector managed care but to do so within a framework of public sector values. These values emphasize the state's role as a "safety net" that is needed to promote recovery for people of low-income who have complex behavioral health needs. DMHAS began operating the General Assistance Behavioral Health Program (GABHP) in 1997.

Components of the GABHP include:

- ❑ Statewide network of Behavioral Health Units designed to evaluate and make treatment referrals.
- ❑ Care and Case Management Program designed to help clients who were repeated users of acute care services to connect rapidly to rehabilitation services following an acute care episode.
- ❑ Administrative Services Organization (ASO) to process provider claims, perform utilization management functions, and review provider credentials.

An increased array of behavioral health services has been made available to general assistance clients, thereby improving access to care. The percentage of general assistance clients using behavioral health services has increased to 46 percent. Compared to other clients, those served in the Care and Case Management Program:

- ❑ Are more likely to become involved in rehabilitative care following discharge from acute care, rather than cycling through acute care services.
- ❑ Have improved "level of functioning" scores on a standardized clinical rating instrument.
- ❑ Have fewer acute inpatient admissions.

### **Financing Mental Health Services in Connecticut**

Mental health services in Connecticut are funded in several state agencies (DMHAS, DCF, Department of Correction and in the Court Support Services Division of the Judicial Branch) through state and federal funding sources. These funding sources include state General Fund appropriations, Medicare and Medicaid and a small amount of private funds. In addition,

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municipalities support mental health services (e.g., school social workers and school psychologists) in local school systems.

Within DMHAS, funding for mental health services totaled \$257 million in FY 1996 and \$290 million in FY 1999. Much of the increase in the Department's budget for mental health services since FY 1996 can be attributed to programs for new client groups, including programs for State Administered General Assistance recipients needing behavioral health services, clients with Acquired or Traumatic Brain Injury, clients transitioning from DCF, and individuals with special mental health needs requiring community supervision. Excluding these new populations, and adjusting for inflation, the DMHAS budget for other mental health services increased by 0.5 percent between FY 1996 and FY 1999.

Recognizing the need to decrease the percentage of people with psychiatric disabilities in the state's prisons and jails, in June 2000, \$3.1 million was appropriated and approved by the legislature and the Governor to expand the current jail diversion program to the remaining 11 lower court districts.

**Insurance parity**--Insurance benefits for behavioral health have not been comparable to those available for general medical services. This lack of insurance parity has restricted the supply of mental health services and has had negative impacts on professionals in mental health. In 1999, the General Assembly passed a comprehensive parity law (P.A. 99-284, Special Session; Sections 27-28). In its present form, the Connecticut parity law is one of the most progressive in the nation, covering virtually all mental health and substance use disorders. The new law went into effect on January 1, 2000 and applies to all fully insured insurance policies. However, about 50 percent of all state residents are covered by health insurance self-funded through an employer; and such plans are exempt from Connecticut's mental health parity law. In addition, insurance company compliance with the intent and specific requirements of the parity law has not yet been assessed.

## **Conclusion**

Connecticut can do better. There is no reason that the state with the highest per capita income in the country cannot meet the needs of adults and children with mental health problems. However, the responsibility for supporting the cost of mental health care and ensuring necessary access must be shared in balance between the public and private sectors (including state agencies, health maintenance organizations, managed care companies and insurance companies and other stakeholders). The recommendations of the Governor's Blue Ribbon Commission can be the guide for improving mental health in Connecticut. The State should embrace these recommendations and the vision that supports them so that Connecticut may once again be recognized as a national leader in the delivery of mental health services.

## **Governor's Executive Order**

**State of Connecticut by His Excellency**

**John G. Rowland**

### **Executive Order No. 17 A**

WHEREAS, mental illness is a serious healthcare problem for many Connecticut residents, as evidenced by the fact that over 37,041 adults were treated in 1998-99 by the Connecticut Department of Mental Health and Addiction Services for serious, persistent mental illness; and

WHEREAS, the Surgeon General has issued a report entitled "Mental Health: A Report of the Surgeon General; and

WHEREAS, mental illness of less severe levels effects a large proportion of the Connecticut adult population and their families; and

WHEREAS, mental illness of any form among Connecticut's youth is extraordinarily damaging to their development, if not properly identified and treated; and

WHEREAS, the population expected to be cared for by the public mental health system is expanding in terms of its numbers and the complexity of the conditions to be treated; and

WHEREAS, an effective strategy for addressing mental illness requires a comprehensive approach including prevention, early identification and treatment, and a continuum of care which includes a spectrum of community support and hospital services.

NOW, THEREFORE, I, John G. Rowland, Governor of the State of Connecticut, acting by virtue of the authority vested in me by the Constitution and by the statutes of this state, do hereby ORDER and DIRECT:

1. That there is hereby created a Blue Ribbon Commission on Mental Health (hereinafter Commission) to study the issue of mental illness and make recommendations on how the State can improve prevention efforts and treatment services.

Emphasis shall be placed on determining:

- . How the mental health, child welfare and criminal justice service systems can work together more effectively;
- . How the state can maximize the collaboration of state agencies and the academic and private communities with expertise in the area of mental health; and
- . Potential applications of new knowledge in the area of prevention and earlier identification of mental illness;
- . The treatment approaches that need to be emphasized and more effectively used as the state incorporates increased community-based treatment;
- . The major successes and challenges of the public mental health system from both the national and Connecticut perspectives; and
- . The perspective of the advocacy and consumer community as to what is in the

*REPORT OF THE GOVERNOR'S BLUE RIBBON COMMISSION ON MENTAL HEALTH*

best interest of consumers and their families.

2. That Dr. Albert Solnit shall serve as Chairperson of the Commission. That the Dean of Yale Medical School shall serve as Honorary Chairperson.
3. That the Chairpersons will be assisted by Co-Chairs (the Commissioners of Children and Families and the Commissioner of the Department of Mental Health and Addiction Services) and by a Steering Committee composed of the Commissioners of Social Services, Correction, Public Health, Education; the Chief Court Administrator, the Secretary of the Office of Policy and Management; and five experts from the mental health field to be appointed by the Governor.
4. That the Commission shall be comprised of no more than 50 persons from the medical community, not for profit and service organizations involved in the field of mental health and government and community leaders, consumers and family members appointed by the Governor.
5. That the following persons may also be invited by the Chairperson to serve on the Commission's working groups: the Chief State's Attorney, Chief Public Defender, Probate Court Administrator, Psychiatric Security Review Board's Executive Director, Commissioners from the Insurance Department, Department of Mental Retardation, the Office of Health Care Access, and legislators with expertise or interest in mental health issues.
6. That the Commission shall be staffed by members of the Office of Policy and Management and the Department of Mental Health and Addiction Services and the Department of Children and Families.
7. That the Commission shall report back to the Governor on its conclusions and recommendations on or before August 1, 2000.
8. That this Order shall take effect immediately.

Dated in Hartford, Connecticut this 24th day of January 2000.

JOHN G. ROWLAND, Governor

Filed this 26<sup>th</sup> day of January 2000.

Susan Bysiewicz, Secretary of the State

## Commission and Steering Committee Members

### Steering Committee Members

Solnit, Albert J., Chair	Meltz, Morgan
Kessler, David, Honorary Chair	Morales, Arturo
Kirk, Thomas A., Co-Chair	Robinson, Danielle
Ragaglia, Kristine D., Co-Chair	Ryan, Marc S.
Armstrong, John J.	Schwartz, Harold
Davidson, Kay W.	Sergi, Theodore
Garcia, Joxel	Wilson-Coker, Patricia
Leuba, Robert	

### Commission Members

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Ahluwalia, Satwant	Lewis, Martha E.
Amdur, Sheila	McAtee, Mary
Bailey, John M.	Meehan, John
Breetz, Sheryl	Melville, Frank
Bunnell, Eva	Meyers, Judith
Bunney, Benjamin S.	Morgan, Harry E.
Burton, Rosemarie	O'Meara, Peter H.
Coughlan, Philippa M.	Perlstein, Sherry
Cronin, Kelly	Reider, Jr., George M.
D'Eramo, David	Reigner, Brian
Gates, Heather	Sangster, Yvette
Geballe, Shelley	Silverman, Samuel M.
Gorman, Raymond	Sims, John
Griffith, Ezra	Smyth, Gerard A.
Guzman, Phil	Van Tassel, Janet
Huey, Leighton Y.	Williams, Janet
Jones, Milton	Woolston, Joseph
Kramer, Edward	Zimmerman, Elaine
Kraus, Mark L.	

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Dailey, Wayne	Francis, Irma
Siemianowski, Jim	Luna, Kelly
Dorn, Pamela	Maximin, Colletter

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Henschel, Dawn  
Kangas, Karen  
Lichtenstein, Bob  
Matthies, Jim  
Morgan, Harry  
Murphy, Tom  
O'Connor, Jo-Anne

Reignier, Brian  
Robinson, Danielle  
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Sims, John  
Solomon, Judy  
Werboff, Susan  
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Burton, Rosemarie  
Carrier, Kathleen

duPree, Kathryn  
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Ferrante, Anthony  
Fry, Steve  
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Meltz, Morgan  
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Frisman, Linda  
Geller, Barbara  
Glick, Jennifer

Grace, Susan  
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Huckin, Karen  
Jacques, Marc  
Kraus, Mark  
Krauss, Judy  
Lewis, Martha  
Marcus, Ken  
Mattison, Ed  
Morales, Arturo  
Perlstein, Sherry

Plant, Robert  
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## CHAPTER I - INTRODUCTION

Recognizing the significant impact that mental illness has on the lives of tens of thousands of Connecticut residents, Governor John G. Rowland created the Blue Ribbon Commission on Mental Health on January 24, 2000. In establishing this Commission, the Governor asked that the perspectives of consumers and advocates be of high priority. Opportunities to improve the system for all residents were to be explored. The Commission was to explore strategies for prevention, early diagnosis and treatment for people who are affected by mental illness, and improvements to the system that could be achieved by collaboration among state agencies and other organizations.

Mental illness knows no socioeconomic or geographic boundaries. It affects people who are rich and poor, urban and rural, young and old. However, the frequency with which mental illness occurs and the burdens it imposes are felt disproportionately by people in lower socioeconomic groups (Holzer et al, 1986; Regier et al, 1993).

Historically, Connecticut's government has played a vital role in providing a "safety net" for people with psychiatric disabilities who have not had access to any other care. Like other state governments, Connecticut has funded and operated a statewide system of mental health care in collaboration with private and non-profit agencies. The state-funded mental health system has had certain limitations. Nevertheless, Connecticut's system has helped many people overcome disabilities and achieve considerable independence. It has provided for many a pathway and the potential for recovery.

During the past twenty years, mental health care has shown substantial improvement. Advances have been made in rehabilitation and support systems for clients living in community settings, in the development of counseling psychotherapies, cognitive and behavioral therapies, and in new medications. In addition, continuity of care has been enhanced and there is promise of a decrease in fragmentation of services. Changes in the management, organization, and financing of services have facilitated these advances.

Concurrent with these changes, a growing movement of consumers, families and advocates has refocused the public policy discussion. Issues of fundamental importance that the advocacy movement have brought forward include promoting consumer rights, emphasizing recovery as a goal, advocating for children's mental health services, and highlighting the burdens and prevention of stigma. Advocates have changed the way we look at service provision, having increasingly participated in planning and evaluating these services. They have added richness to our understanding of issues that could not have been achieved otherwise.

Over the years, the state's treatment and support system has grown and matured. However, important gaps still exist in certain areas of mental health care, particularly in services for children and adolescents and for adults with co-occurring (psychiatric and substance use) disorders. In Connecticut, as in most other states, strategies to prevent mental illness and promote mental health have not been systematically developed. While managed care strategies can offer opportunities to improve the quality of care; the current emphasis of most managed

care companies on cost containment has reduced access to treatment and created risks for some of our most vulnerable citizens. The ongoing development of requisite levels of community-based care has been challenged by the high demand for such services. This has occurred coincident with the downsizing and closure of state hospitals. In addition, the recent release of the U.S. Surgeon General's landmark report on mental health provides new information and raises issues that warrant discussion and action.

A decade ago Connecticut was recognized as having one of the country's best community mental health systems for adults (Torrey, et al 1990). Emerging needs and new knowledge challenge the state to build on this strong foundation. Today, there is mounting concern that the system is under extraordinary stress, at a crisis level requiring corrective action to address a wide variety of problems.

Whether a crisis exists or not, no one can deny that there are clear signs of trouble. For example:

- ❑ Spending on publicly funded community-based services has not kept pace with the influx of new client groups entering the system.
- ❑ Cost cutting efforts by private sector managed care companies are reducing access to private services, moving people to seek care in the public system.
- ❑ Critics contend that the closure of two major state hospitals during the past four years and failure to have re-invested all of the savings has stretched the community system beyond its capacity to respond effectively.
- ❑ Absence of appropriate community services has caused gridlock in hospital beds making it difficult to discharge those no longer in need of hospitalization and equally difficult to admit people who need acute inpatient psychiatric care. Gridlock also exists between acute, intermediate length-of-stay and long-term care inpatient units within state hospitals. This prevents the transfer of patients already in these facilities to the appropriate level of inpatient care.
- ❑ A growing number of Connecticut general hospitals have cut back and are considering further reductions in their psychiatric services, because the hospitals are no longer able to afford the financial drain of supporting such services.
- ❑ Criminal justice officials and operators of nursing homes and shelters for the homeless report increasing numbers of people with psychiatric disabilities are entering their facilities.
- ❑ Advocates for the homeless estimate that about 6,000 people with mental disabilities are living in Connecticut shelters.
- ❑ Advocates for children's mental health services point to a disproportionately high percentage of spending on inpatient and residential care, due to insufficient outpatient alternatives. Meanwhile 350 children needing mental health treatment have been placed in out-of-state residential facilities because the services they needed did not exist in Connecticut.
- ❑ There are widely circulated reports of children being held for days in general hospital emergency departments because of a lack of appropriate community service alternatives.

These concerns warrant a comprehensive and objective view of the system as a whole. The work of the Blue Ribbon Commission provides this level of inquiry and promotes a platform for supporting mental health and strengthening prevention, treatment and support services for people throughout their life cycle.

## **The Blue Ribbon Commission and Expert Panels**

The Blue Ribbon Commission consisted of fifty members, including heads of fourteen different state agencies, consumers and advocates, experts in health and mental health, and other community leaders. Fifteen Commission members were selected to form a Steering Committee. The Steering Committee identified priority issues to be addressed by the final report and coordinated input from the various committees, other experts, and the public.

As a means for gathering information and beginning to formulate recommendations, four Expert Panels were created to assist the Commission. The Expert Panels focused on the following areas:

- Advocacy and Consumer Perspectives
- Prevention of Mental Illness and Promotion of Mental Health
- Treatment and Intervention
- Managing and Financing of Services

Two co-chairs led each Expert Panel, one with a background in child and family issues and one representing adult issues. Similarly, panel members were selected to represent a balance of issues, including specialization in issues relevant to children and families and those relevant to adults. Panel members included individuals with experience in one or more of the following areas:

- Advocacy for people with psychiatric disabilities
- Direct experience as user of using mental health services, as a consumer or a family member
- Service delivery in the public and private sectors
- Specialized backgrounds in:
  - inpatient psychiatry
  - rehabilitation
  - community mental health
  - voluntary support services
  - consumer and family advocacy
  - legal rights
  - criminal justice
  - child psychiatry
  - forensic services
  - nursing home care and services for the elderly
  - prevention
  - housing
  - health
  - education

- managed care and insurance
- Policymaking and administration
- Academia and research

The full Commission met five times. The Expert Panels met on a weekly basis over a three and one half-month period, from March through the beginning of June 2000. About every three weeks, the Expert Panels met in combined sessions to discuss their findings and to coordinate issues that cut across panels. On the same schedule, panel co-chairs met with the Commission chair and co-chairs. Some panels held special meetings to conduct interviews with individuals involved with the mental health system.

To maximize public input, the Commission sponsored public hearings in each of the state's five uniform planning regions. Public comment was also received during a meeting of the full Commission.<sup>1</sup> Written public comment was solicited. A briefing reviewed the Commission's work with members of the State's General Assembly. A complete transcript containing all written and oral public comment is located on the DMHAS web site <http://www.dmhas.state.ct.us/>.

## Content of the Report

The remaining sections of the report are organized as follows:

- Current Developments in Mental Health – This section reviews important advances, research and trends in the field of mental health at the national level including some of the findings from the report of the Surgeon General on mental health. These issues provide context for the discussion about mental health in Connecticut.
- The Evolution of Mental Health Care in Connecticut – This chapter includes a brief history of the development of mental health care in the state.
- Mental Health Services in Connecticut Today – This section gives an overview of the present status of the mental health system for children and adults including trends in the availability of services and resources.
- Summary of Priority Recommendations – This chapter includes the Commission's priority recommendations as adapted from the work of the Expert Panels.
- Mechanisms for Implementation – The section includes recommendations for carrying forward the work of the Governor's Blue Ribbon Commission after it ends and contains suggestions for interagency collaboration.
- The Expert Panel Reports – This chapter includes the complete report of each expert panel. The reports include Advocacy and Consumer Perspectives; Managing Services; Prevention; and Treatment and Intervention. These sections identify areas where service system

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<sup>1</sup>An additional public input session was held in Torrington at the request of local Legislators.

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improvements can be made and how Connecticut can promote better mental health among its citizens. The reader is strongly encouraged to review the complete text of the panel reports.

- Conclusion – This section summarizes the main themes of the report.

## CHAPTER II - CURRENT DEVELOPMENTS IN MENTAL HEALTH<sup>2</sup>

### **Defining Mental Health and Mental Illness**

The Blue Ribbon Commission has addressed both mental health and mental illness. They are not viewed as polar opposites, but rather as points along a continuum. Mental health is a state of well being that allows people to build and sustain satisfying relationships with others, to carry out productive activity, to attain a sense of personal fulfillment, and to adapt to change and cope with adversity. At all stages of life, mental health influences an individual's ability to learn and develop new skills, to communicate, to respond effectively to the challenges that life brings, and to maintain self-esteem. Mental health is essential to general health and to the well being and prosperity of individuals, families, communities, and society.

Mental illness is defined as a set of health conditions, mediated by the brain, that adversely affect thinking, mood, and behavior. These conditions cause distress and can limit performance in social, occupational and vocational functioning. Extreme forms of mental illness can have a persistent impact on an individual. One may have recurrent cyclical episodes characterized by acute symptoms, such as disturbances in thinking, mood and behavior. These episodes may be followed by relatively quiescent periods in which these symptoms are markedly reduced or disappear entirely. However, even in quiescent periods, a person with severe mental illness may have problems performing routine life functions that might pose little difficulty for someone who is mentally healthy. This is why the system of care and supports should be extended beyond the goal of reducing symptoms. Supports should encompass assistance in a broad range of life activities, such as housing, self-care, and personal finances, as well as in socialization, education, and employment.

Our understanding of mental illness has grown rapidly during recent decades. There have been considerable advances in neuroscience, molecular genetics, and applied research in treatment and rehabilitation. Yet, even so, the etiology of many forms of mental illness is not well understood. Nor are the factors that contribute to mental health. For example, when individuals experience psychological trauma or extreme stress, some develop mental disorders, but others do not. These differences in resilience and coping ability underscore the complex interplay among biological, genetic and environmental factors as determinants of mental illness.

### **Mental Health Problems versus Mental Illness**

Many people underestimate the significance of having a psychiatric disability and believe that those with mental disorders lack the will power to overcome their conditions. This myth stems from the fact that nearly everyone experiences signs and symptoms that mimic mental illness at some point during their lives. Therefore, it is important to understand the distinction between

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<sup>2</sup> This section relies heavily upon *Mental Health: A Report of the Surgeon General*, published in December, 1999. The Governor's Blue Ribbon Commission wishes to acknowledge the importance of this report as a source of information in the work of the Commission.

mental health problems and mental illness. For example, the death of a loved one can cause mental health problems whose symptoms are nearly identical to those observed in clinical depression. Symptoms might include sleep disturbance, loss of appetite, and diminished ability to think or concentrate. The duration of symptoms over time is a defining characteristic. Mental illness connotes a longer duration. Bereavement symptoms that last less than two months would not be identified as mental illness. However, the emotional pain of bereavement is no less real than the distress of clinical depression. Mental health problems may require interventions to ensure that they do not lead to a mental disorder or other negative consequences. For example, elderly adults who are without supports have the greatest risk for suicide, heart attack or death from other causes (Zisook & Shuchter, 1991, 1993; Frasure-Smith et al., 1993, 1995; Conwell, 1996). Mental health problems lie along the continuum between mental health and mental illness.

## **Mental Health: A Report of the Surgeon General**

In December 1999, the U.S. Surgeon General released the most comprehensive statement on mental health ever made by the federal government. In its nearly 500 pages, the report covers a broad range of issues. Certain items are particularly noteworthy for Connecticut. Here are highlights about the effects of mental illness and the changing perspectives on mental health and mental illness:

### ***Effects of Mental Illness***

- About one in five Americans experience a mental disorder during the course of a single year.
- Approximately 15 percent of those with a mental disorder in one year also have a co-occurring substance use disorder (alcohol or drug).
- Less than one third of those with a mental disorder receive any form of treatment.

### ***Perspectives on Mental Illness and Mental Health***

- A range of effective treatments exists for most mental disorders and their efficacy is well documented.
- Mental health is essential to well being and prosperity.
- Some effective prevention strategies are being developed. Progress in prevention has been slow, partly because the etiology of mental disorders is not well understood and partly because it is difficult to alter the course of some forms of mental illness, even when the cause is known.
- There are gaps between optimally effective treatment and the treatments used in actual practice.
- Mental disorders and less severe mental health problems must be understood within a social and cultural context, thus mental health services should be designed and delivered in a manner that is sensitive to the perspectives of different segments of the population.
- The involvement of consumers and families has become an important force for positive change in service delivery and policy development.
- Renewed hope for recovery has helped consumers attain greater self-reliance and personal satisfaction and to become more fully involved in community life.

The Surgeon General's report outlines a vision for the future of mental health in the United States that has important implications for Connecticut. It includes the following recommendations:

- Continue to build the science base.
- Overcome stigma.
- Improve public awareness of effective treatment.
- Ensure the supply of mental health services and providers.
- Ensure delivery of state-of-the-art treatments.
- Tailor treatment to age, gender, race and culture.
- Facilitate entry into treatment.
- Reduce financial barriers to treatment.

## **The Impact of Psychiatric Disabilities**

During the 1990s the World Health Organization sponsored a landmark study to assess the burden of various diseases in developed market economies. Burden of disease was defined in terms of lost years of healthy life due to premature death or disability. The study found that, in the United States, mental disorders collectively accounted for more than 15 percent of the overall burden of diseases from all causes and for slightly more than the burden associated with all forms of cancer (Murray & Lopez, 1996). The burden of disease study underscores the importance of promoting mental health and ensuring that mental disorders be prevented, properly diagnosed, and treated.

In addition to the enormous suffering that psychiatric disabilities inflict on individuals and families, the economic impact of these disorders is staggering. The cost of psychiatric disabilities can be divided into two categories: direct costs of treatment and indirect costs associated with lost or reduced productivity. The Surgeon General's report noted the indirect costs generated by psychiatric disabilities in the United States in terms of loss of productivity due to illness, incarceration, or premature death. This amounted to \$79 billion in 1990. Direct costs for rehabilitation and treatment of psychiatric disabilities were estimated at \$69 billion in 1996, with an additional \$13 billion spent on treatment of addictive disorders and \$18 billion for treatment of Alzheimer's disease and other forms of dementia.

### **Psychiatric Disabilities among Adults, Children and Adolescents**

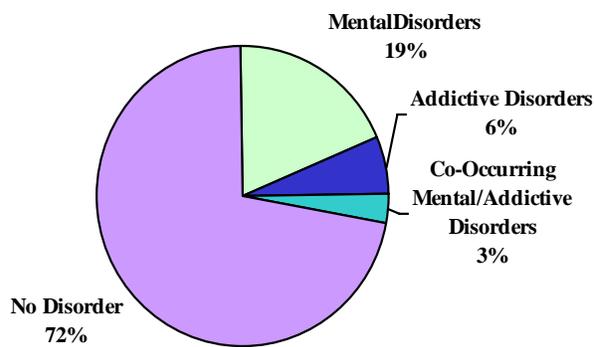
During the past two decades, studies of the number of people with psychiatric disabilities have shown that these conditions occur much more frequently than was previously believed. Two major studies form the basis of estimates of mental illness and substance abuse<sup>3</sup> in the United States. The first study, conducted during the early 1980s, the Epidemiologic Catchment Area Study (Robins et al, 1991) involved more than 20,000 study participants from five cities around

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<sup>3</sup> In this report, unless otherwise specified, the term "substance abuse" refers to both substance abuse and substance dependence. Mental disorders and substance abuse disorders are collectively called "behavioral health disorders".

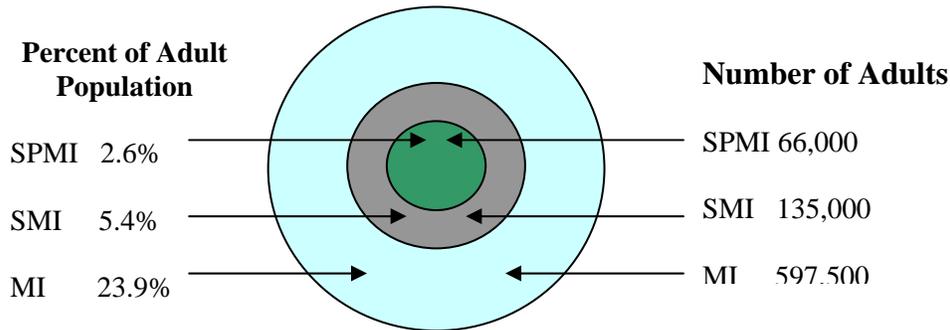
the country, including New Haven. The second study, the National Co-Morbidity Survey (Kessler et al, 1994), was Commissioned by the U.S. Congress and carried out during the early 1990s. It involved about 8,000 research participants, but used a sampling technique that greatly strengthened its scientific validity. These studies show that 28 percent of Americans have symptoms that meet the diagnostic criteria for behavioral health disorders within a 12-month period (see Figure 2-1). A subsequent analysis of this data (Kessler, et al, 1996) estimated that 5.4 percent of the adult population have serious mental illness, while 2.6 percent have severe and persistent mental illness. Figure 2-2 shows how these percentages translate into estimates of people effected by psychiatric disabilities in Connecticut.

**Figure 2-1: Percent of Adults with Behavioral Health Disorders in One Year**



Source: *Mental Health: A Report of the Surgeon General, 1999*

**Figure 2-2: Estimate of Adults with Mental Illness in Connecticut in One Year**



SPMI = Severe and Persistent Mental Illness  
 SMI = Serious Mental Illness  
 MI = All forms of Mental Illness

Source: Estimate based on Kessler et al, 1996

Mental illness prevalence estimates for children and adolescents are not as well documented as those for adults. However, current national estimates indicate that between 14 and 20 percent of all children and adolescents have some type of emotional or behavioral disturbance (Brandenburg, Friedman, & Silver, 1990). Extrapolating these data to Connecticut suggests that 87,500 to 125,000 children and adolescents have a diagnosable mental health condition. Their conditions range across diagnostic categories, including: mood disorder such as depression and bipolar disorder; anxiety disorders such as panic, post traumatic stress, and obsessive-compulsive disorders; adjustment disorders; pervasive developmental disorders such as autism; and psychotic disorders such as schizophrenia.

### Access to Treatment

Yet even with these high prevalence rates, the majority of people with psychiatric disabilities go untreated. The National Co-Morbidity Survey revealed that only about 15 percent of adults receive any form of treatment during a given year. More importantly, only about half of those treated had a condition that qualified as mental illness or an addictive disorder. The remaining half had less severe mental health problems. Thus, only 8 percent of adults (or approximately one third of those with conditions that can be classified as behavioral health disorders) receive treatment during a given one year (see Figure 2-3a).

Figure 2-3b offers additional details regarding where adults receive care. Caregivers were categorized into three groups:

- Specialty Care – including services provided in mental health facilities or by psychiatrists, psychologists, or social workers in private practice.

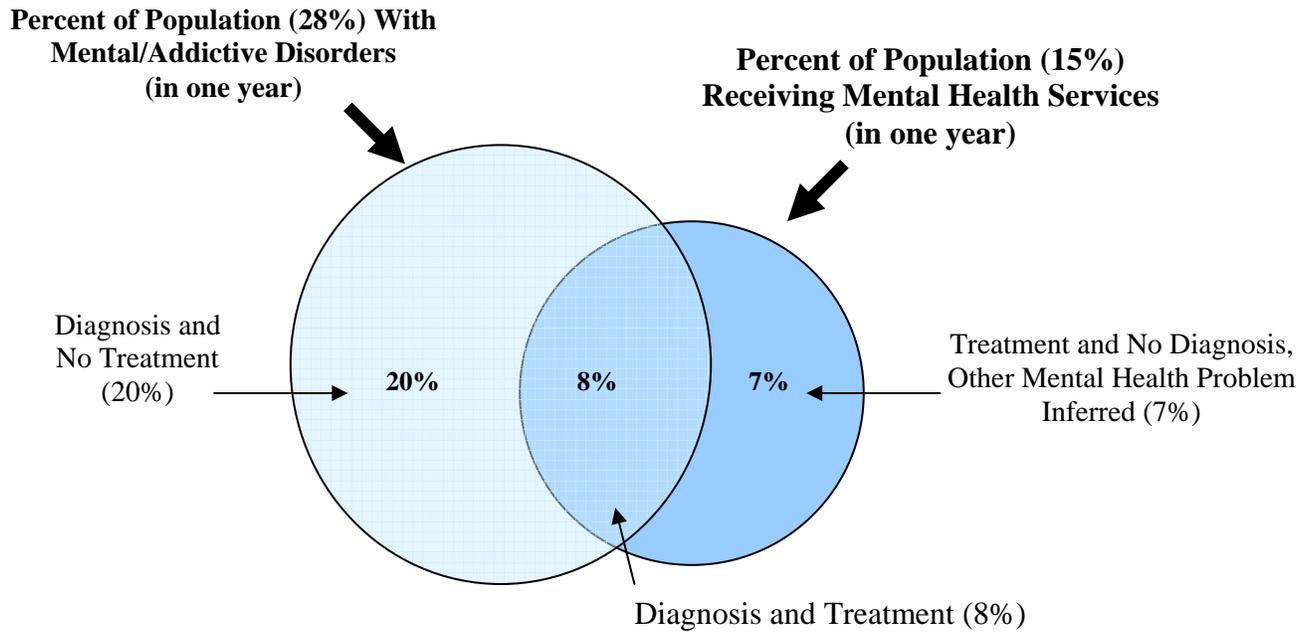
- ❑ General Medical Care – including services provided in non-psychiatric medical settings or by medical professionals not specializing in mental health care.
- ❑ Other Human Services or Voluntary Supports – encompassing services provided by social welfare, criminal justice, education, religious and charitable or volunteer organizations.

As can be seen, only about 40 percent of adults who received care were treated in the mental health specialty sector, while the remainder were served in general medical settings, or by other human providers or volunteers organizations.

Prevalence rates and patterns of care for children and adolescents have some similarities to those seen among adults. For example, it has been reported that of an estimated 21 percent of children with mental health and addictive disorders roughly half receive care during a single year (Shaffer et al, 1996). As with adults, not all children and adolescents receiving services have problems that would qualify as mental disorders. Of the 21 percent of youth who receive care during one year, more than half do not meet diagnostic criteria for mental illness or addictive disorders (see Figure 2-4a.). Furthermore, more than half of all care was provided through school systems. This underscores the importance of devising mental health treatment systems that coordinate care delivery with services provided in the schools.

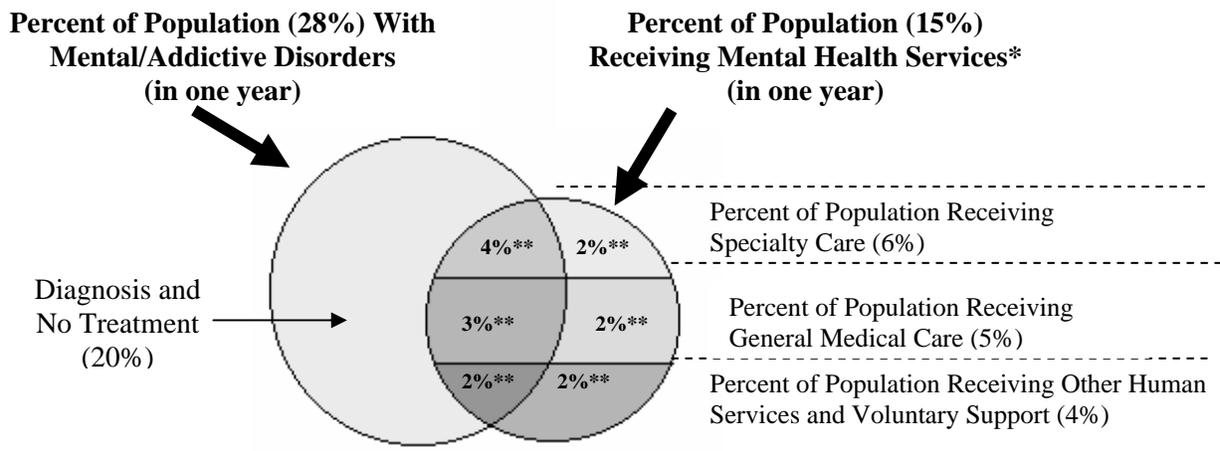
Finally, Figure 2-4b shows that less than one in four children who have conditions that can be classified as mental disorders actually received treatment in the mental health specialty sector. This lack of access to mental health specialists is caused by a variety of factors but appears principally due to the paucity of qualified specialty practitioners for children.

**Figure 2-3a: Annual Prevalence of Mental/Addiction Disorders and Services for Adults**



Source: *Mental Health: A Report of the Surgeon General, 1999*

**Figure 2-3b: Annual Prevalence of Mental/Addictive Disorders and Services for Adults**

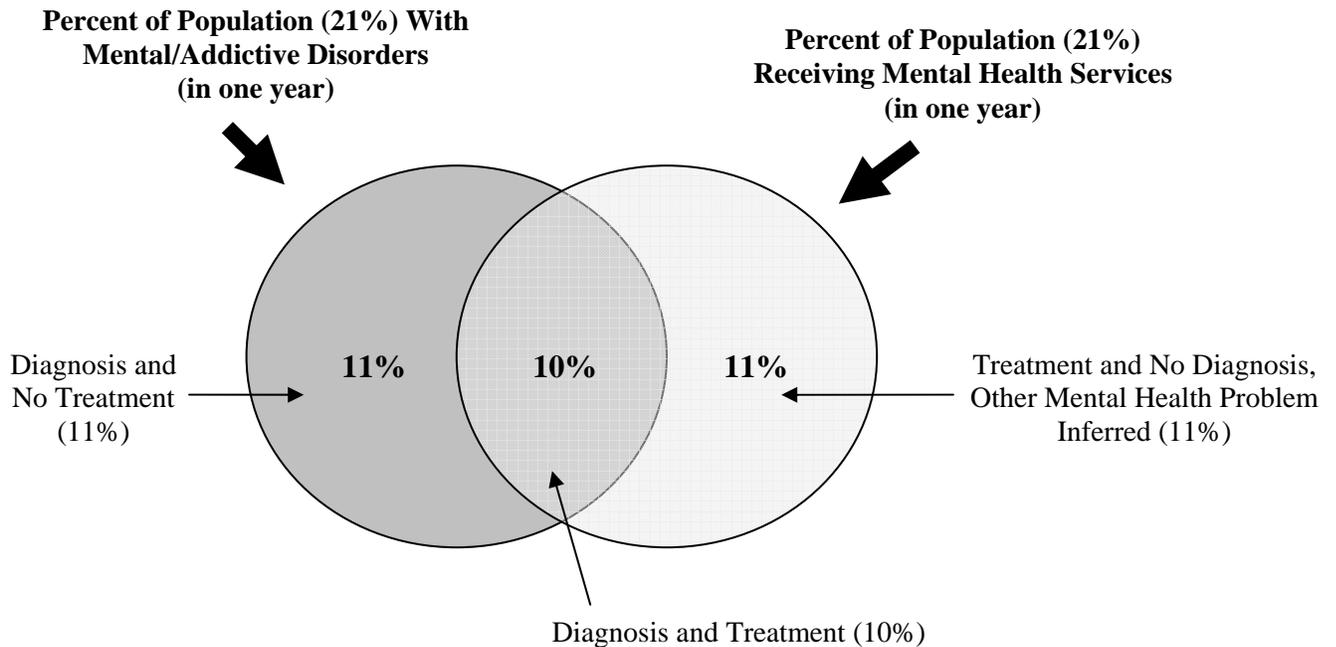


\* Due to rounding, it appears that 9 percent of the population has a diagnosis and receives treatment. The actual figure is closer to 8 percent, as stated in the text. It also appears that 6 percent of the population receives services but has no diagnosis, due to rounding. The actual total is 7 percent, as stated in the text.

\*\* For those who use more than one sector of the service system, preferential assignment is to the most specialized level of mental health treatment in the system

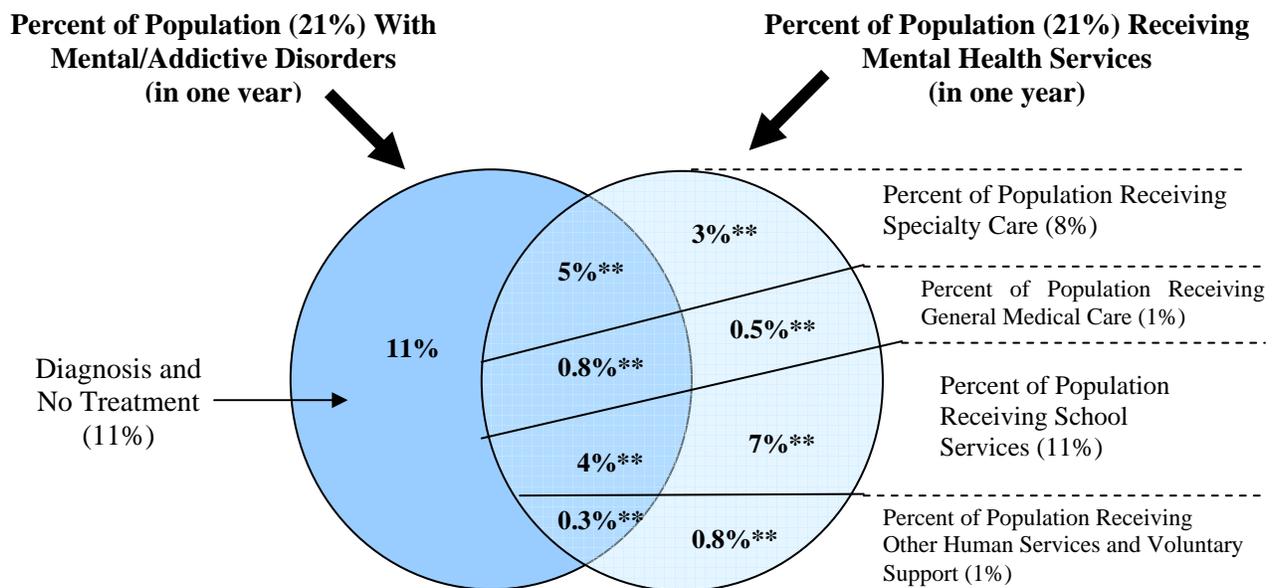
Source: *Regier et al, 1993; Kessler et al, 1996*  
 As shown in *Mental Health: A Report of the Surgeon General, 1999*

Figure 2-4a: Annual Prevalence of Mental/Addictive Disorders and Services for Children



Source: *Mental Health: A Report of the Surgeon General, 1999*

Figure 2-4b: Annual Prevalence of Mental/Addictive Disorders and Services for Children



\*\* For those who use more than one sector of the service system, preferential assignment is to the most specialized level of mental health treatment in the system.

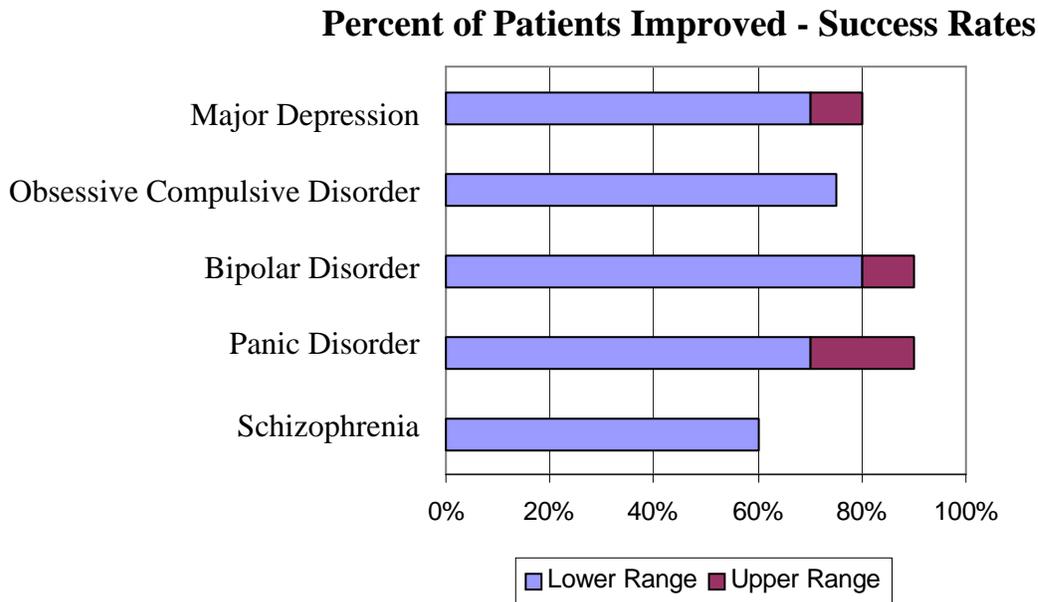
Source: *Shaffer et al, 1996 – Mental Health: A Report of the Surgeon General, 1999*

## Treatment is Effective

Despite the widespread perception -- based on stereotypes about long-term psychotherapy -- that mental health treatments are unstructured and highly subjective, recent comparisons of the effectiveness of contemporary psychiatric treatments to other medical interventions have revealed surprisingly positive outcomes for the mental health field. Although much more remains to be learned concerning the causes, nature, and treatment of psychiatric disabilities, recent advances in clinical research and practice have resulted in the development of effective treatments for most of the major mental illnesses. New generations of medications for affective and psychotic disorders have been developed that are more effective, over a shorter period of time, and with fewer troublesome side effects. In addition, structured and disorder-specific psychosocial interventions have demonstrated efficacy in randomized controlled clinical trials.

Current clinical practice in psychiatry has produced substantially higher recovery rates than had been acknowledged in previous years. Even schizophrenia, long considered to be the most severe, debilitating, and refractory of all psychiatric disorders, now shows a greater recovery rate than many of the chronic physical illnesses.

**Figure 2-5: Effectiveness of Treatment for Various Disorders**



*Source: National Institute of Health*

In spite of clear evidence to the contrary, the continued public perception that psychiatric treatments are ineffective may be accounted for, in part, by a concomitant public perception of stigma associated with mental illness. In addition, there is a lingering belief that mental illnesses are not illnesses, and therefore are not treatable. One other problem misinforms the public about the effectiveness of optimal treatments. In actual settings, the best practices and treatments-- those which have been identified through controlled trials-- are seldom followed.

To address the gap between clinical research and everyday clinical practice, several mental health disciplines have advocated adherence to “practice guidelines” specific to each disorder. However, much work needs to be done. Creating and disseminating the practice guidelines can only work if information about the recommended interventions is also disseminated (Crits-Christoph, 1996). As new treatment approaches and manuals are generated, evaluated, and demonstrated to be effective, and as practice guidelines emerge in relevant areas, future efforts should focus on the broad-based adoption and implementation of effective interventions.

## **The Burden of Stigma**

Stigma associated with psychiatric disabilities places a burden upon individuals and communities. Stigma appears as bias, fear, distrust and avoidance of individuals. It can lead people to avoid employing or working with those believed to have psychiatric disabilities. For a person with a mental disorder, stigma can exacerbate social isolation and reduce self-esteem and hope for the future. It influences people to avoid treatment out of fear of being identified with psychiatric disabilities.

According to the Surgeon General’s report, stigma in our society erodes the confidence that mental disorders are legitimate, treatable health conditions. Insurance policies have considered behavioral health to be different than so-called physical health. Stigma undermines efforts to change this disparity in benefits. Negative bias also extends to renting to or living near a person with psychiatric disabilities and commonly manifests itself as strong community opposition to the siting of group homes and similar treatment facilities. Community resistance is identified as one reason why not enough residential facilities have been developed in Connecticut. This has been a contributing factor in the out-of-state placement of more than 350 children with severe emotional disturbance.

## **The Emerging Role of Consumers, Families and Advocates**

In Connecticut and across the country, consumers, families, and advocates are becoming increasingly influential in the formulation of mental health policy and in the development and implementation of responsive community mental health services. The nationwide campaign, “Nothing About Us, Without Us,” sponsored by the National Alliance for the Mentally Ill (NAMI), illustrates the role of such groups in helping to shape the country’s mental health agenda. The primary goals of the advocacy movement are to:

- Overcome stigma and prevent discrimination in policies and laws affecting persons with psychiatric disabilities.
- Encourage self-help and a focus on personal dignity, consumer rights, and recovery.
- Draw attention to special needs associated with certain disorders or disabilities and promote research to improve treatment.
- Ensure that treatment and support services are responsive to the needs of different age, gender, racial and cultural groups.

In Connecticut, NAMI, Advocacy Unlimited,<sup>4</sup> Connecticut Voices for Children,<sup>5</sup> and Families United for Children's Mental Health<sup>6</sup> are serving as a catalyst to organize consumers and families into a unified and effective instrument for social change. These organizations provide assistance in obtaining services while helping to ensure that the dignity and rights of consumers are supported and protected. They provide comfort and companionship and inspire renewed hope for recovery for adults and children with mental illness and for their families.

Through participation on governing boards and program evaluation teams and by providing vivid testimony on legislation, advocate groups are enlightening mental health professionals, planners, administrators, and lawmakers about how the mental health system works and how to make it more responsive. Citing personal experiences, consumers and their families highlight problems with the delivery of care, thus creating pressure on bureaucracies and lawmakers to make changes. Advocacy and consumer groups are increasing public awareness and focusing attention on key concerns, including barriers to care, service fragmentation, gaps in the service delivery system, and the adequacy of funding. The courage of these advocates, most of whom speak openly about their illness in the face of societal stigma, cannot be overstated.

## **Hope for Recovery**

Until the 1970's, the prevailing view among most health professionals was that severe psychiatric disabilities, such as schizophrenia, worsened as the disease progressed, eventually causing permanent deficits in most functional capacities. This conclusion was based on observations of long-term psychiatric patients who were held, sometimes for decades, in custodial settings that fostered nearly total dependence and eliminated virtually all client choice. However, the stereotype of poor prognosis began to change as former patients were discharged to community settings with adequate treatment and support services.

Despite predictions that they were incapable of living outside the hospital, many former patients exceeded the expectations of professionals. With appropriate rehabilitation and support, they were able to adapt successfully to community life (DeSisto et al, 1995a, 1995b). A twenty-five-year follow-up study of patients discharged from Vermont psychiatric hospitals found that "One half to two thirds had achieved considerable improvement or recovered in contrast to statements in DSM-III<sup>7</sup> that predicted a poor outcome for schizophrenic patients." Although a wide variety of outcomes were reported, former patients with the most positive outcomes were those who had obtained the community services that they need. (Harding et al, 1987).

The concept of recovery from mental illness is based on the idea that with the right combination of treatments and supports, people can learn to manage their illnesses, sometimes to the point where symptoms and functional deficits completely abate. As recovery progresses, the individual becomes more independent and better adjusted to community life while

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<sup>4</sup> The largest consumer-run organization for adults who have used mental health services in Connecticut.

<sup>5</sup> A statewide child advocacy organization that works on a range of issues pertaining to the well being of children and youth, including children's mental health.

<sup>6</sup> A new statewide support and advocacy organization run by families of children and youth with emotional, behavioral and mental health needs.

<sup>7</sup> DSM III is the Diagnostic and Statistical Manual, Third Edition of the American Psychiatric Association.

simultaneously reducing reliance on the mental health system. Thus, movement toward recovery produces a greater sense of empowerment, self-determination and self-satisfaction. Individuals who achieve stability and a sense of recovery often become excellent role models for others who are learning to grapple with psychiatric disabilities.

In order to maximize the prospects for recovery for those with severe disorders, the National Alliance for the Mentally Ill (NAMI) has developed model legislation, designed to be introduced in state legislatures. This legislation contains eight critical components considered to be important to recovery:

- Increased Consumer and Family Participation in Services Planning
- Equitable Health Care Coverage
- Access to Newer Medications
- Programs for Assertive Community Treatment (PACT)
- Work Incentives for Persons With Severe Mental Illness
- Reduction of Life-Threatening and Harmful Care (Restraints & Seclusion)
- Reduction of Criminalization of Persons With Severe Mental Illness
- Increased Access to Permanent, Safe Affordable Housing With Appropriate Community-Based Services

### **Responding to Cultural Needs**

The Surgeon General states, "The U.S. mental health system has not been very responsive to the needs of racial and ethnic minorities." Responding to the needs of diverse racial, ethnic, and cultural groups represents a major challenge for the mental health system in America. In Connecticut, the population of African Americans, Hispanics, Native Americans, and Asian American and Pacific Islanders has grown proportionately faster than the overall population growth, with population growth rates at, respectively, 4, 11, 9 and 27 times the rate of growth of the general population (CT DPH, 1999). African Americans are the largest minority group in Connecticut today (8.4 percent), followed by Hispanics (7.9 percent). Hispanics account for the greatest increase in absolute numbers among all minority groups. Asian Americans and Pacific Islanders have shown the fastest growth rate in Connecticut (U.S. Bureau of the Census, 1980, 1990).

Persons of different cultures and ethnic groups are disproportionately represented in lower socioeconomic groups. Multicultural Health, a report issued in 1999 by the Connecticut Department of Public Health, indicates that African Americans and Hispanics, the two largest minority groups in Connecticut, are more likely to be born poor compared with other groups. Research has shown that both of these groups have more health problems compared to the general population (CT DPH, 1999). As has been noted, lower socioeconomic status, income, education and occupation are strongly associated with increased risk for psychiatric disabilities.

Experts in the field of cultural competence have shown that, when cultural standards are applied universally in the delivery of mental health services, the outcomes may vary for consumers from different racial, ethnic, or cultural groups. In order to create a behavioral health care system in Connecticut that adequately addresses the needs of its increasingly diverse population, the state must develop cultural competence at all levels of care. Cultural competency has been defined as “a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables the system, agency or professionals to work effectively in cross-cultural situations (Cross et al, 1989).

Cultural competency must also be extended to the treatment of sexual minority populations in Connecticut. Over the last ten years, there have been radical shifts in public awareness and public policy regarding sexual minority youth, adults and families. Lesbian, gay, bisexual and transgender youth are identifying as sexual minorities at significantly earlier ages and bringing children into their lives and families at record rates. People in sexual minority groups in Connecticut continue to suffer the ill effects of societal stigma, isolation, and bias as evidenced by their substantially higher rates of substance abuse, depression and other mental health disorders; suicidality; homelessness; family violence; truancy; sexual acting out and other at-risk behaviors. Mental health care and substance abuse professionals are not immune to the impacts and effects of homophobia. More states are enacting laws protecting and expanding the rights of this population. Connecticut has been a trend-setter in setting public policy in this arena.

Cultural competency must be interwoven into every aspect of the design, implementation, and ongoing operation of the system. It cannot be viewed as a fragment or “special” area of focus. Rather it must be a perspective that permeates every aspect of the development and operation of the mental health system. To achieve a culturally competent system of care, people at all levels will need to make a concerted effort. Resources must be committed to finding and removing the barriers to effective care at all levels within the system.

Currently, the state agencies involved in mental health services in Connecticut are at different stages of addressing cultural competency. To create a seamless culturally competent mental health system, Connecticut will require a single comprehensive strategic plan that measurably improves the quality and effectiveness for all service recipients, with special emphasis on improving outcomes for diverse ethnic and cultural groups.

### **Implications of the Olmstead Decision**

When Congress passed the Americans with Disabilities Act (ADA), it included a prohibition of discrimination against individuals with disabilities in the provision of public services by state and local governments. Section 12132 of Title II of the Americans with Disabilities Act states:

“...no qualified individual with a disability shall, by reason of his disability, be excluded from participation in, or be denied benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by such entity.”

Pursuant to a Congressional mandate, the U.S. Attorney General issued regulations defining the forms of discrimination that are prohibited by this section of the law. This regulation, commonly

referred to as “the integration mandate,” states: “A public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities,” (28 CFR Section 35.130(d)).

These regulations also include a “reasonable accommodation” requirement that mandates public entities to “make reasonable modifications” to avoid “discrimination on the basis of disability,” but does not require measures that would “fundamentally alter” the nature of the entity’s programs, (Section 35.130(b)(7)).

In June of 1999, the U.S. Supreme Court issued a decision that upheld the validity of the Department of Justice regulations and specifically found that unnecessary segregation and institutionalization constitute discrimination under the ADA. The case involved the rights of two women to receive services in a community setting, pursuant to the ADA’s integration mandate (*Olmstead v. L.C.*, 119 S.Ct. 2176 (1999)).

In this decision, known as the *Olmstead* decision, the Court noted that Congress intended that the ADA be used to secure community living opportunities for persons with disabilities. The decision makes it clear that public entities have a responsibility, within reason, to promote community integration by means settings that enable individuals with disabilities to interact with non-disabled persons to the fullest extent possible.

However, the Court also recognized that a number of factors must be considered in determining a state’s compliance with the *Olmstead* decision. The state can rely on the reasonable determination of state professionals to assess whether community services are appropriate. States must consider the placement preference of the individual, including the fact that a person cannot be compelled to leave an institutional environment. Further, in evaluating a “fundamental alteration” defense, courts must consider not only the cost of providing community-based services to individuals, but also the range of services the state provides to others with disabilities and the state’s obligation to equitably distribute those services.

The Court suggested that a state might show compliance by demonstrating that it has a “comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that move(s) at a reasonable pace not controlled by the state’s endeavors to keep its institutions fully populated.” The state’s plan for community integration must assure that there are appropriate community services available that meet individual needs. The Court also noted that institutional settings are needed and must remain available.

The fundamental responsibility of the state to promote community integration under the ADA is clear, although technical questions remain as to the implementation of the *Olmstead* decision. There is general agreement that the decision applies not only to state hospitals, but also to all institutional settings, both public and private, and that the state’s responsibility extends to the needs of individuals who are at risk of unnecessary institutionalization.

With the support of the Governor, the Connecticut Department of Social Services (DSS) initiated activities in January 2000 to develop a plan in compliance with the *Olmstead* decision. DSS was

viewed as the appropriate agency to lead these efforts because it is the state Medicaid agency and it is also the lead agency for persons with disabilities, as identified in state law. DSS will coordinate the planning with other state agencies and with persons with disabilities, advocates, providers, and legislators.

Connecticut is positioned well for this effort. The Connecticut General Assembly established a planning process for long-term care services for older persons in 1998. That plan already included many of the state agencies (including DMHAS) and legislative representatives necessary for developing a comprehensive plan to support community options. As a means of providing continuity, the state will build upon the existing process and modify it as needed to focus on the unique issues raised by the Olmstead decision. The plan will supplement and incorporate other state planning activities including the work of the Governor's Blue Ribbon Commission on Mental Health.

As work on Olmstead related planning continues, it is extremely important that the needs of people with psychiatric disabilities are adequately represented. Therefore, the Governor's Blue Ribbon Commission recommends that the final report of the Olmstead planning group specifically delineate how community integration of people with psychiatric disabilities in institutional settings will be addressed. While still in draft form, the Olmstead plan should be shared with the Mental Health Policy Counsel (proposed to be established as the means for implementing the recommendations of the Blue Ribbon Commission on Mental Health; see section below entitled: "Mechanisms for Implementation").

### **The Need for a Behavioral Health Approach**

For several decades, mental health professionals and professionals in the field of addiction treatment have struggled to find a model for treating individuals who need services for both mental illness and substance abuse (SAMHSA, 1997). The prevalence of co-occurring mental disorders and substance use disorders has been under study. According to data from the Epidemiologic Catchment Area study (Regier et al, 1990), nearly half of the individuals with a lifetime diagnosis of schizophrenia or schizophreniform disorder also had a substance use disorder. According to data from the National Co-Morbidity Survey, commissioned by Congress in 1990, between 41 percent and 65.5 percent of those with an addictive disorder also have at least one mental disorder. Of those with a mental disorder, 51 percent have at least one addictive disorder at some point during their lifetime (Kessler et al, 1996).

The widespread co-occurrence of mental illness and substance abuse may have been caused by the convergence of two events during the same period. De-institutionalization from the large mental health hospitals has taken place at the same time as American society has become increasingly infatuated with illegal drug use (Minkoff & Drake, 1991). Young adults who remain in the community throughout the course of their mental illnesses are inevitably exposed to alcohol and illegal drugs, whereas people of the previous generation who were institutionalized for much of their lives did not have that kind of exposure to alcohol and illegal drugs. Currently, co-occurring disorders are so widespread in many settings that they can be considered "The expectation, rather than an exception" (Minkoff & Drake, 1991).

Developing the Connecticut Behavioral Health Model has been a major focus of the Department of Mental Health and Addiction Services since its reorganization in 1995. This model addresses the full range of co-occurring disorders through longitudinal clinical management and rehabilitation (DMHAS, 1996). As outlined in the report of the DMHAS Dual Diagnosis Task Force, the Connecticut Behavioral Health Model provides guiding principles for implementation. It lists clinical competencies required of service providers. These form the basis for comprehensive training. It also includes a conceptual model that addresses the clinical complexity of numerous sub-groups of co-occurring disorders. The conceptual model delineates interventions that range from “consultation” to “collaboration” and, finally, to full “integration” of mental health and addiction treatment, depending on the consumer’s current needs and motivation to change (see Figure 2-6).

**Figure 2-6: Connecticut Behavioral Health Model**

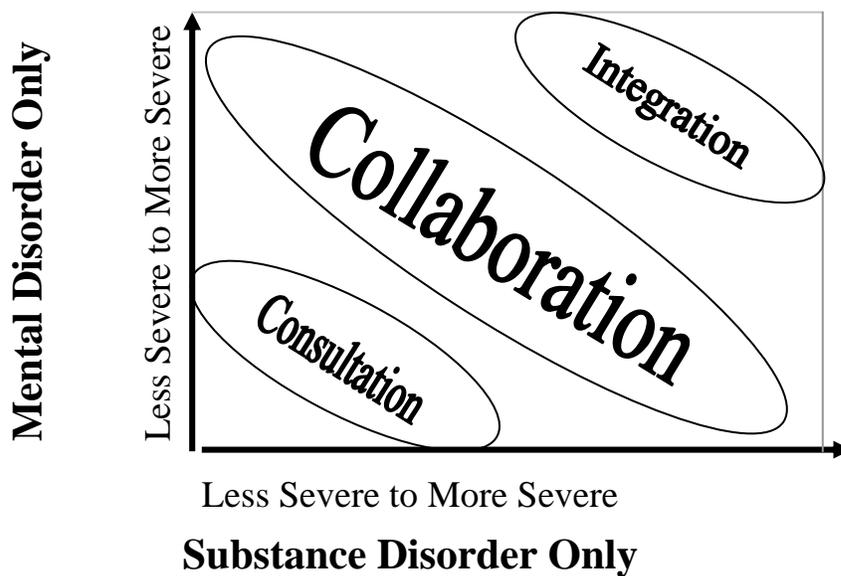


Figure 2-7 demonstrates how the “Connecticut Model” captures some of the variety of needs seen among the 4,380 people identified within the DMHAS system as having both mental illness and a substance use disorder during FY 1998:

**Figure 2-7: DMHAS Clients with Co-occurring Disorders**

Substance Use Severity ↑	Psychiatric Severity			
	Mild	Moderate	Severe	
Dependence	7% 3118	32% 1414	17% 749	56%
Abuse	3% 122	16% 705	23% 1002	42%
Misuse	0% 8	1% 34	1% 28	2%
	10%	49%	41%	

Clearly, there is no single description of people with co-occurring disorders. Therefore, treatment interventions must be tailored to meet individual needs. The Connecticut Behavioral Health Model provides a basis for moving forward with prevention and treatment strategies for people with mental illness and substance use disorders within our state. In order to achieve the full potential of this model, additional program development will be necessary.

### Mental Illness and Violence

The intense focus on violence in American society has contributed to a re-examination of the controversial relationship between violence and mental illness. An enduring public view that psychiatric disorders and violence must be linked is being fueled by current media portrayals. In contrast, advocates for persons with psychiatric disabilities contend there has been no substantiation of an association between violent behavior and mental illness. Empirical studies are hampered by factors associated with studies of violence in general. For example, across studies, violent behavior is not consistently defined. In one investigation, a shove, a push or a kick may be defined as violent behavior. In another, only acts which result in felony charges are included. In addition, violence is often poorly documented and under-reported, especially in families.

Recent emphasis on violence in the American society has led to collaborative efforts to investigate the relationship between violence and mental illness while addressing the limitations

of previous studies<sup>8</sup>. Research studies using appropriate control groups and longitudinal follow-up have identified a modest association between mental illness and violence under specific conditions. The following statements summarize current research findings:

- There is no evidence that violence is associated with psychiatric illness in general.
- The risk of violence by persons with psychiatric disabilities (in the absence of substance use) was higher than that by the general public only when persons were symptomatic (e.g., delusional). For persons with active psychotic symptoms, the risk of violence was 17 percent compared to 2 percent in the comparison group that had no mental illness or substance abuse (Link, 1992).
- The psychiatric symptom most related to violence is a delusion about being threatened and controlled by others (Link, 1992).
- The presence of delusional symptoms and non-adherence to treatment is associated with increased risk of violence, in a small but important subset of people with severe mental illness.
- Substance use, including alcohol, is the main factor associated with increased risk of violent behavior whether mental illness is present or not. The use of alcohol and illicit substances was associated with a 2- to 3-fold increase in the rate of violence (Swanson, 1990; Steadman, 1998; Link, 1992).

Ongoing research is leading to methods of assessment and management of risk that should be implemented in Connecticut. Essential elements of effective programs include:

- Risk assessments that incorporate comprehensive information from a broad range of sources familiar with the client.
- Ongoing training in risk assessment and risk management for all clinical and case management personnel.
- Use of both actuarial and clinical risk assessments to identify persons who require additional services. Actuarial risk assessment involves past history and demographic information. Clinical risk assessment involves current levels of functioning and symptoms.
- Assertive community outreach and “wrap-around” community services. Wrap-around services include housing, food, clothing and similar necessities.
- The integration of treatment for substance abuse and mental health treatment as a key element of effective risk management.
- Collaboration between mental health services and other community agencies, such as the criminal justice system, the police, and agencies related to residential and occupational services. These collaborations are established with a commitment to respect for the client and family, the preservation of confidentiality and clients’ rights, and regard for public safety.

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<sup>8</sup> The MacArthur Study on Violence and Mental Illness is one multi-site prospective investigation focused on factors associated with violence.

Under Connecticut law, if an individual who is dangerous to self or to others refuses voluntary treatment, a physician can order a 15-day involuntary hospital commitment on an emergency basis. Similarly, a physician may order an involuntary hospital commitment for a person who is gravely disabled<sup>9</sup> as the result of mental illness. Other laws provide for continuation of hospital commitment by a probate court. These laws include safeguards to protect individual rights and ensure due process. However, some experts and members of the public have questioned whether current laws go far enough to protect public safety. Their concerns focus on those few people with mental illness living in the community who have a pattern of very risky behaviors and who refuse treatment or do not adhere to treatment plans, yet do not meet emergency commitment criteria (CT DMHAS Needs Assessment, 1999; Dailey et al, in press).

In 1995, in response to these concerns, legislation for outpatient commitment was introduced into the Connecticut General Assembly. It was not passed, due to public outcry citing practical obstacles, as well as basic questions about civil liberties. In 1996, the legislature established a task force to conduct a study of outpatient commitment and its alternatives. The task force did not support the outpatient commitment legislation. Again, in the 2000 legislative session an outpatient commitment bill was submitted but did not pass.

As of 1999, 40 states and the District of Columbia had enacted laws providing some form of outpatient commitment. Generally, these laws use a court order to compel an individual to comply with the requirements of outpatient treatment, including medications. However, due to problems in implementation, the majority of these laws are not being systematically implemented (Gervasi et al, 2000).

Connecticut should avoid the mistake of believing that outpatient commitment is a panacea or a quick fix. Instead, the state has the opportunity to explore and evaluate promising alternative strategies for engaging traditionally difficult-to-treat clients in treatment. For example, in the most recent legislative session, the General Assembly approved a plan to pilot the use of "peer engagement specialists" in conducting outreach to these individuals.

## **The Criminalization of Mental Illness**

Over the past decade, the public has been increasingly concerned about the "criminalization" of mental illness – that is, the increase in the proportion of inmates in jails and prisons who have mental disorders (Torrey, 1992). This phenomenon is often blamed on de-institutionalization and inadequate funding for community care (U.S. Dept. of Justice, 1999). It results from a combination of social factors, including substance abuse, lack of adequate social support, medical complications (such as HIV), and the difficulty of maintaining long-term engagement in treatment (DMHAS, 1995). It should be noted, in addition, that the total number of incarcerated persons is at an all time high, with 1.8 million Americans are in jail or prison (U.S. Dept. of Justice, 1999).

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<sup>9</sup> As in most states, Connecticut law defines 'grave disability' as an inability to provide food, clothing or shelter for oneself.

Certainly, de-institutionalization is a part of this story. Overall, the closing of psychiatric facilities in favor of community care has produced enormous gains for persons with mental illness. Former patients are able to live and work in the community successfully, without ever becoming involved with the criminal justice system (Dailey et al, in press). However, with increased freedom, there is increased risk. The presence of more people with psychiatric disabilities living in the community has resulted in an increase in the arrest and incarceration of some of these individuals, particularly for those involved in minor offenses. (See Chapter 4, section entitled "Community Adjustment Among Adults with Serious Mental Illness".)

As a result of all these factors, rates of serious mental disorder among the U.S. jail and prison population are considerably higher than in the general population. The most careful studies of the past decade have indicated that approximately one-tenth of jail and prison detainees have serious mental disorders. Studies by Teplin (1994, 1996) indicate that over 6 percent of male inmates have a current severe mental disorder, such as schizophrenia, bipolar illness, or major depression. The six-month prevalence of severe psychiatric disabilities among women prisoners is approximately 15 percent. A survey conducted by the National Alliance for the Mentally Ill (NAMI) reported that about 7.2 percent of inmates have a serious mental disorder (Torrey et al., 1992). The NAMI survey also documented the opinion of prison officials in 41 states that the rate of incarceration of persons with psychiatric disabilities had dramatically increased in the previous decade. More recent data from the U.S. Department of Justice (1999) indicates that 16 percent of inmates of jails and prisons identify themselves as having psychiatric disabilities.

## **Financing of Mental Health Care at the National Level**

In order to understand how mental health care is financed, it is useful to distinguish between the contributions of the public and private sectors. The term "private sector" refers both to services directly operated by private agencies and to services financed with private resources (e.g., employer-provided insurance). The term "public sector" refers both to services directly operated by government agencies (e.g., state and county mental hospitals and mental health centers) and to services financed with government resources (e.g., state general fund appropriations, Medicaid and Medicare), including those provided by private organizations<sup>10</sup>.

In a national study of mental health care, the NASMHPD Research Institute (1999) noted that mental health is the only sector of health care where government maintains a separate treatment system and where commercial insurance benefits often do not cover the range of conditions that require care. Thus, the public system forms both a "safety net" and a "safety valve" for an incomplete and often-inadequate private sector response to mental health needs.

The Surgeon General's report notes that approximately 47 percent of the costs of mental health treatment are borne through private sources. More than half of private funding comes from private insurance, with the remainder largely attributable to out-of-pocket payments. Out-of-pocket payments include: co-payments from individuals with private insurance; co-payments and

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<sup>10</sup> Medicaid is a Federal operated in partnership with the states for financing health care services for people who are poor and disabled. Medicare is a Federal health insurance program primarily for older Americans and people who retire early due to disability.

prescription costs that are not covered by Medicare or Medigap insurance; and payments for direct treatment for the uninsured or those who are insured but choose not to use their insurance coverage to pay for mental health care. The remaining 53 percent of mental health funding comes from public sources. Public funding for mental health includes Medicaid and Medicare funding, federal mental health block grant funds, and state and local general fund appropriations.

Table 2 – 1, produced by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), illustrates expenditures by type of payer. Table 2 – 2, also a SAMHSA product, shows that 58 percent of expenditures on mental health care involve specialty providers. Specialty providers include psychiatric hospitals, psychiatrists, psychologists, social workers, counselors, community mental health centers, residential treatment facilities for people with psychiatric disabilities, and partial hospital care. The general health care service system accounts for the remaining 42 percent of expenditures. General health care providers include general hospitals, primary care physicians, home health agencies, and nursing homes. Expenditures on pharmaceuticals are also included in this category.

**TABLE 2 – 1 SAMHSA Estimated Expenditures on Mental Health Care by Payer, 1996**

	<u>\$Millions</u>	<u>%</u>
<u>Private - Total</u>	<b>31,632</b>	<b>47.4</b>
Out- of- Pocket	11,608	17.4
Private Insurance	17,911	26.9
Other Private	2,112	3.2
<u>Public – Total</u>	<b>35,073</b>	<b>52.6</b>
Medicare	9,607	14.4
Medicaid <sup>1</sup>	12,585	18.9
Other Federal Government <sup>2</sup>	1,322	2.0
Other State/Local Government	11,558	17.3
Total Expenditures	66,704	100.0
<sup>1</sup> Includes both state and Federal Medicaid expenditures.		
<sup>2</sup> Includes Veterans Affairs, Department of Defense, and Federal Block Grants.		
<i>Source: Mark, McKusick, King, Harwood &amp; Genuardi (1996). National Expenditures for Mental Health, Alcohol and Other Drug Abuse Treatment, 1996. Rockville, MD: U.S. Department of Health and Human Services. 30.</i>		

**TABLE 2 – 2 SAMHSA Estimate of Mental Health Expenditures by Provider, 1996**

	<u>\$Millions</u>	<u>%</u>
<u>General Service Providers - Total</u>	<u>28,195</u>	<u>42.3</u>
Community Hospitals <sup>1</sup>	10,774	16.2
Physicians	6,558	9.8
Home Health	277	0.4
Nursing Homes	4,714	7.1
Retail Prescription Drugs	5,871	8.8
<u>Specialty Providers - Total</u>	<u>38,509</u>	<u>57.7</u>
Psychiatric Hospitals	11,083	16.6
Psychiatrists	3,682	5.5
Other Professionals <sup>2</sup>	9,475	14.2
Residential Treatment Centers for Children	2,642	4.0
Multi- Service Mental Health Organizations <sup>3</sup>	11,627	17.4
Total Expenditures	66,704	100%
<sup>1</sup> Includes psychiatric treatment units.		
<sup>2</sup> Includes psychologists, social workers, and counselors.		
<sup>3</sup> Comprised of a variety of providers including community mental health centers, residential treatment facilities for people with psychiatric disabilities, and partial hospital facilities.		
<i>Source: Mark, Tami, et al. 1996. National Expenditures for Mental Health, Alcohol and Other Drug Abuse Treatment, 1996. Rockville, MD: U.S. Department of Health and Human Services. 27.</i>		

The Surgeon General reported that spending for mental health care has declined as a percentage of overall health spending over the past decade. Further, public payers have increased their share of total mental health spending. According to the federal Health Care Financing Administration (HCFA), in 1996, public payers accounted for just under 46 percent of all health care spending but picked up the tab for nearly 53 percent of mental health spending.

During FY 1997, State Mental Health Authorities (SMHAs), directly controlled \$16.1 billion in expenditures for mental health services. Although total SMHA expenditures increased by 14 percent, between FY'93 and FY'97, this represents a decrease of 2 percent when adjusted for inflation. In contrast, expenditures for all health care increased by 21 percent. This reflects a continuing trend of decreasing purchasing power of mental health service dollars. During the 17-year period from FY'81 to FY'97, expenditures controlled by SMHA's increased by 164 percent. However, when adjusted for inflation, the rate of expenditure decreased by 7 percent. Some of the decline in resources for mental health relative to total health care may be due to reductions in the use of inpatient hospitals and other improvements in efficiency (NASMHPD Research Institute, 1999).

Despite declining purchasing power, states have managed to significantly increase the proportion of dollars spent on community-based services compared to those spent on inpatient services. SMHA-controlled inpatient expenditures decreased from 65 percent of total SMHA spending to 46 percent in FY'97. In addition to these efficiency improvements, the decreased purchasing power of mental health service dollars also may reflect increasing reliance on other public human services which are not specifically identified as mental health services.

In Connecticut, expenditures controlled by SMHA's were \$99.14 per capita in FY'97. This was the third highest per capita spending in the United States. Per capita spending in New York and in the New England states is shown in Table 2 – 3. The table also provides information regarding average per capita funding in the New England region and in the United States. Labor costs (average wages) are higher in New England states than in other parts of the country and higher in Connecticut than in elsewhere in New England.<sup>11</sup> This makes it more expensive to provide mental health care in Connecticut.

In summary, spending on mental health services has increased more slowly than spending on other health care services over the last decade. In particular, private funding has grown at an annual rate that is nearly 2 percent less than public funding (see Table 2 – 4). This is primarily a result of cost cutting measures by managed care. As the burden of mental health funding has shifted toward the public sector, the expenditures under the control of SMHA's have not kept pace with inflation.

**Table 2 – 3 SMHA-Controlled Mental Health Per Capita Spending and National Spending Rank During Fiscal Year 1997<sup>12</sup>**

State	SMHA Per Capita Spending	National Spending Rank
New York	\$112.57	2
Connecticut	\$99.14	3
New Hampshire	\$99.02	4
Vermont	\$92.38	6
Massachusetts	\$90.19	7
Maine	\$88.29	8
Rhode Island	\$62.99	21
Regional Average	\$91.07	N/A
U.S. Average	\$60.83	N/A

<sup>11</sup> Connecticut's average annual wage in 1998 was \$40,915 compared to a U.S. annual average of \$31,908 (source: Connecticut Department of Labor, Office of Research and the U.S. Bureau of Labor Statistics).

<sup>12</sup> Source: Lutterman T, Hirad A, and Poindexter B. *Funding Sources and Expenditures of State Mental Health Authorities, Fiscal Year 1997*. National Association of State Mental Health Program Directors Research Institute, July 1999.

**TABLE 2 – 4 SAMHSA Estimate of Average Annual Growth Rate of Expenditures on Mental Health Treatment by Payer, 1986-1996**

<b><u>Private – Total</u></b>	<b>6.3%</b>
Out- of- Pocket	3.3
Private Insurance	8.7
Other Private	7.6
<b><u>Public – Total</u></b>	<b>8.2%</b>
Medicare	9.2
Medicaid <sup>1</sup>	8.7
Other Federal Government <sup>2</sup>	3.6
Other State/Local Government	7.7
<b>Total Expenditures</b>	<b>7.3%</b>
<sup>1</sup> Includes both state and Federal Medicaid expenditures.	
<sup>2</sup> Includes Veterans Affairs, Department of Defense, and Federal Block Grants.	
<i>Source: Mark, Tami, et al. 1996. National Expenditures for Mental Health, Alcohol and Other Drug Abuse Treatment, 1996. Rockville, MD: U.S. Department of Health and Human Services. 67.</i>	

## CHAPTER III - EVOLUTION OF MENTAL HEALTH CARE IN CONNECTICUT

### A Perspective on History

"We must welcome the future, remembering that soon it will be the past; and we must respect the past remembering that once it was all that was humanely possible" <sup>13</sup>

During colonial times people with psychiatric disabilities were described as morally deficient or as the instruments of Satan. They were often forced to live as vagabonds and beggars or consigned to workhouses. Those believed to be dangerous were confined to jails where they were shackled in cages or pens. These people were subjected to extreme deprivation and physical punishment (Carini et al, 1974).

By the mid-sixteen hundreds, Connecticut history records an early recognition that government must play a role in helping to care for people who could not provide for themselves. In 1656, and again in 1673, Connecticut passed laws requiring towns to assist with the financial support of the "insane." However, conditions remained abysmal. It was not until 1821 that the state's Medical Society determined that Connecticut needed an institution exclusively for people with psychiatric disabilities.

The first mental health facility in the state, the Connecticut Retreat for the Insane, opened on April 1, 1824. Later called The Hartford Retreat, it is now The Institute of Living. (Carini et al, 1974). The institution's humanitarian philosophy represented a marked change from the past and was fundamentally different from the practices found in other states where punitive management of people with mental disabilities continued to prevail. However, too few people with psychiatric disabilities in Connecticut had access to the Hartford facility and, as in other states, the majority remained sequestered in private homes and almshouses or manacled in jails.

Conditions remained essentially unchanged until the mid-eighteen hundreds when social reformer Dorothea Dix began raising public awareness about the plight of poor people with mental disabilities. Her efforts led to the establishment of thirty public asylums throughout the United States. In 1866, she came to Connecticut. With the state's Medical Society, she convinced the General Assembly that it was time to build a mental health facility accessible to the poor. In 1887, the General Hospital for the Insane was built in Middletown, Connecticut. It is now called Connecticut Valley Hospital.

The policy of sending people with psychiatric disabilities away from their own communities to large public institutions that were located in bucolic farm-like settings prevailed throughout the United States for another century. Connecticut built two more large facilities, Norwich Hospital in 1902, and Fairfield Hills Hospital in 1933. In the early 1950's, at the height of their operations, these three hospitals housed more than 9,000 Connecticut residents. The state's

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<sup>13</sup> Cardiff I: The Wisdom of George Santayana: Atoms of Thought. Peter Owen, LTD., London, 1964.

population was little more than half of what it is today. These hospitals functioned as small towns in providing for the basic needs of their inhabitants. However, successful treatments proved illusive. There were no services available for indigent people with serious mental illness in the community.

The next major transformation of mental health care to unfold was the result of four principal factors:

- Deeper and broader understanding of how people can recover from psychotic conditions and benefit from rehabilitative care;
- The discovery of anti-psychotic medications;
- Rulings of Federal District Courts;
- Changes in the financing of mental health care.

By the mid-1950's, there were more than 550,000 people in state-operated psychiatric hospitals throughout the United States. Then, a breakthrough was made with the discovery of compounds with anti-psychotic properties. For the first time, some of the immense suffering caused by disorders like schizophrenia was alleviated as a result of scientific progress. It was found that a common mineral, lithium carbonate, could be used to treat people with bipolar disorder, a severely disabling form of mental illness. Some of the earliest research on the effectiveness of lithium was conducted at Norwich Hospital.

Meanwhile, several landmark Federal District Court rulings<sup>14</sup> established:

- The patient's right to treatment;
- Use of non-hospital, community-based alternative courses of treatment;
- The right to treatment in the least restrictive environment;
- Prohibitions against unnecessary confinement in a hospital.

This meant that hospitals could no longer detain people with psychiatric disabilities who could live in the community. Thus, the doors of the asylums began to open.

In a related and perhaps more significant development, the federal government changed Medicaid health care entitlement rules. This made it possible for nursing homes to receive Medicaid reimbursement for serving people with psychiatric disabilities. In Connecticut, and throughout the country, thousands of state hospital patients were moved to nursing homes as states sought relief from the huge financial burden of caring for this indigent population.

These events ushered in a period of so-called "de-institutionalization." During the 1960's and 70's, state hospital populations declined dramatically. However, most of the former hospital patients were merely relocated into nursing homes where they adapted to yet another institutional

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<sup>14</sup> Rouse v. Cameron 373 Fed. 2d. 451 (D.C. Cir. 1966). Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966). Wyatt .v Stickney 325 F. Supp. 781(M.D. Alabama, 1971). O'Connor v. Donaldson, 422 U.S 563 (1975).

environment. Some former hospital patients returned to communities, but those communities generally did not welcome their arrival (Lamb, 1994). Although the state hospitals became depopulated, few closed. Few resources were shifted to development of community services. In the mid-70's, 90 percent of all Department of Mental Health (DMH) funding was spent on inpatient care.

In 1964, Congress passed and funded the Community Mental Health Centers Act. However, most of the mental health centers established as a result of this Act were not able to serve large numbers of people with serious psychiatric disabilities. As a result, tension began to mount. Community leaders and a growing number of advocates for people with psychiatric disabilities became frustrated with the slow pace of community mental health service development. No where was this more evident than in Connecticut (Wolf, 1990).

While the community mental health system for adults continued to languish, concerns were also being raised about mental health care for children. Children's services were then part of the Department of Mental Health (DMH). At that time, there were virtually no community services for children with severe emotional disorders. In response, the General Assembly created the Department of Children and Youth Services in 1974. It is now called the Department of Children and Families (DCF).

In response to continued concerns about services for people with addictive disorders that were being provided as part of DMH, in 1975, the General Assembly established the Connecticut Alcohol and Drug Abuse Commission.

The groundswell of dissatisfaction with community mental health care for adults led to the passage of legislation in 1975 creating the Regional Mental Health Boards (P.L. 75-563). These citizen boards, comprised of consumers and service providers, were designed to evaluate community mental health services, advocate for additional resources and advise DMH on mental health funding decisions. Gradually, adult community mental health care began to receive increased financial support. However, these services were still woefully insufficient and under-funded.

Community pressure continued to mount until 1982 when, with the arrival of a new Commissioner at DMH, Governor William A. O'Neill appointed a Blue Ribbon Task Force on Mental Health. Supported by the Executive, the task force report raised public awareness and prompted the General Assembly to respond. What followed was the most extensive period of community mental health service development for adults in Connecticut history. Dozens of new programs were established including case management, psychosocial rehabilitation, vocational, emergency crisis intervention and residential programs. DMH established a statewide network of Local Mental Health Authorities (LMHAs) that had clinical and administrative accountability for the care of all poor people with serious psychiatric disabilities within a geographic area.

In 1995, the legislature reunited mental health care with the service system for people with substance use disorders. The Department of Mental Health and Addiction Service was created. This newly formed organization has begun to develop a coordinated approach to the treatment and support of people with co-occurring mental illness and substance use disorders. An

important example of the benefits of service coordination came in 1997 with the development of the General Assistance Behavioral Health Program. This innovative program uses managed care technologies within a public sector framework to improve outcomes for some of Connecticut's most vulnerable citizens.

By the mid-1990s, the community system was considered to be sufficiently strong to permit closure of two of Connecticut's three large state-operated psychiatric hospitals. Following the national trend to shut down these facilities, Fairfield Hills Hospital closed in 1995, followed by Norwich Hospital in 1996. Concurrently, a variety of new community programs were established specifically for the patients being discharged. Others were expanded. The state contracted with several general hospitals and a private psychiatric hospital for acute inpatient psychiatric services. Some patients who could not be placed in community programs were transferred to Connecticut Valley Hospital, which expanded its bed capacity to accommodate them.

Following a trend prevalent throughout the United States, Connecticut continued to reduce its reliance on the use of state hospital beds. The remaining long-term patients were those who were hardest to place appropriately in other facilities. The patient population showed an increased percentage of forensic patients, individuals who had committed crimes and had mental illness. There was also a higher percentage of patients with complex clinical needs. They were more difficult to place in existing community programs when they no longer required inpatient care.

Although state hospital inpatient beds have decreased in recent years, since 1997 DMHAS has increased its use of psychiatric inpatient beds in general and private hospitals. During SFY'99, DMHAS purchased 8,262 bed days in these facilities on a per diem basis. That includes 7,240 bed-days purchased under the DMHAS General Assistance Behavioral Health Program, and 1,022 bed-days paid for under other DMHAS contracts with these facilities.

Finally, as a means of ensuring additional protection for people with psychiatric disabilities involved in commitment hearings through the Probate Courts, Connecticut enacted trend setting legislation that guaranteed constitutional and due process rights. Subsequently, a broad "Patients' Bill of Rights" was also established (CGS Sec. 17a-530 et seq.).

## CHAPTER IV - MENTAL HEALTH SERVICES IN CONNECTICUT TODAY

### **Connecticut's Mental Health Services for Children, Adolescents and their Families**

**An overview** – For almost twenty-five years, the Connecticut Department of Children and Families (DCF) has maintained statutory responsibility for children's mental health services. As a consolidated children's agency, DCF also has statutory responsibility for child welfare, substance abuse, juvenile justice and prevention services. In addition, DCF is mandated to license, monitor, and evaluate certain categories of services provided by private and community providers, including outpatient mental health clinics for children, extended day treatment services, foster homes, group homes, emergency shelters and residential treatment centers. These legislative mandates reflect Connecticut's historical belief that the wide range of services demanded by the needs of children and their families can best be realized in a consolidated state agency which values partnerships with families, municipalities, community agencies, local education authorities, private providers, consumer advocacy groups, other state agencies and the federal government.

Connecticut was the first state to legislate the structure for an integrated children's agency, recognizing that creating a single administrative entity would benefit programming for the unique developmental needs of children. The restructuring of children's services in 1974 reflected the concern and advocacy of Dr. Solnit and others who insisted that the mental health needs of children were too often lost within the adult system. Further, children require a specialized set of interventions that are distinct from adults. This integrated approach acknowledged that the same children who have experienced abuse or neglect might also be involved in the juvenile justice system or have significant emotional and behavioral difficulties. The result was the consolidation of protective services, juvenile justice and mental health services for children. In this way, it was expected that seriously disadvantaged children in Connecticut would receive services necessary to remain safe and to address their individualized needs.

While theoretically sound, building a consolidated children's agency has proven challenging. Inherent conflicts and competition for resources exist within the multiple mandates. Children's safety issues, combined with media attention to deaths and abuse at the hands of caretakers, have resulted in an emphasis on child protection issues at the expense of other programs, including mental health. For many years funding was not available to provide all the support services necessary for the youth placed at Long Lane, the department's juvenile justice facility. Only after the suicide of a female adolescent at Long Lane School in 1998, did public attention turn to the mental health issues of children within the juvenile justice system. Mental health, although an integral support to both the child welfare and juvenile justice systems, has received relatively little attention in terms of public focus or administrative oversight despite the fact that in 1999, DCF spent over 120 million dollars on residential treatment and hospitalization for children involved in the DCF system and the department's juvenile justice facility.

**Children's Mental Health Planning Council** - A mandated planning structure and process has been developed to monitor the department's activity across mandates and to lend clinical

expertise to the service delivery system. The planning process for children's mental health services in Connecticut includes representatives from provider and consumer groups in every region of the state. The overall coordinating committee for this process is called the State Advisory Council (SAC), a statewide consumer and provider group appointed by the Governor to advise DCF. The SAC receives input from five Regional Advisory Councils (RAC's). In addition, the SAC receives recommendations specific to children's mental health from the SAC Subcommittee on Children's Mental Health. This group includes a member from each RAC, and from private and community providers. Parents, foster and adoptive parents of children with serious emotional disturbance (SED) comprise more than 51 percent of this committee. This subcommittee, which serves as the State Planning Council for Children's Mental Health, assists with planning resource development and reviews services and strategies. In addition, the subcommittee advises about the implementation of Public Act 97-272 "An Act Concerning the Mental Health Mandate of DCF". This hallmark legislation provides the vehicle by which parents/guardians can obtain state funded mental health resources for their child without relinquishing guardianship. The law further defines the terms "child or youth with mental illness" and "placement risk" and provides a framework for System of Care development in Connecticut.

During the 2000 Legislative Session, Public Act 00-188, established a Children's Behavioral Health Advisory Committee composed of representatives from key state agencies, appointees from the Governor's office and other key legislative leaders, in addition to members appointed by the existing Statewide Advisory Council. Parents of children with SED comprise 51 percent of committee composition. With this expansion, the Planning Council will benefit from on-going legislative input, further advancing the programmatic scope of children's mental health initiatives.

**Access to Service** – The mental health mandate within the Department of Children and Families ensures access to quality mental health services for *all* children in the state of Connecticut. However, it is important to note that while DCF is responsible for overseeing a comprehensive array of services for all children with varying levels of need, unless these services are Medicaid funded or provided to children in the custody of DCF, they are *not considered entitlements*. Thus, the Department must balance need with available appropriations. DCF-funded services are coordinated with the mental health services that are provided through local school systems, and those paid through private and public insurance.

Children and youth in the custody of the Department, through protective services or juvenile justice, may receive mental health services as part of their overall treatment plan. Children and families under protective supervision may use mental health services coordinated and partially funded by DCF. Children with serious emotional disturbance who are not involved with the child welfare or juvenile justice systems, whose needs extend beyond the resources available within the traditional community and school based programs, can access additional help through the Voluntary Services program. Any child exhibiting emotional or behavioral problems can receive services through one of the 26 child guidance clinics. These clinics are funded by DCF to develop and maintain an infrastructure that allows outpatient access to treatment for all in need, irrespective of income or status with the Department.

## **DCF Structure for Mental Health Services**

Central Office Mental Health Division – The Mental Health Division of DCF oversees and coordinates mental health program development and policy on a statewide basis. The division is part of the Bureau of Health, Mental Health, Substance Abuse and Education. It is staffed with a Director, a Program Director, two Children's Services Consultants, a Psychiatric Social Worker, a Health Care Advocate Supervisor, and five Health Care Advocates. In addition, the division is staffed by a supervisor and seven consultants who are part of the Central Placement Team which is responsible for locating and matching children with residential treatment facilities. The Division of Mental Health establishes in collaboration with the Children's Mental Health Planning Council, parents, advocacy groups and providers, the standards and practices for DCF-funded behavioral health programs. In addition, Division staff helps create policy, coordinate planning efforts, develop new initiatives, and establish liaisons with other state agencies. They identify and procure federal mental health dollars to supplement DCF funding to children's mental health services. Seven new positions are anticipated for 7/1/00 to assist in various new initiatives currently under way.

Regional Office Activities – The Department of Children and Families is divided into five regions with a total of 14 offices. The five regions were created to develop a wide range of community-based programs tailored to fit the needs of a geographical area. Each region is staffed with contracts personnel who review and monitor mental health contracts, and with a systems coordinator whose role it is to design, develop and manage treatment services for all children within the DCF mental health mandate. This responsibility has evolved to design local community-based collaboratives to meet the individual treatment needs of youth at risk of residential placement. Each DCF office has a Voluntary Services Unit staffed with social workers familiar with children's mental health issues. When necessary, they help families with youngsters with serious emotional disturbance to procure necessary mental health services, including residential services. Five new mental health positions are anticipated for July 2000 to provide additional oversight.

### Facilities

*Riverview Hospital* for Children and Youth is the only state-administered psychiatric hospital for children under eighteen years of age in Connecticut. Operated by the Department of Children and Families on a 65 acre campus in Middletown, Connecticut, the hospital represents the unification of three free standing hospitals: Altobello Youth Center, Housatonic Adolescent Hospital and Riverview Hospital. The new hospital, which opened in 1993, provides inpatient care to 98 of Connecticut's most troubled children and youth. In 1998, Riverview received a "Three Year Accreditation With Commendation", the highest recognition awarded by the Joint Commission on the Accreditation of Healthcare Organizations. With the development of a forensic unit to evaluate and treat youngsters from juvenile justice settings, the total bed capacity of the hospital will increase to 107 in mid-June, 2000.

Since the number of psychiatric beds in the private sector has been reduced by 65, Riverview has consistently run a waiting list that averages 20 youth per day. This unfortunate situation reflects the current crisis that has befallen children in need of psychiatric hospitalization in terms of

diminished availability of acute care resources combined with limited community-based programs needed for adequate discharge planning. In the recent DSS study, Delivering and Financing Children's Behavioral Health Services in Connecticut, it was determined that from July-December 1999, 55 percent of children in DCF custody who were in private acute care hospitals were ready for discharge to a less intensive setting. Almost half of the children waiting discharge from these hospitals had been there for longer than 90 days. In addition, this study revealed that 13 percent of children discharged from psychiatric hospitals were readmitted within 30 days, which the authors suggest, is due to problems with discharge planning and follow-up.

*Connecticut Children's Place*, which began as an orphanage in the 1880's, currently provides residential care and educational instruction for abused and neglected children between the ages of 10 and 18. Located in East Windsor, CCP has a 54-bed capacity and serves approximately 200 children per year. The facility provides extensive diagnostic evaluation and brief treatment services to children waiting alternative placement. A positive incentive-based behavior management program is woven throughout the daily curriculum to help children learn to live, work and play cooperatively with their peers. Though the length of stay at CCP was designed to be approximately 90 days, this has increased dramatically in the recent past. Primarily, this is the result of the competition with hospital sub-acute patients for a finite number of discharge options.

*High Meadows* is a 42-bed residential treatment facility located in Hamden, Connecticut. The facility serves boys and girls between the ages of 12 and 18 who need a highly structured emergency placement or short-term residential care including psychiatric assessment and clinical treatment for those in need of intensive clinical services and individualized assessment and treatment. As has been the case with other DCF facilities, the length of stay at High Meadows has been increasing due to the limited number of discharge options.

DCF-Funded Private Residential Treatment Facilities DCF pays for residential treatment services for children and youth in need of intensive treatment for a variety of behavioral health issues that surpass the capacity or the scope of services at Connecticut Children's Place or High Meadows. Children access residential treatment through DCF's child welfare system, the juvenile justice system or through Voluntary Services. As of 1999, DCF had placed over 1,250 children in residential treatment programs. Almost 350 of these placements were out of state, in facilities specializing in treatment of sexual offenders, highly aggressive youth and/or youth with specific and physical and cognitive challenges. Each facility is licensed as a Connecticut provider by DCF and each child's progress is monitored through periodic review of the treatment plan. Every effort is made to return the youth to a less restrictive, community-based setting when ready for discharge. However, discharge planning to community-based services remains a problem. As a result, many children remain in residential longer than necessary.

#### Community-based DCF Funded Services

The backbone to DCF's community mental health delivery system has been the 26 child guidance clinics. Receiving over 10 million dollars of DCF funds, the clinics provide mental health services to children and families throughout the state. While DCF dollars provide only partial payment for the services provided, the grant dollars do ensure that a mental health

infrastructure is available for necessary clinical services. Services offered by child guidance clinics include:

- Assessment/evaluation
- Individual, family, and group treatment
- Parent guidance, education and parent support services
- Consultation to schools
- Crisis intervention and emergency mental health services

Clinics and community-based mental health providers receive over 20 million dollars for specialized clinical or mental health support services, such as extended day treatment, intensive home based services, parent aid services, and respite services. Every effort is made to ensure that services are delivered in a culturally competent fashion.

While there is much to praise about the quality of care provided within the community-based service system, waiting lists show that lack of easy access is becoming an increasing problem. Lack of adequate funding for home-based programs and emergency mobile psychiatric services, combined with a limited number of child psychiatrists who wish to enter the public sector, make service delivery within the community a challenge.

**Systems of Care** – A System of Care is defined by the Center for Mental Health Services (CMHS) as:

*A comprehensive spectrum of mental health and other support services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with serious emotional disturbances and their families. The creation of such Systems of Care involves a multi-agency, public/private approach to delivering services and array of service options, and flexibility to meet the full range of needs of children and their families. Mechanisms for managing, coordinating and funding services are necessary.*

In 1997, the state legislature passed P.A. 97-272. It provides the blueprint for a community-based mental health delivery system aimed at meeting the needs of youth who are seriously emotionally disturbed while keeping them at home and in their communities. The theoretical foundation for the System of Care model can be traced back to the 1980's when the need to identify an array of services and to integrate these services into broader systems began to receive national attention. In 1982, the National Institute of Mental Health (NIMH) and the State Mental Health Representatives for Children and Youth met to explore the needs of youth with severe emotional disturbances. These meetings corresponded with Jane Knitzer's (1982) seminal work Unclaimed Children, which documented the failure of children's services to adequately meet the needs of youth with severe emotional disturbance. Knitzer identified the fragmentation within the existing mental health delivery system for children and called for a fundamental shift towards establishing an appropriate continuum of care for children with serious emotional disturbance.

In 1984, recognizing the need for change, the United State Congress funded an initiative to build locally based systems to serve children. Under the auspices of the CMHS, the Child and Adolescent Service System Program (CASSP) was established. The CASSP initiative was created to promote systems change, assist states and communities in the development of comprehensive community-based systems of care and encourage collaboration among service providers, parents, advocates and policymakers. Through the \$972 thousand dollars obtained from the State's Federal Community Mental Health Block grant, DCF has been able to partially fund several core services designed to promote the development of these local collaboratives, including respite care, extended day treatment services, and emergency mobile psychiatric services. Case managers (care coordinators) and family advocates have also been hired through this grant as well as funding from the state DCF budget.

Additional funding is needed to further develop and enhance this service delivery model. With the recent publication of the DSS study, Delivering and Financing Children's Behavioral Health Services in Connecticut, the need for more community-based services is highlighted. The report focuses on the need to develop a funding structure for community-based services and challenges Connecticut to shift focus from costly and often unnecessary residential and hospital care toward a more flexible funding model that will provide reimbursement for intensive clinical services and those non-clinical support services necessary to keep children with SED home. The recent focus on systems "gridlock" and the number of children flooding the emergency rooms in need of inpatient beds that are currently filled with patients waiting discharge to a less restrictive alternative, only highlights the need for significant systems change.

**Transitional Services** – The system's lack of responsiveness to the unique developmental demands of this population compounds the problems facing older adolescents in need of continued state supported mental health services. In 1997, DCF and DMHAS agreed to collaborate around a project to identify youth who are "aging out" of the DCF system and who demonstrate behaviors that place themselves and the community at risk. Together, the agencies began designing and developing a new kind of highly individualized program that combines clinical intervention with services that are both appealing and highly motivating for the youth involved. The Special Populations project currently serves almost 50 youth, providing opportunities for supervised, supported living, educational/vocational programming, therapeutic recreation and life skills training. In 1999, a similar program, the Transitional Services Program, was started. Serving adolescents with significant emotional and behavioral problems that are anticipated to be life long, the program began placing youth in supervised apartments in April 2000. It will provide service for up to 30 youth during its initial stage. Both these projects mark the beginning of a creative and collaborative process for a population whose needs have not been met within the system.

**Youth Suicide Advisory Board** – In 1989, in response to the *Final Report to the General Assembly of the Task Force on Youth Suicide Prevention*, the Senate and House enacted Public Act 89-191, "An Act Concerning the Prevention of Youth Suicide". As a result of this public act, the Connecticut Youth Suicide Advisory Board was created within the Department of Children and Families. The mission of the Advisory Board is to have a statewide coordinating and advisory role on the topic of youth suicide.

Among their recent activities, the Advisory Board has published posters and flyers alerting the public to the warning signs of teen suicide. In addition, Commissioner Ragaglia has appeared in televised public service announcements aimed at highlighting the warning signs of suicide and reminding the public that help is available.

With heightened attention to the issue of depression and suicide among young people, the Department has committed additional resources to the Advisory Board and anticipates greater integration of this group into future children's mental health initiatives.

## **Adult Mental Health Services in Connecticut**

Connecticut's mental health system for adults is comprised of many sub-components; some are well coordinated, others operate in relative autonomy. Scores of organizations provide mental health care which is supported by a variety of different funding streams. Often, requirements of the funding source or *payer* determine the extent to which these components work collaboratively to ensure continuity of care for the people they serve. For adults with severe and persistent forms of mental illness, the issue of collaboration among caregivers is paramount.

### **Adult Service System Components**

Providers of adult mental health services include:

- DMHAS-Funded and Operated Facilities:
  - Fifteen Local Mental Health Authorities (LMHAs) covering the entire state, including six operated by DMHAS and nine run by DMHAS-funded private non-profit agencies, plus over ninety affiliated private non-profit community-based organizations. The LMHAs provide a broad range of services including outpatient, residential, vocational, emergency crisis, case management, psychosocial rehabilitation clubhouses and other specialized programs.
  - DMHAS-operated inpatient psychiatric hospitals, including Connecticut Valley Hospital in Middletown and Cedarcrest Hospital in Newington and two smaller DMHAS-operated inpatient units operated by DMHAS.
- Facilities and Services Provided by Other State Agencies, Private Organizations and Other Entities:
  - Inpatient and ambulatory psychiatric care provided by general hospitals and two private psychiatric hospitals.
  - Services provided by private mental health practitioners.
  - Services provided by private not-for-profit mental health providers that are not funded by DMHAS.
- Involvement of the Probate Courts in assessing the need for psychiatric and substance abuse inpatient commitments, assignment of conservators to manage the affairs of

“incapable” people with psychiatric disabilities, involuntary medication orders and in other mental health related legal proceedings.

- Mental health services provided to Department of Correction inmates in Connecticut prisons.
- Services provided to people with mental illness through the state’s Court Supported Services Division.
- Services offered through community outpatient clinics (e.g., Federally Qualified Health Centers), Health Maintenance Organizations, and primary care physicians.
- Services operated by the Veteran’s Administration, including 28 inpatient psychiatric beds in West Haven and outpatient services in West Haven and in Newington. Counseling services are also available in five Veteran’s Centers around the state.
- Pastoral counseling offered by religious organizations.
- Volunteer-run peer support and self-help groups.

### **DMHAS Client Characteristics**

The demographic characteristics of clients served in DMHAS inpatient and community-based mental health are shown in Figures 4-1, 4-2 and 4-3.

As can be seen in Figure 4-1, although the gender mix of clients served in community-based programs matched that of the general population, men were significantly more likely to be served in DMHAS inpatient facilities than were women.

Figure 4-2 shows that people of different cultures and ethnic groups were more likely to be served in community-based programs. African Americans and people of “Mixed/Other” race were about twice as likely to be seen among clients served in DMHAS community mental health settings as compared to their percentage in the Connecticut general adult population. High percentages of people of different cultures and ethnic groups in the DMHAS population underscore the importance of developing and maintaining culturally responsive services.

African Americans and people of Mixed/Other races were more likely to be served in DMHAS inpatient facilities. This pattern of overrepresentation among African Americans in inpatient facilities has been observed elsewhere (Snowden & Cheung, 1990). Connecticut must ensure that its mental health system is not inadvertently shunting people of different cultures and ethnic groups into inpatient care when community-based services are less restrictive. The high level of inpatient utilization found among non-whites in this report deserves further study in order to establish its causes and to determine whether these individuals might be more appropriately served in community settings.

The age of DMHAS clients in inpatient and community-based settings is shown in Figure 4-3. People aged 18 to 24 were under-represented in DMHAS community-based programs as compared to their numbers in the state’s general population. This may reflect problems with access to mental health services by young adults.

Information about the principal diagnosis of DMHAS inpatient and community-based clients is shown in Figure 4-4. More than half of all inpatients had a principal diagnostic of Schizophrenia

or “Other Psychotic Disorder” as compared to 40 percent with such disorders in DMHAS-funded community-based programs. This means that DMHAS inpatient and community programs were treating a seriously disabled population. Although relatively few inpatients and community clients had a principal diagnosis of Substance Abuse/Dependence (4.9 and 12.6 percent, respectively), others had these disorders as a secondary diagnosis.

**Figure 4-1: DMHAS Mental Health Clients Profile – Gender**

	Inpatient %	Community Clients %	CT Population (>18 yrs)
Male	66	50	48
Female	34	50	52

Source: DMHAS November 1999

**Figure 4-2: DMHAS Mental Health Client Profile – Race/Ethnicity**

	Inpatient %	Community Clients %	CT Population (>18 yrs)
White	58	75	89
African American	25	18	7
Mixed/Other	17	7	4
Hispanic	13	15	5

Source: DMHAS November 1999

**Figure 4-3: DMHAS Mental Health Client Profile – Age**

Age	Inpatient %	Community Clients %	CT Population (>18 yrs)
18-24	13	8	12
25-49	72	67	50
50-64	12	19	20
65+	3	6	18

Source: DMHAS November 1999

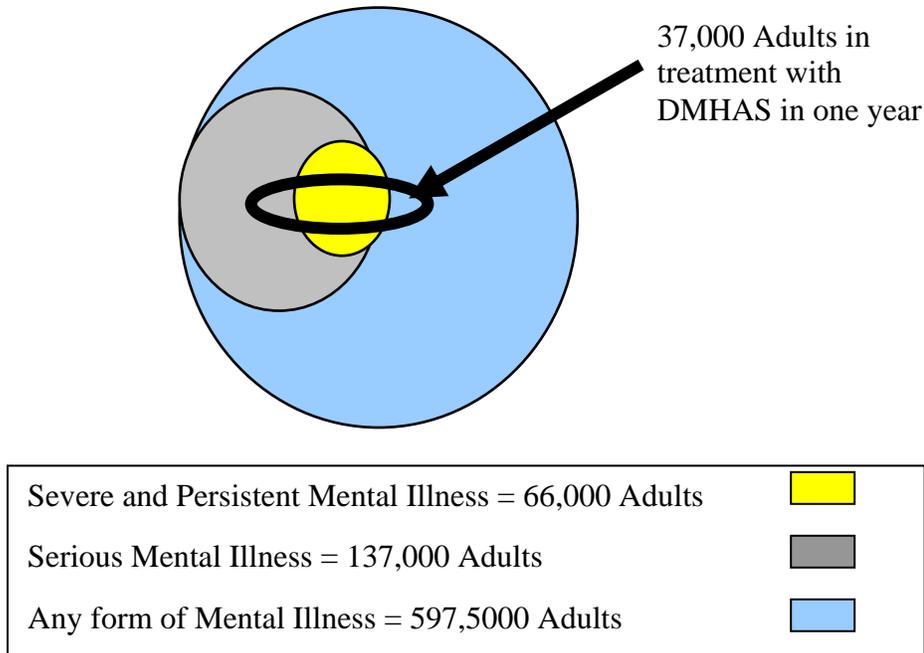
**Figure 4-4: Diagnosis of DMHAS Inpatients and Community-based Clients**

Diagnostic Group	Inpatient %	Community Clients %
Substance Abuse/Dependency	4.9	12.6
Major Mood Disorder	7.6	23.6
Schizophrenia and Psychotic Disorders	50.7	39.8
Personality and Non psychotic Disorders	23.3	16.8
No Diagnosis or Diagnosis Deferred or Missing	13.4	7.2
<b>Total</b>	<b>100%</b>	<b>100%</b>

*Source: DMHAS; Principle diagnosis of clients in DMHAS facilities and in DMHAS funded non-profit community agencies, active on 6/30/99*

The majority of people served in the DMHAS system are those with severe and persistent mental illness. The population served by DMHAS spans all levels of mental illness, but those with the most severe disorders are served in higher proportions (see Figure 4-5). Not all people with serious psychiatric disabilities are served in public sector supported programs. Many people receive care in the private sector and their care is supported by private insurance, self-pay, and other third party benefits. Some critics contend that this emphasis on the seriously disabled population prevents access to treatment for persons with less serious forms of mental illness, especially in minority communities. Although it is difficult to establish precise estimates, Connecticut, like other states, has many people with mental disorders who are not receiving any form of treatment.

**Figure 4-5: Adults with Mental Disorders Compared to those in Treatment with DMHAS during One Year**



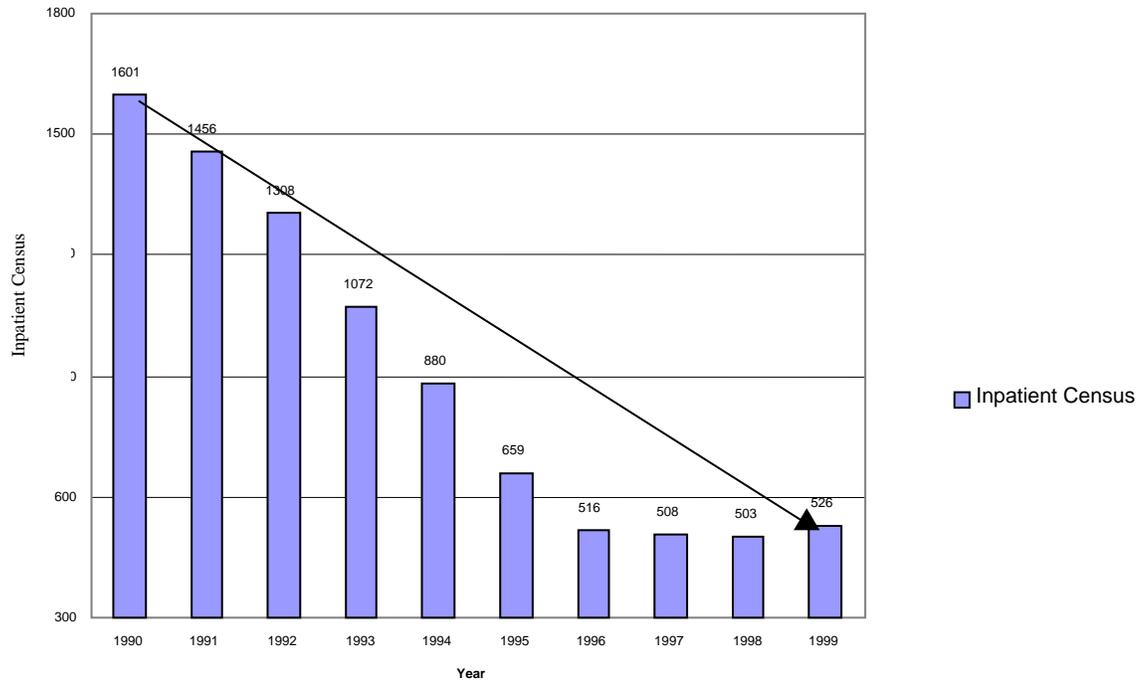
Source: DMHAS Service Data, FY99;  
Prevalence Estimate based on Kessler et al, 1996

**Trends in the Utilization of Adult Mental Health Services**

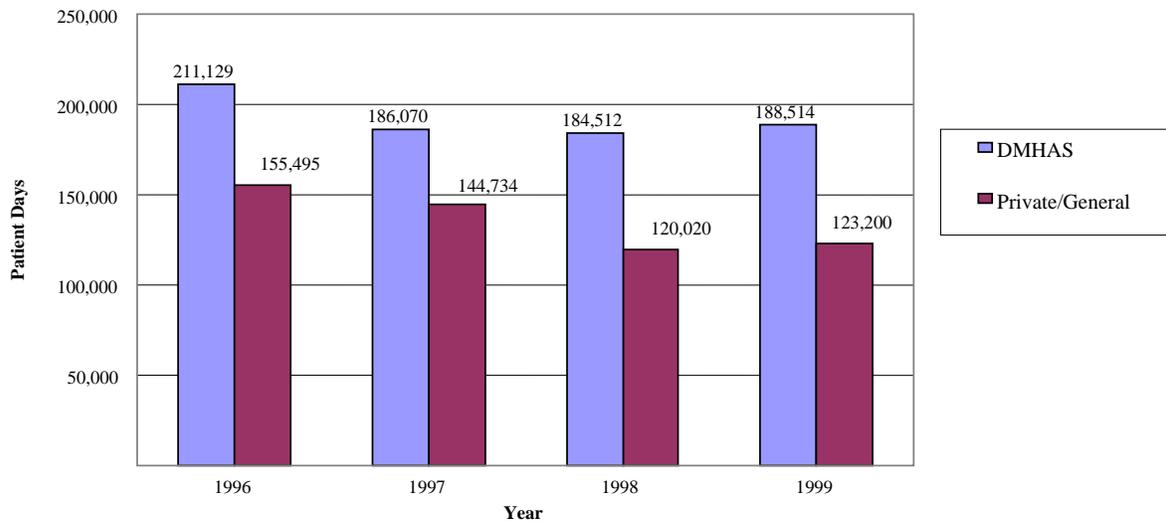
State operated and private mental health services in Connecticut have undergone significant changes in recent years. The following figures highlight several significant trends in the delivery of inpatient and outpatient services. Figure 4-6 examines the inpatient census in DMHAS facilities as of July 1 in each of the years from 1990 through 1999. The figure shows that the inpatient census decreased by 67 percent over the ten-year period. This reflects the national trend of reduced utilization of state operated inpatient psychiatric facilities. It should be noted that the DMHAS inpatient census has remained relatively constant over the past four years, following the closure of Norwich and Fairfield Hills hospitals.

Figure 4-7 shows the number psychiatric inpatient bed days provided in facilities operated by DMHAS and in private psychiatric hospitals and general hospitals which have inpatient psychiatric units. The most significant decline followed closing of Fairfield Hills Hospital in December 1995 and Norwich Hospital in October 1996. Private and general hospital bed days also showed a steady decline over the past 4 years. The impact of managed care and continued problems with reimbursement for the private and general hospitals are likely contributors to this phenomenon. The Average Length of Stay (ALOS) has generally remained constant in the private system implying that fewer clients are being served in private inpatient care.

**Figure 4-6: DMHAS Inpatient Census**

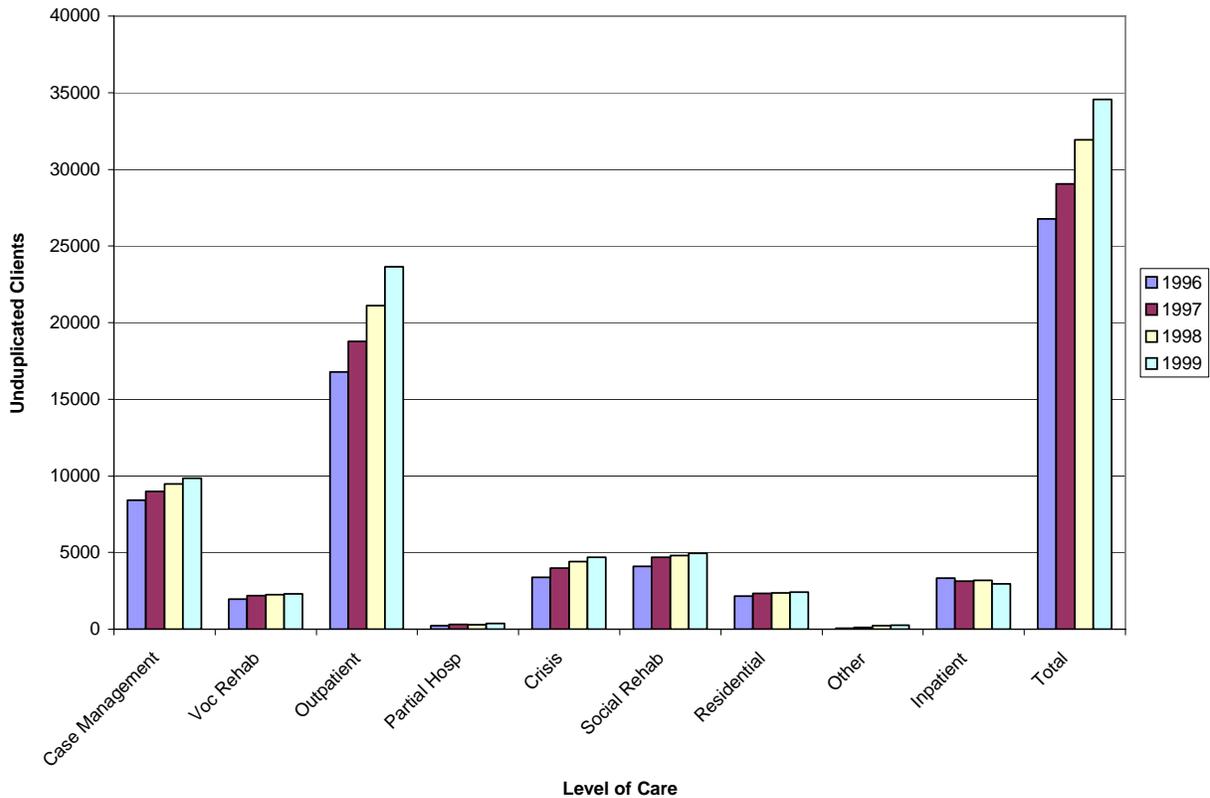


**Figure 4-7: DMHAS and Private General Hospitals**



For clients who would otherwise be served in the inpatient system, the reduction in inpatient beds has forced increased reliance on community services. Figure 4-8 shows the increase in community services from 1996-99. This figure examines the number of unduplicated clients<sup>15</sup> within each DMHAS Level of Care (LOC) or program type. The same client may be counted in more than one LOC because clients can be enrolled in several programs. However, clients are never counted twice within the same LOC. The number of clients within levels of care significantly increased since 1996. The total number of clients served in various DMHAS LOC's in 1996 was 40,411 compared to a total of 51,465 unduplicated clients in 1999. The figure demonstrates the increase in clients served in community programs over the past four years.

**Figure 4-8: Unduplicated Clients by Level of Care**

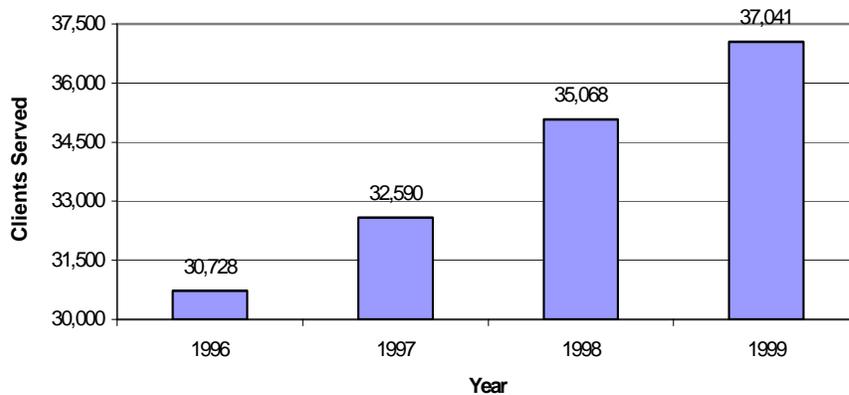


Increased access to care is also evident when one examines the number of unduplicated clients within the entire DMHAS system. Figure 4-9 provides another analysis of unduplicated clients served by DMHAS in 1996 through 1999. The number of clients served in the entire DMHAS

<sup>15</sup> In order to determine the number of clients served it is necessary to unduplicate the client count. Unduplication is necessary because clients can be enrolled in more than one program at the same time or they can have more than one episode of care during a single year. There are two principal methods for unduplicating the client count. One method involves unduplication within Levels of Care (or program types). The other involves unduplication across Levels of Care. The results of both methods are presented here. The latter method, indicates the number of clients served in the entire system of DMHAS funded and operated programs.

system rose from approximately 30,000 in 1996 to approximately 37,000 in 1999, a 20 percent increase. The increase in clients does not appear to be related to any single factor. However, one possible explanation is that funding restrictions in the private sector imposed by managed care have forced more clients to seek treatment with DMHAS as the “payer of last resort.”

**Figure 4-9: DMHAS Mental Health Clients Served by Fiscal Year**



### **Community Adjustment Among Adults with Serious Mental Illness**

A 1996 study conducted by DMHAS examined how nearly 7,000 adults with serious psychiatric disabilities receiving care in the DMHAS system were adjusting to community life, (Dailey et al, in press). About 92 percent of the study’s participants had the most severe forms of mental illness (59 percent with schizophrenia or schizoaffective disorder; 25 percent with major depressive disorder; and 8 percent with “Other Psychotic Disorders”).

Here are a few highlights from the study:

- Although about 80 percent of clients were doing reasonably well adjusting to community life, the remaining 20 percent were having difficulty. This included about 3 percent who were rated as “unable to adjust.”
- About 16 percent of the DMHAS study clients had had a significant problem with alcohol or drug abuse during the prior year as compared to about 11 percent of adults in the general population with such problems (Kessler et al, 1996).
- Social isolation and victimization (i.e., clients who are victims of crimes) were significant problems among study participants. Women with serious psychiatric disabilities were the most likely to be victimized. Rape and sexual assault rates were much higher among DMHAS study clients than in the general adult population.
- The most significant predictors of client community adjustment are factors that can be directly influenced by well-planned therapeutic interventions and adequate support services. In other words, people with serious psychiatric disabilities who stay on their medications, do not drink or use drugs, stay out of trouble, live in safe decent housing and are less socially isolated, adapt more successfully to community life. These are all issues that can and should be addressed by a well functioning, adequately funded mental health system.

### **The General Assistance Behavioral Health Program**

In June 1997, the General Assembly granted DMHAS authority to operate a managed behavioral health program for recipients of State Administered General Assistance (SAGA). DMHAS had been developing a public sector model for managed care for about two years. The model was designed to utilize the best technologies of private sector managed care but to do so within a framework of public sector values. These values emphasize the *safety net* role historically embraced by state government and considered necessary to promote recovery for poor people with complex behavioral health needs. DMHAS began operating the General Assistance Behavioral Health Program (GABHP) in August 1997. The GABHP was established in recognition of the following:

- The state should retain policy setting authority when designing, implementing and operating a behavioral health program for public sector clients.
- The state should retain the financial risk of operating the program in order to remove any incentives for managed care companies or providers to deny access to care.
- Quality performance indicators should be used to measure client outcomes and to examine provider compliance with service requirements. Provider performance should be linked to re-credentialing and continued contracting.
- Traditional *medical necessity* criteria that focus merely on reducing symptoms are not appropriate for poor people with severe behavioral health disorders. Criteria for the authorization of services must address the broader notion of *psychosocial necessity*, encompassing a client's entire recovery environment including supports such as housing, financial support, transportation and vocational pursuits.
- A public sector managed care program must be responsive to the age, gender and cultural characteristics of its target population.
- Consumer and provider participation in identifying problems and suggesting solutions that can be rapidly implemented is essential to the success of a public sector managed care program.
- An Administrative Services Organization (ASO) can assist the state with certain functions such as claims processing, enrolling and verifying the credentials of providers, and performing utilization management functions such as prior authorization, continued stay and discharge reviews.

DMHAS established a statewide network of Behavioral Health Units (BHUs). The Behavioral Health Units evaluate and make treatment referrals for recipients of general assistance who require mental health and substance abuse care. In addition, in order to improve outcomes for clients who were repeated users of acute care services (often a sign of prior treatment failure or poor client outcomes), DMHAS established a *Care and Case Management Program* designed to help clients rapidly connect to rehabilitation services following an acute care episode.

As an important adjunct to the GABHP, after planning and consultation with nationally recognized experts, DMHAS launched the *Basic Needs Program* (BNP) in 1998. This program

is an innovative case management resource that reduces barriers to care through non-cash supports<sup>16</sup> that assist clients to concentrate on clinical aspects of their recovery.

Preliminary data indicate that the GABHP is working as planned:

- The penetration rate<sup>17</sup> of SAGA clients in behavioral health services has increased to 46 percent.
- An increased array of behavioral health services has been made available to SAGA clients.
- Compared to other clients, those served in the Care and Case Management Program:
  - Are more likely to become involved in rehabilitative care following discharge from acute care (instead of continually cycling through expensive acute care services).
  - Have improved *level of functioning* scores on a standardized clinical rating instrument.
  - Have fewer expensive acute inpatient admissions.

The GABHP is seen as a model that can be successfully adapted for use with other populations such as disabled adult Medicaid recipients.

## Financing Mental Health Services in Connecticut

Mental health services in Connecticut, as at the national level, have two basic sources of funding, private and public. Private funding of mental health includes insurance payments and out-of-pocket insurance co-payments, as well as the direct payment of services by self-insured persons. Public mental health services are financed through several state and federal funding sources, including state General Fund appropriations, Medicaid and Medicare. These funds support programs in DMHAS, DCF, the Department of Correction, and in the Court Support Services Division of the Judicial Branch. In addition, municipalities support mental health services (e.g., school social workers and school psychologists) in local school systems.

Within DMHAS, funding for mental health services totaled \$257 million in FY 1996 and \$290 million in FY 1999. These amounts include both state dollars and federal funding in the form of Community Mental Health Services and Social Services block grants. This funding is used to pay for inpatient treatment, outpatient and case management services, supportive housing, and court diversion services. Much of the increase in the Department's budget for mental health services since FY 1996 can be attributed to programs for new client groups that have been added to the DMHAS target population. These include programs for State Administered General Assistance recipients needing behavioral health services, clients with Acquired or Traumatic Brain Injury, and Special Population clients, that is clients transitioning from DCF and those with special mental health needs requiring community supervision. Excluding these new populations, and adjusting for inflation, the DMHAS budget for other mental health services increased by 0.5 percent between FY 1996 and FY 1999.

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<sup>16</sup> BNP supports include such items as vouchers for food and clothing and direct payments to landlords and utility companies for housing related expenses. The BNP replaced direct cash payments to clients, many of whom were substance dependent.

<sup>17</sup> Penetration rate is defined as the percentage of individuals receiving services within a given population.

As the number of clients served increased by 20.5 percent between FY96 and FY99, the level of funding for community mental health services has made it difficult for the Department to meet the demand (with the exception of the aforementioned special populations clients and specialty services) for these services. If additional funds were available they could be used immediately in the following areas:

- To reduce the number of people with psychiatric disabilities in Connecticut's homeless population by increasing supported housing opportunities. Currently, DMHAS' combined state and federal funding for mental health housing and rental assistance totals approximately \$2.7 million, or less than 1 percent of the Department's total budget for mental health services.<sup>18</sup>
- To decrease the percentage of people with psychiatric disabilities in the state's prisons and jails through the provision of additional jail diversion programs and treatment, supervision and support services specifically developed for ex-offenders. Jail diversion services without additional community-based resources for former inmates will merely exacerbate existing problems with an already overburdened community-based treatment system. The Department of Correction and the Judicial Branch report more than \$12 million in annual expenditures for people with mental disabilities. According to the February 1, 2000 report to the Joint Standing Committee of the General Assembly entitled "The Costs and Effectiveness of Jail Diversion," approximately \$3.1 million would be required to extend DMHAS' jail diversion program statewide, in addition to the \$824,422 currently budgeted. In fact, this was appropriated and approved by legislature and the governor in the most recent legislative session. Additional correctional beds would become available if the number of people with psychiatric disabilities in DOC facilities were reduced.
- To relieve the gridlock in state inpatient facilities by increasing the availability of intensive case management programs, emergency-crisis services and intensively supervised residential programs. These programs would accommodate individuals currently in state hospitals who could be placed in community settings with the appropriate level of treatment, supervision and support.
- To relieve the stress created in the community mental health system by funding increases that have not kept pace with the inflated cost of providing care.
- To improve Medicaid reimbursement rates so that they reflect service costs.

### **Insurance Parity**

Community mental health care has growth significantly during the past 20 years. However, the historical absence of parity in insurance benefits between mental health and general medical services has restricted the supply of mental health services and treatment professionals. In Connecticut, the General Assembly moved to correct certain aspects of this inequity in 1997 by passing partial parity legislation<sup>19</sup> (P.A. 97-8, Special Session). A second, comprehensive parity law was passed in 1999 (P.A. 99-284, Special Session; Sections 27-28). In its present form, the

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<sup>18</sup> The FY 2001 DMHAS budget includes an additional \$2,000,000 to begin implementing the PILOTS housing initiative.

<sup>19</sup> Parity laws require that insurance policies offer similar service limits (e.g., maximum number of inpatient days) and financial limits (e.g., life time and annual limits, co-payments and deductibles) for treatment of mental health disorders as compared to general medical conditions.

Connecticut parity law is one of the most progressive in the nation, covering virtually all mental health and substance use disorders. The new law went into effect on January 1, 2000 and applies to all fully insured policies. About 50 percent of all state residents have insurance that is self-funded through their employer. Such self-funded ERISA plans are not subject to state insurance regulation and are therefore exempt from Connecticut parity law.

It is too soon to evaluate the impact of Connecticut mental health parity legislation because the provisions of the law take effect only when policies are issued, renewed or continued. Thus, the "roll-out" period is expected to last one to two years. Some insurance parity provisions for mental health benefits exist under federal law; however, because of various restrictions and limitations the impact of federal parity legislation on people with psychiatric disabilities has been minimal.

## CHAPTER V – SUMMARY OF PRIORITY RECOMMENDATIONS

This chapter provides a summary of the Commission's primary recommendations. The recommendations were formulated based on discussion of Commission and Steering Committee members, input from public hearings and the findings and recommendations of the Expert Panels. These recommendations have been selected because they:

- Offer significant benefits over time for the mental health system and for Connecticut residents across the life cycle.
- Reflect issues so compelling that they must be addressed at this time.
- Reflect issues identified during the public hearings or in connection with the work of the Expert Panels.
- Offer the greatest feasibility of implementation in an environment of competing fiscal demands, needs and priorities.
- Concur with national issues identified in the Surgeon General's Report that are also of concern to Connecticut.

The priority recommendations are as follows:

### **Address Gridlock in Care Delivery for Children and Adults**

*Issue:* Inadequate or unavailable local community and residential services for children and adults with serious mental illness have resulted in unnecessarily lengthy inpatient stays. Children are also being held for extended periods in emergency rooms because of the absence of appropriate alternatives. Managed care related cost containment efforts have caused some providers to discontinue care to vulnerable populations.

*Recommendation:* Immediate steps must be taken to ensure timely access to acute inpatient care for children and adults by developing a continuum of services without compromising the availability and quality of inpatient care.

### **Enhance Community Services**

*Issue:* Some children with serious emotional disturbance and adults with serious mental illness are not well served in many parts of Connecticut. Treatment is hindered by long waiting lists for treatment, the absence of basic service elements, or programs that do not follow best clinical practices. Necessary community services include, among others, outpatient psychiatric evaluation and treatment, rehabilitative and residential services, and non-clinical supports.

*Recommendation:* DMHAS and DCF, in collaboration with appropriate agencies and consumers, should assess existing community resources and based on identified service-gaps, expand the community-based system to include a full spectrum of services that respond to:

- Specific disorders and functional impairments.

- Age, gender and cultural needs.
- Individuals involved in the juvenile or criminal justice systems and ensure adequate support, treatment and supervision of people with mental illness released from jails and prisons.

State agencies and providers working with academic institutions and researchers should identify and implement best care practices.

### **Continue to Develop Locally Based Systems of Care**

*Issue:* When services are not locally managed continuity of care and client treatment outcomes are adversely affected.

*Recommendation:* DCF and DMHAS must continue to support the development and enhancement of locally based Systems of Care that include private and public providers and utilize lead agencies to coordinate planning, policy implementation, and service delivery within specific geographical areas.

### **Bring Home Connecticut Children Placed in Out-of-State Residential Facilities**

*Issue:* The absence of specialized programs in Connecticut for youth with behavioral disorders has made it necessary to place more than 350 children in out-of state residential facilities. When they finally return home, follow-up care has been made more difficult by the fact that most have no sustained connection to their families or communities of origin. Programs for this population are difficult to establish because of high costs, neighborhood opposition and provider reluctance to face this opposition.

*Recommendation:* Out-of-state placements should be halted as soon as necessary services are developed in Connecticut. At that point, children who are placed out-of-state should be returned home to Connecticut. The services required to meet the needs of these children should be made available within the state.

Further, legislation should be adopted that prevents municipalities from using zoning regulations to prohibit DCF or DMHAS or any provider under contract with these state agencies from rendering behavioral health treatment or support to any child or adult living in the community.

### **Ensure Coordinated Care for Young Adults Transitioning from DCF to DMHAS**

*Issue:* Too often, young adults become disconnected from needed mental health services as they transition from the responsibility of DCF to DMHAS. This occurs because historically the two agencies have focused on different target populations (DCF on children with serious emotional disturbance and DMHAS on adults with severe and persistent mental illness). Lack of timely services at this crucial developmental stage increases the risk that these young people will end up in jails, in psychiatric hospitals, on the streets, or idle at home with neither gainful employment nor hope for the future.

Recommendation: The program for transitional youth currently developed by DCF and DMHAS should be expanded. This model must emphasize ongoing collaborative planning among DCF, DMHAS, juvenile courts, DOC, DSS and other agencies to ensure access to services previously unavailable to this population.

### **Enhance Opportunities for Recovery Through Consumer and Family Member Involvement and Empowerment.**

*Issue:* An effective and efficient mental health care system must consult with, respect, inform and support its consumers and family members. Generally, consumers and family members have not been sufficiently involved in decisions about the delivery of mental health services. In addition, there is a need for more consumer/family-friendly information regarding treatment options, the role consumers/families in the development of treatment plans, and their rights when accessing and utilizing public services. There is insufficient advocacy assistance to help consumers and families secure services that effectively meet their stated needs and desired outcomes. Without meaningful consumer and family input, the state will not expend funds in the most appropriate and cost-effective fashion.

Recommendation: The state should quickly develop and implement a plan to strengthen consumer and family member input into the design and implementation of mental health policy and services. The plan should address the following areas:

- How to assist consumers and families in developing a better understanding of the mental health system.
- Provision of the necessary resources for effective self-advocacy and advocacy support, including coordinated consumer and family empowerment and advocacy services.
- Development of a comprehensive enforceable universal bill of consumer rights.
- Development of a consumer-staffed customer relations office at DCF.

### **Implement an Ongoing Community Education Campaign**

*Issue:* Connecticut residents need to be better informed about mental health, mental illness, the consequences of stigma, and availability of treatment options. By teaching children and adolescents about behavioral health, local school systems can promote the emotional well being of children and adolescents.

Recommendation: Connecticut state agencies should collaborate with consumers, families, academic, private institutions and local school systems to develop and promote an ongoing statewide education campaign that:

- Increases public understanding and awareness of mental illness.
- Promotes early detection and treatment of mental health problems.
- Provides information about how to obtain treatment.
- Support recovery from mental illness.

- Collaborates with local school systems to ensure behavioral health education for grades Kindergarten – 12<sup>th</sup>.

### **Integrate Primary Prevention into the State System**

*Issue:* A number of strategies and program models have evolved during the past two decades that can be used to prevent mental illness and promote mental health. Yet, most current prevention efforts are fragmentary and are neither well funded nor coordinated. Connecticut can save human and economic costs associated with the consequences of mental illness by helping to address factors that put people at risk for these disorders.

*Recommendation:* State government should support primary prevention programs designed to promote mental health, improve health outcomes, and generate net cost savings. State agencies should collaborate on the development of a comprehensive plan to promote mental health across the life cycle, based on state-of-the-art prevention research and practices. The plan should include:

- A prevention budget across departmental lines.
- Indicators and benchmarks to guide planning and measure program effectiveness.
- Prevention training and education targeted to the community-at-large, existing prevention providers, and health systems involved in prevention efforts.

In addition, grants should be used to establish model prevention programs throughout the state. Much has been learned in the area of substance abuse prevention that can serve as the basis for development of effective mental illness prevention programs (especially for those disorders that are not caused primarily by biological and genetic factors).

### **Improve the Cultural Competence of Mental Health Service Delivery**

*Issue:* Cultural competence research indicates that cultural issues impact the mental health service delivery system in many ways, including level of client trust, access, retention, recidivism, cost effectiveness and quality of care. Connecticut must adopt new approaches for addressing the rich cultural diversity of persons who need mental health services.

*Recommendation:* State agencies involved in the delivery of mental health services should incorporate principles of cultural competence into the design, development, purchase and implementation of such services. State agencies should engage in high-level interagency collaboration to develop and implement cultural competence clinical standards, outcome measures, policies and procedures.

### **Resource Development**

To determine whether there are enough resources in a complex system, one must consider whether new resources are needed. The following issues need to be fully explored:

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- In a system where expenditures are measured in the hundreds of millions of dollars per year, it is always possible to find new ways to use resources more efficiently and effectively.
- Systems that experience a moderate amount of financial stress tend to become better at economizing and creatively solving resource-related problems.
- Programs and services that do not perform adequately or that no longer address important needs should be discontinued thus freeing up resources for redeployment.
- Opportunities to increase Federal financial participation and philanthropic support should be vigorously pursued.

Nevertheless, at some point, belt tightening, effective management and reallocation are simply not enough. The Governor's Blue Ribbon Commission on Mental Health has concluded that additional resources are needed to address mental health care needs in Connecticut based on the following:

- As already described, there are too few highly structured community-based programs for children and adults. This makes it difficult to find suitable placement to discharge patients from psychiatric inpatient beds who no longer need a hospital level of care. Similarly, children and adults are held in emergency rooms because of the lack of community services. This, in turn, restricts the availability of inpatient beds sometimes making it very difficult to admit patients to hospitals during emergency situations. The result is gridlock in hospitals and emergency departments.
- As previously indicated, as of last year, over 350 Connecticut children had been placed in treatment facilities out-of-state because of the lack of appropriate facilities in the state.
- Connecticut has not taken full advantage of mental health funding available through Medicaid. Failure to implement the Medicaid Rehabilitation Option has meant that possible federal revenues have not been recovered to support the cost of these vital services.
- About 12 percent of 17,000 inmates in Connecticut prisons and jails need mental health treatment. Correction officials report that the percentage of total inmate population with mental illness is steadily increasing.
- Historically, mental health insurance benefits have not been comparable to those of other health conditions. This has caused restriction in the development of mental health services. Although the problem has recently been addressed by the passage of insurance parity legislation in Connecticut, the effectiveness of the new law has not yet been assessed. In addition, the new legislation does not apply to many existing insurance policies or to the uninsured population (an estimated 10 percent of Connecticut adults).
- Inflation adjusted support for DMHAS-funded and operated mental health services has increased by 0.5 percent, while the number of clients served in the community system has increased by 20 percent. Although system efficiencies may have absorbed some of the spread, this trend strongly suggests that more clients are receiving less service than in prior years.
- General hospitals, traditionally major players in the mental health treatment delivery system, are under increasing pressure to cut back or eliminate their behavioral health programs because revenue does not support the cost of providing these services. General hospitals report the following:

- Managed care has reduced payment for behavioral health services an average of 35 to 50 percent.
  - The Federal Balanced Budget Act of 1997 capped reimbursement rates at 1997 levels.
  - Hospitals are no longer able to underwrite losses in their behavioral health services for indigent or Medicaid clients by cost shifting from other services within their facilities.
  - Elimination of the Medicaid co-pay last year for dual eligible Medicaid/Medicare patients adversely affected a disproportionate number of individuals with prolonged mental illness.
- Responding to concerns about the potential negative impact of General hospital behavioral health service cutbacks and bed closures, the Office of Health Care Access (OCHA) has asked for a voluntary moratorium on further cutbacks until January 1, 2001.

In combination, these factors strongly suggest that an infusion of new resources is needed to stabilize the mental health system and to improve the quality of care. Resources are needed in the following areas:

Connecticut children and families need to improve access to:

- Emergency mobile psychiatric services.
- In-home and school-based services.
- Extended day treatment.
- Respite, crisis respite and monitoring services.
- Community-based outpatient mental health services.
- Therapeutic systems coordinators.
- Case managers.
- Family advocates.

Adults with severe and persistent mental illness need increased access to:

- Intensive case management and assertive community treatment (and other services designed to engage and motivate clients for treatment and improve adherence to treatment plans and the appropriate use of prescribed medications).
- Intensive residential programs for clients with high-risk behaviors.
- Jail diversion programs and specialized services for those diverted from incarceration or being released from jail/prison who need continued mental health treatment and supervision.
- Specialize programs for clients with co-occurring psychiatric and substance use disorders.
- Specialized programs for young adults transitioning into the adult mental health treatment system.

In order to implement the priority recommendations of the Governor's Blue Ribbon Commission on Mental Health, as contained in this chapter, the following recommendations are made:

### **Address the Programmatic and Financial Needs of the Mental Health System**

DCF, DMHAS, Judicial Branch and other impacted agencies should develop multi-year plans containing specific programmatic and financial proposals for the next biennium. These plans should set priorities for each year recognizing that it will take several years to fully address some needed enhancements. The plans should:

- Specify the type, service capacity and number of proposed programs to be implemented during each year.
- Specify provider performance objectives.
- Create economies of scale and maximize the efficient use of resources.
- Support the integrity of the existing services.
- Integrate the management of multiple funding streams including Medicaid and state grant dollars.

Programmatic proposals should be based on a clinical/functional needs assessment of the children, adolescents and adults to be served by the programs.

Programmatic proposals should be made for the next biennium should be completed before October 1, 2000.

Concurrently, OPM, DSS, DCF and DMHAS should develop plans to:

- Maximize the use of optional Medicaid State Plan services, including rehabilitation services and targeted intensive case management services.
- Utilize Medicaid waivers to expand services to adults and children.
- Conduct an ongoing outreach initiative to enroll eligible individuals in Medicaid. This will ensure Federal reimbursement for services.

### **Adjust Rates to Ensure Adequate Support for Mental Health Services**

*Issue:* In many cases, reimbursement rates for inpatient and community-based services are unreasonably low. This reduces access to care for vulnerable populations, contributes to hospital gridlock, and increases homelessness and incarceration among children and adults with emotional and mental disorders.

*Recommendation:* State agencies, including OPM, DSS, DCF and DMHAS should examine and adjust payment rates for inpatient and community services to support the cost of providing care, where appropriate.

## CHAPTER VI – MECHANISMS FOR IMPLEMENTATION

This chapter describes the two principal mechanisms that need to be in place to assure that the recommendations of the Blue Ribbon Commission will be implemented: a vehicle for follow-up to the work of the Commission and opportunities for interagency collaboration.

### **Mental Health Service Enhancement (A Vehicle)**

The Governor's Blue Ribbon Commission on Mental Health has been an effective tool as policymakers, state administrators, service providers, consumers, family members and advocates have begun exploring ways to prevent mental illness and to enhance the quality of mental health care in Connecticut. In creating the Commission, Governor Rowland recognized the significance of mental health as a factor influencing the quality of life for Connecticut residents of all ages. During the Commission's brief tenure much has been learned that will help to improve mental health policies and practices, however, much more needs to be done. Therefore, it is critically important that a vehicle be created to continue the work started by the Commission.

### **Mental Health Policy Council -- A Vehicle for Follow-up**

It is recommended that a permanent statewide Mental Health Policy Council be established to promote mental health, prevent mental illness and to ensure the accessibility and quality of mental health services for Connecticut residents across the life cycle.

It is expected that the Mental Health Policy Council will perform the following functions:

- Follow-up on Commission Report – To refine and review the implementation of recommendations made in the report of the Governor's Blue Ribbon Commission on Mental Health Work, in collaboration with various stakeholders. This would also include an evaluative role that reviews goals and outcomes of the implementation.
- Policy Development – To suggest areas for coordination of the policies and practices of state agencies with responsibility for mental health care.
- Case Conferences – To use material gathered from regularly scheduled multidisciplinary case conferences as the basis of policy change and to provide immediate practical assistance to children, families and adults with mental health related problems. Cases would be selected for review based on criteria such as: complexity of the problem(s) presented, need for the involvement of multiple agencies in developing a viable solution, past failure to resolve problems of a similar nature, implications for policy change, educational and teaching value. In order to safeguard human rights, these case conferences should be conducted in accordance with state and federal confidentiality requirements.
- Consumer Voice – To support the participation and contributions of consumers, family members, and advocates in the evolution of mental health policy.
- Best Practices – To identify ways to promote mental health and ensure the use of best practices in the areas of prevention, early identification, intervention and treatment.
- Public Education – To focus public attention on mental health issues, to decrease stigma. and to promote recovery from mental illness.

- Safety Net – To ensure that the state's historical role as a *safety net* for poor, disabled and vulnerable citizens is preserved and protected.
- Cultural Responsiveness – To ensure that mental health services are provided in a culturally competent manner.
- Legislative Initiatives – To propose legislation designed to improve the service delivery system, reduce barriers to care and enhance coordination and collaboration among state agencies and service providers.
- Policy Coordination – To coordinate its efforts with those of the Connecticut Alcohol and Drug Policy Council, the State Advisory Board of Mental Health and Addiction Services and the DCF Advisory Council.

The Council should be comprised of consumers, family members, providers, community leaders, and representatives from state agencies, the Judicial Branch, the probate courts and academic institutions. State agencies that fund or provide services and those that have an indirect role should be involved. The Council should be empowered to form any subcommittees of special workgroups that may be required to conduct detailed analysis of complex issues. Finally, the Council should coordinate its efforts with those of the Connecticut Alcohol and Drug Policy Council to ensure that the needs of people with co-occurring mental disorders and substance use disorders are adequately addressed. Staff from DMHAS, DCF and OPM should assist the Council in accomplishing its work.

In order to capitalize on the momentum created by the Governor's Blue Ribbon Commission, the Policy Council should be established by appointment of a steering committee as soon as possible after the Commission completes its work. Later, as may be deemed necessary by the General Assembly, the scope, purpose and membership of the Council should be codified in statute.

### **Opportunities for Collaboration**

Service fragmentation and problems with the continuity of care are important barriers to effective service delivery and mitigate against successful treatment outcomes. State agencies are acutely aware of such problems and have worked to promote coordination of their efforts. Many examples of such collaboration exist (see Appendix B). There are future opportunities for enhancing these efforts and involving additional partners. As the two principal state agencies responsible for mental health services, DCF and DMHAS should develop collaborative efforts with:

- **Advocates, family members and people with mental illness** - to ensure that services are responsive to client needs, that the service delivery system is based on a recovery philosophy, and that the rights and dignity of people with mental illness are preserved and defended.
- **Universities and research scientists** - to identify best practices for the prevention and treatment of emotional and mental disorders and to ensure that these practices are consistently applied throughout the system and that the measurement of client outcomes is used as a means of improving quality of care.

- **Public/private partners** - to develop and enhance local systems of care and improve access to services. Such efforts should emphasize the needs of people with co-occurring psychiatric and substance use disorders.
- **The Judicial Branch** - to prevent incarceration of young and adults with emotional and mental disorders when mental health treatment is the appropriate alternative.
- **The Department of Correction** - to ensure that people with mental illness who are released from prisons and jails are adequately supported, supervised and treated.
- **The Department of Education, the Probate Courts and local school systems** - to help identify and implement strategies for the prevention, detection and early treatment of mental illness. In addressing the need for collaboration with local school systems the state should consider assuming or sharing the financial burden of mental health treatment for children as a means of removing the present disincentive for municipalities to identify such cases. This action would tend to promote detection and early intervention thereby reducing the potential for problems with much greater human and economic costs.
- **The Department of Mental Retardation** - to ensure adequate access to psychiatric services for people with combined intellectual and functional impairments.
- **The Department of Social Services** - to maximize federal revenue and to implement behavioral health managed care programs for Medicaid recipients as have been proposed in recent studies involving DSS, DCF and DMHAS. As the state's Medicaid authority DSS has lead responsibility for insuring that these proposals are developed and implemented consistent with state requirements and Medicaid regulations.
- **OPM and the Legislature** - to refine and elaborate plans and to insure Executive and Legislative support.

This list of collaborations is not meant to be exhaustive; it merely serves to focus on key areas where additional work is needed. Many other collaborative activities should be identified and developed to strengthen mental health prevention and treatment in Connecticut.

## CHAPTER VII – THE EXPERT PANEL REPORTS

## Advocacy and Consumer Perspectives

Clifford Beers' classic book *A Mind That Found Itself* (1908) began to mobilize people in recovery from mental illness to become advocates for enhancements in care. Since then, the role of people who use mental health services in defining, delivering, and critiquing such services has become progressively more pronounced.

As the *Surgeon General's Report on Mental Health* notes, "On a systems level, the consumer movement has substantially influenced mental health policy to tailor services to consumer needs.... Consumers are now involved in all aspects of the planning, delivery, and evaluation of mental health services, and in the protection of human rights."

Similarly, advocacy by parents on behalf of children with behavioral health problems – "family advocacy" -- "has experienced spectacular growth and influence since its beginnings in the late 1970s." As the Surgeon General notes, "...among the most noteworthy accomplishments of the family movement has been the emergence of family participation in decision-making about care for children, one of the decisive historical shifts in service delivery in the past 20 years."

In addition, advocacy has encouraged the development of a mental health system that views recovery as a defining goal and recovery-based outcomes, as defined by those it serves, as the measure of success. It has helped assure that the system remains responsive to individual needs, flexible enough to accommodate new ideas, and committed to long-term solutions that promote recovery, not short-term quick fixes. Finally, advocacy has promoted the vision that the broader community must become a community of recovery that affords equal opportunity for people in recovery and fosters health and wellness.

To be most responsive to the needs of those it serves, a mental health system caring for people across the full life cycle includes at least three, overlapping elements:

- ❑ Meaningful personal involvement by people who use mental health services and their families in the planning, design, implementation, staffing, and evaluation of those services, as well as the involvement of people with behavioral health needs in navigating their own road to recovery.
- ❑ Effective advocacy through a range of initiatives that assure that people who need services receive them in a timely and clinically and culturally appropriate manner, that the concept of recovery is central to service delivery, and that the safety and emotional well being of all served is assured.
- ❑ Creation of a well-informed, caring community, nurtured through an effective public education campaign, that views the enhancement of mental health, the promotion of recovery from mental illness, the de-stigmatization of mental illness, and access to timely appropriate care as matters of paramount importance.

While Connecticut's adult and children's mental health systems currently include a number of relevant components, they fall short of any unified plan to assure that these three essential elements exist. This section of the Commission Report first briefly summarizes current efforts to enhance "consumer" voice, advocacy, and public education and understanding. It then describes specific recommendations and enhancements to markedly bolster Connecticut's system, as well as expected impacts from these enhancements.

### **Current Efforts to Bring Consumer Perspectives into Policy and Practice**

DMHAS and DCF understand the importance of involving people who use mental health services and their families as collaborators and advisors in decisions about their own care, in policy-making (needs assessments and program and service design, implementation, staffing, and evaluation), and in research. However, significant involvement of such people is not yet ubiquitous, consistent, or well supported in Connecticut.

DMHAS emphasizes that its approach to treatment is "grounded in the rehabilitation/recovery model" and states that "for this model to be effective, consumers/survivors and family members must have an active role in treatment and in service planning at all organizational levels." Specifically, DMHAS states that integral to the implementation of its mission of providing an integrated network of comprehensive, effective and efficient mental health and addiction services that foster self-sufficiency, dignity and respect are its efforts to:

- ❑ Promote the empowerment of clients and families;
- ❑ Value the experiences of recovering people;
- ❑ Seek their advice in departmental activities and advisory structures and facilitate their employment in the DMHAS system;
- ❑ Advocate on all levels for the prevention and reduction of stigma;
- ❑ Recognize that citizen advisory structures are an essential component of system planning;
- ❑ Acknowledge the unique contributions of families, friends and communities; and
- ❑ Value input from interested parties, including consumers and families, to continuously maintain and improve service systems.

Because of this commitment, DMHAS says it "strongly supports consumer/survivor and family advocacy networks and programs" [Community Mental Health Services Block Grant, 1999]. Indeed, as outlined in Appendix C, DMHAS includes on nearly all of its advisory boards some representation by people recovering from mental illness.

DCF also acknowledges the importance of involving children, youth and families in its planning processes: the "planning for children's mental health services in Connecticut includes representatives from provider and consumer groups in every region of the state" [Community Mental Health Services Block Grant, 1999]. In particular, the Mental Health Subcommittee of the DCF Statewide Advisory Council includes parent representatives and serves as a forum to "encourage involvement and participation of families at all levels of service planning for children" and "increase public awareness of the mental health needs of children." [Community Mental Health Services Block Grant, 1999] Notably, however, DCF has fewer opportunities than does DMHAS for the voice and perspectives of users of services to be involved in critical planning functions (See Appendix C).

Despite DMHAS' and DCF's expressed commitment to consumer voice and perspective in policy-making and practice, challenges remain. Current consumer representation is on boards that are advisory only, with significantly limited power to make policy change. In addition, the majority of the statutes that establish DMHAS' and DCF's advisory bodies require the presence of some number (or some proportion) of persons who are not "service providers," rather than explicitly requiring that "consumers" be included. This leaves open the potential for token representation by actual consumers (or family members of consumers). In addition, consumers now serving on DCF and DMHAS advisory boards do not consistently receive compensation for their time, and oftentimes have delayed (or no) reimbursement for their travel and child care expenses. Consumer representatives now serving on DCF and DMHAS boards also believe that there is a need for enhanced training to enable them to become more effective board members, and enhanced pre-service training opportunities for consumers interested in being appointed.

In addition, like 26 other states, DMHAS has established an Office of Customer Relations, staffed by people in recovery. The Office of Customer Relations reports directly to the DMHAS Commissioner, providing a unique and important channel for "consumer" voice and perspective in internal agency discussions and decision making. DCF has no comparable office.

### **Current Advocacy Resources**

People using mental health services and their families benefit from programs promoting three types of advocacy to assure access to necessary care:

Self-advocacy - These programs build skills that enable people using mental health services (and their families) to be more effective advocates on their own behalf. They can include a) comprehensive information and referral systems and help lines; b) advocacy and empowerment training programs; c) effective grievance processes and assistance in using them.

Advocacy assistance - These programs provide non-legal and legal advocates to assist people using mental health services to better access appropriate care and to negotiate complex systems. Such advocates may also act as the primary advocates for people who are unable to help themselves because of age or other limiting condition (including children no longer in the custody of their parents).

Systems/legislative advocacy - Programs of this type seek to address systemic barriers and recurring issues relevant to the timely delivery of clinically and culturally appropriate care.

To be most effective, however, these three levels of advocacy must be formally linked and their efforts coordinated. For example, there must be a mechanism for communicating the information, data, problems, and barriers to the delivery of mental health services that are identified by people who are using those services (or their advocates) to those people who are engaged in systems and legislative advocacy. In this way, the systems/legislative advocacy is well grounded in and informed by the direct experiences, needs, and expressed choice of people grappling with systems' deficiencies. Conversely, there must be mechanisms for changes in law and policy to be rapidly communicated to those who are using mental health services.

One excellent model of such interconnected advocacy is Connecticut's Children's Health Infoline, a part of the Children's Health Council and the Connecticut Children's Health Project that is operated by United Way/Infoline and funded by the Department of Social Services. The Children's Health Infoline is a markedly enhanced information and referral line that not only helps individual children who are eligible for HUSKY (Healthcare for Uninsured Kids and Youth) gain access to needed services, but also identifies and documents systems' problems through analysis of records about calls received, case studies, and the experiences of Children's Health Infoline staff. Identified problems are then brought, on a regular basis, to the Children's Health Council (a legislatively established policy body) that convenes key policy makers (including appropriate state agency and provider representatives) to resolve these issues, thereby facilitating structural improvements to the delivery of services. In addition, the Children's Health Infoline is linked to a larger operational arm –the Connecticut Children's Health Project, which does data analysis and community health education, providing an outlet for outreach and dissemination of policy changes.

**Existing Advocacy Resources for Adults** - DMHAS has taken a number of significant steps to enhance advocacy resources for adults who are using mental health services. These steps include (but are not limited to):

- ❑ Information and referral services include a toll-free 800 telephone information and referral line answered by trained staff who maintain updated materials on mental illness, trauma education, substance abuse, patients' rights/grievance procedures, veterans affairs, and support services; a web-site with information about DMHAS services; and the CT Clearinghouse web-site.
- ❑ Individual advocacy training programs are available through the DMHAS-funded Advocacy Unlimited and NAMI-CT programs.
- ❑ Advocacy assistance is available from various sources including: a Consumer Liaison for each Local Mental Health Authority (LMHA) (to assure collaboration with agency management and consumer voice in LMHA deliberations); a Family Liaison for each LMHA (to be involved in specific projects involving families); a seven person Customer Relations Division (staffed by people in recovery) that reports directly to the Commissioner of DMHAS and is charged with improving service quality, directing the Patient/Clients Rights Program and statewide grievance process and providing training on rights and the grievance process; the CT Legal Rights Project; the CT Network for Women with Behavioral Health Needs and their Children; Advocacy Unlimited; and NAMI-CT.

**Existing Advocacy Resources for Children, Youth and their Families** - Advocacy resources for Connecticut children using mental health services are less well developed than resources are for adults, though advocacy on their behalf is no less important. As outlined in Appendix D for example, children and their families have limited access to legal services such as are provided to adults by the CT Legal Rights Project, have no advocacy presence within the department comparable to DMHAS' Office of Customer Relations, lack an individual advocacy training program like Advocacy Unlimited's program for adults, lack comparable access to internal grievance process and grievance officers and other staff specifically designated to helping

children and families negotiate systems challenges. A recent Office of Legislative Research report on primary mental health services found that the number of DCF's system of care case managers (16.5 FTEs) and Family Advocates (8 FTEs) was inadequate (Children's Primary Mental Health Care Report, 2000). On the other hand, children and families in HUSKY have access to the Children's Health Infoline, described above as a model of integrated advocacy services.

The development of statewide organizations for families of children with emotional, behavioral, or cognitive problems in Connecticut over the past five years has been limited. NAMI-CT, using donations and dues, has developed two "Child and Adolescent Network" support groups, and 18 other family support groups to which some family members of children or adolescents with mental illnesses belong. However, NAMI receives no funding from DCF. The Family Advocates, who work through the CT Mental Health Association, provide help to individual children and families but are overwhelmed by large caseloads. The report entitled Delivering and Financing Children's Behavioral Health Services in Connecticut (February 2000), recommended that the state actively support the development of a statewide family support network with local chapters, explaining that "Connecticut needs a strong statewide family organization that can be instrumental in building the capacity of parents to participate in developing plans of care for their own children as well as at the state and local systems level."

### **Current Need for a Better Informed, Caring Community**

As earlier discussed, stigmatization of people with mental illness is pervasive in our society. Stigma is manifest not only in individual action, but in social policy, such as mandatory incarceration laws that result in the imprisonment of people with mental illness for minor offenses related to their illness, a town's use of zoning ordinances to block housing for people recovering from mental illness, and the denial of true parity by health insurers. It is manifest also in continued, covert denials of employment and/or promotion and the continued expectation of some professions, such as law, medicine, and public safety, that people hide their disabilities. Further, this culture of stigmatization makes people who are labeled outcasts, leading to their further isolation.

DMHAS' Federal Fiscal Year 2000 Mental Health Plan proposes to "develop strategies to address stigma of mental illness in our communities" through such tools as a statewide Speakers Bureau, a public awareness campaign, and documentaries. However, there appear to be no plans to launch a statewide, cross-agency public education campaign that promotes recovery and mental health, increases public understanding and awareness of mental illness, promotes early detection and treatment of mental health problems, and provides necessary staff training.

*A SPECIAL NOTE REGARDING THE IMPORTANCE OF CULTURALLY SENSITIVE SERVICES* : As Connecticut's population grows increasingly diverse, the importance of developing culturally competent mental health services becomes paramount. "Early cultural competence research and experience indicate that cultural issues influence dropout rates, recidivism, cost effectiveness, access and quality of care...mental health services based on assumptions of mono-culturalism and universality tend to create chaos and confusion among the under-served ethnic and cultural populations" [Community Mental Health Services Block Grant, 1999]. For this reason, "...mental health programs attempting to serve diverse populations must

incorporate an understanding of culture, traditions, beliefs, and culture-specific family interactions into their design” [Mental Health: A Report of the Surgeon General, 1999]. Such understanding should necessarily encompass purposeful inclusion of representatives of all minority populations (including those who identify as gay or lesbian) on the boards and councils that are involved all aspects of the planning, delivery, staffing and evaluation of services, as well in the design and implementation of a public education campaign and creation and implementation of a coordinated advocacy network, as is herein proposed.

*A SPECIAL NOTE ON THE TARGET POPULATION:* Because the needs of people using or in need of mental health services must be viewed holistically, the following recommendations assume that the population for whom advocacy is needed, and whose voice and perspectives should be heard, should be defined broadly. It includes all people using or in need of mental health services regardless of -- for example -- age, income, place of residence (e.g., community, mental health facility, prison, nursing home), severity of disorder, or presence of co-occurring disorders (e.g., addiction, developmental disability).

### **Advocacy Panel Issue #1 – Involvement in System Design and Evaluation**

Those who use mental health services rightfully claim that nothing concerning the design, delivery, staffing, and evaluation of those services should be done without their active involvement. “Nothing about us, without us” is an oft-repeated refrain. The importance of the voice and perspective of individuals who use mental health services and their families cannot be overstated. Only with this perspective can one be assured that Connecticut’s system of mental health services will be appropriately responsive to the needs of those whom it serves.

Although service users are becoming increasingly involved not only in decisions about their own care, but in policy-making bodies, there is no mandate in Connecticut to involve these informed voices in non-token numbers in all aspects and levels of decision-making. Neither is there a mandate to involve such people in more than just advisory bodies, such as giving them oversight responsibilities for contract performance. There is also limited financial support for the involvement of these individuals, and a need for regular training to enable them to be effective members of policy-making bodies.

Also, although some state agencies have a “Bill of Rights” (see Appendix E), Connecticut lacks a comprehensive Bill of Rights for all children, youth, adults, elders and families using mental health services that establishes what they consider to be the fundamental baseline for care and that reflects their right to clinically and culturally appropriate care provided in a timely and respectful manner. Connecticut lacks, as well, a grievance procedure that is uniform across all involved state agencies and includes a reporting mechanism to a central body to help track challenges to quality of care. Instead, access to informal dispute resolution processes regarding the adequacy, timeliness, and quality of care varies depends on the age of the person being served and important quality control information is lost. Finally, there is no Consumer Guide to State Services that can help citizens understand how to most effectively access needed assistance.

**Advocacy Panel Recommendation #1 – Ensure Participation in Decision Making**

All Connecticut agencies involved in mental health services should include significant numbers of representative individuals and families who are using, or have used, mental health services on all policy making and oversight bodies. These individuals should be central in defining the basic principles for care and the mechanisms to assure all care is consistent with such principles.

**Proposed Enhancements** – This recommendation will enhance consumer “voice,” and bring consumer perspective to all aspects of mental health care by:

- ❑ Mandating and facilitating the inclusion of significant numbers of people using mental health services on all advisory councils, boards and other policy making bodies by amending all enabling statutes to require at least 51percent “consumer” participation. Assure involvement on every board, council, or committee that has power over the design, delivery, financing, and monitoring of services, and assure that the representatives reflect the cultural diversity of the community being served;
- ❑ Providing funding support to programs that offer training to interested “consumers” to enable them to become competent board members. Develop a Talent Bank of people who have completed the training program from which appointing authorities can identify new “consumer” members. Provide “consumer” representatives with compensation for the time they give to service on boards, timely reimbursement for their out-of-pocket expenses, and other supports as are necessary to facilitate involvement (e.g., child care);
- ❑ Developing an Office of Customer Relations within DCF's Office of the Commissioner comparable to the Office at DMHAS. This Office of Customer Relations for Child Behavioral Health, staffed with parents of children with behavioral health problems and/or young adults in recovery, will enhance service delivery and assure constant "consumer" perspective within the agency. The Office of Customer Relations will complement the consumer advocacy efforts by professional staff at all levels and the work of Family Advocates by bringing a consumer perspective directly to policy development and service implementation and evaluation at DCF's highest level. In addition, the Office of Customer Relations within both DMHAS and DCF should act in partnership with and solicit input from advocates in the community, creating an effective dynamic of internal and external advocacy. Additionally, these Offices should focus consumer "voice" on the tasks of developing values, policies, structures, budgetary supports, and environments that are inclusive of cultural diversity; and
- ❑ Using the contracting process to strongly encourage providers to involve consumers and family members on their governing boards.

In addition, people who have used services should be involved in:

- ❑ Developing a comprehensive, enforceable Bill of Rights that reflects the views of those who use mental health services about the fundamental principles that must guide such care --

across all agencies providing mental health services, and across the full life span. Provide all people who receive mental health services with a copy of this Bill of Rights.

- ❑ Developing and implementing a uniform Statewide Grievance Process for all agencies providing and/or funding mental health services. Adequate resources should be provided so that trained advocates can assist people to effectively use the process. All agencies providing and/or funding mental health services to file a quarterly Report on Grievances (with adequate detail about the nature of each grievance filed and its resolution) with the Office of Protection and Advocacy (OPA) and/or the Mental Health Policy Council. Include in all state contacts with service providers the mandate that they adhere to the Bill of Rights and grievance procedures, enforceable by funding sanctions.
- ❑ Developing a Consumer Guide to State Services for all people (and their families) who receive mental health-related services from state agencies (e.g., DMHAS, DCF, DOE, Local Education Authorities (LEAs), DSS, DMR, Bureau Rehabilitation Services (BRS), OPA, DOC, DPH), state-funded agencies, Probate Courts and the Judicial Branch. This Guide should include: the Universal Bill of Rights, the Universal Grievance Process, an Index of Commonly Used Terms, a listing of the programs and/or supports provided by each agency of cognizance (including eligibility criteria), a listing of advocacy and other types of support services and how to access them, and a number of “how to” pages that increase consumer understanding of process.

**Expected Impact** - Simply put, the enhancements proposed are the only way to assure that Connecticut’s mental health system for children and adults competently and efficiently meets the needs of those served, for it assures that the personal experience, needs, and preferred choices of those served are essential parts of all decisions regarding this system. The proposed consumer guide provides people using services with the tools to access services most efficiently. A universal Bill of Rights and grievance procedure establishes an enforceable baseline for care and assures adherence to such fundamental principles of care as respecting the dignity of the client, assuring the involvement of the client in care planning, meeting the client’s needs for care, and protecting the safety of the client. A Consumer Guide enables consumers to more readily and effectively access services and negotiate complex systems. (See Appendix F)

### **Advocacy Panel Issue #2 – Enhancing and Coordinating Advocacy Resources**

A well-integrated mental health advocacy system is needed to ensure that all children, adolescents, adults, elderly and families who make use of mental health services have the tools necessary to assure access to the services that they need in a timely manner.

This system should include such essential components as: a) comprehensive information and referral services and help lines; b) effective care and case coordination assistance; c) advocacy and empowerment training to help people become better self-advocates; d) meaningful grievance procedures and advocates to assist in them; e) non-legal advocacy services to assist people in their advocacy efforts (as well as those who lack the capacity to advocate on their own behalf); f) legal advocacy services when needed; and g) a mechanism to integrate and coordinate all aspects of the system (working in concert with provider organizations whenever appropriate) so that systems problems can be identified and addressed.

Currently, barriers and limitations exist in Connecticut's mental health advocacy "system," including resource and advocacy staffing limitations, missing services, and lack of a statewide coordination mechanism. Cumulatively, these barriers and limitations impede people's ability to access comprehensive and appropriate advocacy services, and as a result impede access to appropriate care.

Connecticut's current advocacy efforts must be enhanced by providing new, culturally sensitive advocacy services across, and integration among all three of the following levels to people of all ages who are using mental health services:

- ❑ Individual/Self Advocacy - Access to Individual/Self advocacy education and empowerment programs is crucial for all people who make use of mental health services, for they provide the tools that enable people to take responsibility for shaping their own destinies. Support for individual advocacy is important, as all individuals are unique and have unique needs, goals, health needs and expectations for recovery. Such supports are not universally available across the life span.
- ❑ Advocates on Behalf of All People Who Make Use of Mental Health Services - People who cannot advocate for themselves, or who need assistance in their advocacy efforts, often turn to lay and/or legal advocates. Although some advocacy resources are in place, Connecticut does not currently have a system-wide, culturally representative cohort of lay and legal advocates who are easily accessible and adequately trained to assist on behalf of -- and for the expressed choice of -- people who make use of mental health services. Connecticut also does not have a standardized training and certification program for mental health advocacy providers, nor formal training in advocacy for key state agency staff and other key stakeholders, such as teachers/educators and community members. Additionally, there currently is no network of mental health advocates that regularly meets to facilitate the exchange of information, the identification of themes and challenges, and the framing and implementation of improvements in advocacy work.
- ❑ Systems Change Advocacy - The experiences of people using mental services and those who advocate on their behalf should be an essential part of identifying and addressing needed changes in state policy regarding the design, delivery, funding, staffing, and evaluation of mental health services. Policy changes should be made with the full involvement of people who make use of mental health services. This is not current practice. Currently, no established state-wide forum exists in which people who make use of mental health services and their advocates meet regularly to identify core principles and values, identify service gaps and problems, and work together to more effectively guide the development and provision of mental health services. Currently, no formal statewide mechanism exists to facilitate the flow of information across the advocacy levels, so that the experience of people using mental health services and their advocates informs and guides systems' advocacy efforts, and that changes in policy gained through systems' advocacy are speedily communicated to people using mental health services.

**Advocacy Panel Recommendation #2 – Establish a Mental Health Advocacy Network**

All Connecticut State agencies that provide and/or fund mental health services should support and fund an *integrated, coordinated, statewide, system of mental health advocacy services -- the Connecticut Mental Health Advocacy Network*.

**Proposed Enhancements** - To develop and maintain a well-functioning, comprehensive, integrated system of mental health advocacy services and assure implementation of the recommendations of this Blue Ribbon Commission on Mental Health, the following enhancements are proposed:

- Establish and maintain a Connecticut Mental Health Advocacy Network. The Network should encompass all mental health advocacy programs and other entities providing mental health-related advocacy (e.g. Ryan White case managers, advocates within DOC). Its work should be coordinated by a council with representation from each advocacy group. The Network will assure ongoing oversight and technical assistance in the planning, development, implementation, and evaluation of the full continuum of advocacy services across the life span. It will address the need for individual as well as systems' advocacy, be multi-faceted, easily accessible, readily available, culturally sensitive and representative, and effective in protecting and advocating for the rights of all children, adolescents, families, and adult consumers of mental health services.

Funding should be specifically designated in both DMHAS and DCF's budgets (through separate line items) to support the full continuum of advocacy services in the Network and coordination of the Network. While the Network's operating budget should be provided by DMHAS and DCF, the Network should be programmatically independent of both agencies. Immediate funding should be provided to:

- Markedly increase the number of Family Advocates funded by DCF and DMHAS;
- Expand legal services comparable to the Connecticut Legal Rights Project for children, youth and their families who are using mental health services and to better meet current legal needs of adults being served in the community, or provide some comparable mechanisms to meet these needs for legal assistance;
- Fund the startup and continued operation of a statewide, family-based advocacy organization, such as the Federation for Families;
- Employ a sufficient number of "engagement specialists" to link people and families to care; and
- Quickly expand training opportunities for children, youth, adults, and families so that might become more effective self-advocates.

Additionally, the Mental Health Advocacy System Network, through its coordinating council, should:

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- Designate representatives to the Mental Health Policy Council and its Consumer/Advocacy Subcommittee;
  - Meet regularly to share information, identify common issues and systems' challenges, develop advocacy strategies, and coordinate advocacy efforts;
  - Create a defined menu of state-funded mental health advocacy services that should be universally available and a statewide plan to assure an integrated system of mental health advocacy;
  - Enhance the network of existing advocacy services by identifying gaps in services (by service type, geography, age/ethnicity of client) and advocating for enhancements of services to address currently unmet needs and existing inequities between adult and children's advocacy resources;
  - Develop a set of core principles for advocacy and help ensure that mental health advocates and advocacy programs adhere to these principles; and
  - Create a Connecticut Mental Health Infoline modeled on the current Children's Health Infoline. In addition to using trained case managers to provide timely, easily accessible information and referral services and assist in problem resolution for all Connecticut residents using mental health services, the program should gather data from calls and provider responses, track trends, and report important systems' issues to the Mental Health Advocacy Network (and state agencies and oversight councils when appropriate). This office should be staffed by parents of children with behavioral health problems and/or adults in recovery.
- Assure that the state's network of lay and legal advocates is sufficient to meet need, and that advocates have access to appropriate training and professional development, necessary resources, and legal, administrative, and medical support and technical assistance services so that they can provide optimal advocacy services. Assure that lay and legal advocates have sufficient independence to advocate freely. Create a mechanism to assure a seamless transition in advocacy support as a person transitions from one agency to another.
  - Enhance existing advocacy resources for people who are incapable of requesting assistance or advocating for themselves, including by expanding statutory mandated reporting requirements to assure the reporting of abuse of any person receiving mental health services to the appropriate entity (e.g., Office of Protection and Advocacy, DCF) and requiring periodic unannounced visits by licensing authorities of every facility providing mental health services.
  - Provide on-going training to teachers, judicial personnel, probate court personnel, police officers and other professionals whose lives touch those who may be using, or may need, mental health services so that they can also effectively advocate for their care.

- Ensure that agency staff and service providers receive training about the Network, so that they will support its work and learn how to access it appropriately.

**Expected Impact** - The new Mental Health Advocacy Network will ensure that the most appropriate and effective mix of advocacy services is available in all areas of Connecticut and across the life span of people who use mental health services. This comprehensive system of mental health advocacy services will better assure that all involved in the mental health system receive the care they choose and need to recover. The integration of advocacy services across the life span also will assure that the mental health systems for children and adults remain ever responsive to changing needs and demands. Specific impacts include:

- Through improved self-advocacy and advocacy assisted by lay and legal advocates, there will be increased consumer participation in and control over their own health care. This fosters increased self-awareness, a feeling of hope and meaning in life, the capacity to get the services that are needed rather than just those that are readily available, and – ultimately -- increased independence from the mental health system and a better quality of life.
- Through systems and legislative advocacy, individual rights will be better protected and services enhanced, resulting in an environment that fosters real independence and recovery. Also, public funds will be most effectively used (since services that are funded and delivered will more closely reflect true service needs as defined by those served), service quality will be enhanced (since a mechanism will exist to bring attention to successes and gaps), and funding provided will more closely match funding needs (since a more powerful constituency will exist to advocate legislatively for such funds).

### **Advocacy Panel Issue #3 – Enhancing Public Understanding**

Lack of public knowledge and understanding of mental health and mental illness predictably results in stigma, lack of treatment, lack of decent housing, employment discrimination, feelings of worthlessness and even death for people with mental illness. Four of the top ten leading causes of disability are mental disorders. Nearly half of Americans with a serious mental illness do not seek treatment, in large part because of stigma. According to the Surgeon General's Report on Mental Health, stigma surrounding mental illness erodes confidence that mental disorders are health conditions like any other, and that they respond to medical intervention.

“...the history of social psychiatry teaches us that cultural conceptions of mental illness have dramatic consequences for help seeking, stereotyping, and the kinds of treatment structures we create for people with mental illnesses...Rather than waning, recent research suggests that stereotypes of dangerousness are actually on the increase and that the stigma of mental illness remains a powerfully detrimental feature of the lives of people with such conditions” [Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance, 1999]. Public ignorance and widespread misunderstanding about mental health and mental illness, due to a lack of appropriate, accessible information can and does result in a variety of negative consequences, stigma, trauma, and even death to people with mental illness and mental health needs.

**Advocacy Panel Recommendation #3 – Develop Community Education Campaign**

Connecticut state agencies (including DMHAS, DCF, DPH, DOE, DOC) should collaborate on the development and implementation of an on-going statewide education multi-media campaign designed to promote recovery and mental health, increase public understanding and awareness of mental illness, and promote early detection and treatment of mental health problems.

**Proposed Enhancements** – This recommendation will help to reduce stigma and prejudice and promote public awareness, understanding, and sensitivity. In carrying out the recommendation Connecticut should:

- ❑ Launch a statewide public education campaign - Connecticut should initiate an on-going, statewide, multi-media public education and information campaign on recovery, mental health and mental illness. The campaign should be a public-private partnership, with full interagency collaboration. For its design and implementation, it should draw upon the expertise of DMHAS, DCF, DPH, and DOE, and involve people and families who have used mental health services, service providers and advocates in the development of its messages. The campaign should be both sensitive and responsive to the state's cultural and geographic diversity, should be available in multiple languages and media, and should have, as its primary focus, the promotion of recovery and mental health.
- ❑ Enhance professional training - All state agencies and state-funded and/or state-licensed agencies whose staff have direct contact with children, youth, adults and elders who may have mental illness or serious emotional disturbance (including but not limited to DOC, Department of Public Safety (DPS), the Judicial Branch, DOE and local school districts, DCF, DMHAS, DMR, Probate Judges, and local police departments) should develop and provide specialized training on recovery, mental health, and mental illness to such staff to reduce stigma, enhance early detection and intervention, and facilitate appropriate referrals to clinically and culturally appropriate care. Such training should be included in pre-service training programs for new staff and in-service training for current staff. The state should provide funding and technical assistance, including necessary overtime support for staff, to support such training efforts and OPM should establish an interagency working group to facilitate collaboration. Consumers and family members must play an important part in the development and presentation of such training.

**Expected Impact** - All people experience stress and periods of less than optimal mental health during their lives, to varying degrees. Educating the public about mental health, mental illness, and recovery from an early age will have a number of important impacts. It will:

- ❑ Reduce stigma, increasing the willingness of people with mental health needs and mental illness to seek care and treatment and thereby improving the quality of their lives and, in that way, saving lives;
- ❑ Empower people recovering from mental illness to become more actively involvement in advocacy work on behalf of themselves and others;

- ❑ Better assure the safety of people who have revealed their recovery status;
- ❑ Assure the delivery of more normative, recovery- and community-based care and treatment to children and youth with a serious emotional disturbance;
- ❑ Promote prevention and early detection of mental illness and provide children and adults with skills to better handle stress and stressors;
- ❑ Increase sensitivity to the needs of person with mental illness among peers, professionals, parents and the public and an understanding that recovery is possible and a way to save lives;
- ❑ Demystify mental illness and promote open dialogue and respect for all people, thereby helping to remove the community barriers that prevent people with mental health issues from becoming a true part of our communities in housing, employment, etc;
- ❑ Provide positive recovery role models for children and adults with the same issues as the presenters and, in that way, help foster hope and facilitate participation in needed supports.

**Advocacy Panel Issue #4 – Role of Kindergarten-12<sup>th</sup> Grade Education System**

After the family, schools have perhaps the greatest influence on children’s development. Though their primary function is education, they necessarily play a primary role in the early identification of children and youth in need of mental health services, and referral to appropriate care. Their educational mission must also include education about mental health. The promotion of student’s mental health must be an integral part of all aspects of classroom management. In these respects, schools – with parents – are the primary “lay” advocates in any mental health system for children and youth. Schools also are increasingly important mental health service providers. According to the Surgeon General’s Report on Mental Health, fully half of the mental health services provided to children and youth are through schools. In addition, schools also play a critical role in creating learning environments for children and youth that reduce stigma and prejudice, are emotionally supportive and respectful of diversity, and help students learn skills to manage conflict and cope with stress. The full potential of schools to be major partners in this work has not yet been realized.

**Advocacy Panel Recommendation #4 – Targeted School-Based Behavioral Health Education**

The State Department of Education, in collaboration with DMHAS, DCF, DPH and parents, should develop and implement a model Kindergarten-12<sup>th</sup> grade behavioral health education curriculum to enhance current health education in schools and establish coordinated school health programs in every school. All school personnel, including administrators, should receive appropriate training (including in the early identification of and appropriate interventions for at-risk students and require a course in behavioral health education as part of the teacher certification process).

**Proposed Enhancements** – This recommendation will make Connecticut's schools a full partner with DMHAS, DCF, and parents in the advancement of children's mental health. In order to carry out this recommendation, Connecticut must:

- ❑ Amend state statutes to supplement currently mandated Kindergarten-12<sup>th</sup> grade (K-12) health education (i.e., instruction about alcohol, tobacco, drugs, and AIDS, as required by Conn. Gen.State. 10-19) with additional behavioral health education components that should, at a minimum, include social problem solving, conflict resolution, stress management, and other life skills; child abuse and suicide prevention; prevention of alcohol, tobacco, and other drug use; nutrition; physical and mental illness (including prevention thereof); human sexuality and teen pregnancy; respect for diversity; and parenting and child development.
- ❑ Require the State Department of Education, in collaboration with DCF, DPH, and DMHAS, to develop a model K-12 behavioral health education curriculum that is culturally sensitive and developmentally appropriate and provides current and accurate information about the topics listed above.
- ❑ Require that all components of the K-12 health education curriculum be taught, or co-taught, by school staff competently trained in the given area.
- ❑ Require a course in behavioral health education as part of the teacher certification process, and include such a course in ongoing staff development training for all school personnel, including administrators. Coursework for certification should include social-emotional learning; early identification of, and interventions for, at-risk and/or trauma exposed students; prevention of child abuse; suicide prevention; prevention of alcohol, tobacco, and other drug use; human sexuality and teen pregnancy; parenting and child development; safe and positive school climate; home-school communication; domestic violence; and confidentiality of student information.
- ❑ Require the State Department of Education to collaborate with institutions of higher education to develop a brief version of the course described above. Teachers who are already certified may take this course for CEU credit. Completion of this course should also be encourage for child and youth workers engaged in recreation programs, the juvenile justice system, residential programs, vocation services, and mentoring and other prevention programs.
- ❑ Require the State Department of Education, in collaboration with DCF, DPH, and DMHAS, to provide guidelines and technical assistance to encourage school districts to establish *coordinated* school health programs in Connecticut's public schools. Components of such systemic programs would include creation of healthy school environments; health education; nutrition services; physical education; school health services; counseling, psychological and social services; health promotion for staff; and family and community involvement. The curriculum and mental health service components would be complemented by prevention strategies such as mentoring, conflict resolution and peer mediation programs; programs to reduce bullying and violent behavior; use of positive behavioral supports and classroom

management techniques; programs for prevention and reduction of drug, alcohol, and tobacco use; and home-school communication and support.

- ❑ Require the DOE, DCF, DPH, and DMHAS to submit annually their recommendations to the General Assembly and the Governor concerning how to improve the coordination and provision of adequate and appropriate services, in the least restrictive settings, for children and youth with situation-based stresses and serious emotional disturbance.

**Expected Impact** – the proposed enhancements would:

- ❑ Enhance schools' efforts at early identification of and early intervention with children and youth with mental health needs, mental illness and serious emotional disturbance;
- ❑ Enable schools to more consistently identify children with situation-based stresses in their lives (such as parental illness or death, family abuse, peer suicide) and link them to appropriate services and supports to promote their mental health.

In addition, it is expected that by involving the DOE and local school systems in the development, planning, and delivery of mental health-related services, service duplication and fragmentation will be reduced and resources will be more effectively used, children will be better able to cope with the normal – as well as the occasional extraordinary – stresses of growing up, and more normative, recovery-based and community-based care of children and youth with serious emotional disturbance will be possible.

### **Advocacy Panel Issue #5 – Integration of Person with Behavioral Health Needs into Communities and Neighborhoods**

Highly publicized neighborhood opposition to the development of behavioral health programs (e.g., group homes, and other residential and psychosocial programs) has made it very difficult for DMHAS and DCF to find suitable homes and programs locations in communities throughout Connecticut. The so-called NIMBY (not-in-my-backyard) phenomenon is well known in Connecticut. Ironically, when such homes and programs are blocked, the same consumers often end up living in the community without adequate supervision. Still other consumers are forced to live in degrading conditions or in dangerous areas where they are prone to criminal victimization. This makes it harder for them to meet the already difficult challenges of recovery from mental illness. The absence of sufficient numbers of community-based residential settings also creates a domino effect making it more difficult to discharge patients from hospitals when they no longer need hospital care. This, in turn, creates a dangerous backlog for acute care hospital admissions.

As of last year DCF had placed 350 children who carry a label of severe emotional disturbance out of state. Many of the out of state placements occurred because there was an insufficient number of homes and programs to accommodate these children in Connecticut. Local zoning restrictions have been a major contributor to the problem.

Federal laws, such as the Fair Housing Act, protect people with disabilities from discrimination in housing. Challenges to the zoning restrictions and other potentially discriminatory acts have been successful in Connecticut. Unfortunately, to challenge these discriminatory acts requires a large coordinated legal defense, which is not always available. Hence the need for zoning override legislation protecting consumers of DMHAS and DCF similar to those protections afforded consumers of Department of Retardation.

**Recommendation #5 – Zoning Override Legislation**

Legislation should be adopted that prevents municipalities from using zoning regulations to prohibit DMHAS and DCF or any provider under contract with these state agencies from rendering treatment or support to any adult with a behavioral health disorder or any child with a severe emotional disturbance living in the community.

**Proposed Enhancement** – This recommendation will protect consumers by:

- Enacting legislation that will enable development of community-based treatment facilities for both children and adults, such as the Fair Housing Act which protects people with disabilities from discrimination in housing.

**Expected Impact** – The proposed Zoning Override Legislation will ensure that the most appropriate and effective mix of mental health services is available in all areas of Connecticut and across the life span of people who use mental health services.

## Managing Services

The creation of a comprehensive, coordinated mental health service delivery system that is responsive to the needs of children and adults is perhaps the single most challenging task facing the Governor's Blue Ribbon Commission on Mental Health. Managing and financing services for persons with mental health problems has become increasingly complex. Differing funding streams (e.g., private insurance, public sector, philanthropic) and differing procedures (e.g., fee-for-service, capitated managed care) have created confusion, difficulties with access, and burdens on providers and consumers. Many people simply do not receive care, and others receive insufficient or inappropriate care.

The State of Connecticut can do better. There should be no reason that Connecticut, the state with the highest median income in the country, cannot create a system that meets the needs of adults and children with mental health problems. Connecticut already has developed principles to guide the child and adult service systems (see Appendix G). These principles indicate that Connecticut must embrace a vision for mental health services that includes:

- ❑ The development of a full continuum of services and supports in which consumers have choice regarding services and providers;
- ❑ The requirement that the service system is responsive and provides for easy access to services;
- ❑ The right for recipients of services to be treated with dignity and respect and to have their legal rights protected;
- ❑ The expectation that services are guided by the best scientific findings about effective practices;
- ❑ The responsibility of the service system to be culturally competent and sensitive to the needs of diverse groups and individuals;
- ❑ The acknowledgement that mental health care should provide significant focus on early intervention and prevention;
- ❑ The recognition that Connecticut must care for its own citizens, within its own borders;
- ❑ The necessity to provide adequate funding and reimbursement for mental health services;
- ❑ The importance that mental health services improve self-sufficiency and a person's quality of life;
- ❑ The statement that service delivery decision-making should be done at a local level, with consumers and family members as equal partners;
- ❑ The need to reduce stigma associated with mental health services and promote recovery.

Connecticut recognized, more than twenty years ago, that children with mental health problems require services separate from those provided for adults, as their service needs are different. Based on this understanding, the state consolidated all services provided on behalf of children, in order to ensure that children's issues and services receive the necessary attention. By doing this, the state hoped to achieve two goals: the elevation of children's issues and services within state government, and the integration of service delivery for children. Although each service system shares common goals, the Blue Ribbon Commission acknowledges the importance of emphasizing the uniqueness of children, and the need to ensure the strength and expertise of each

system. For this reason, this section of the Blue Ribbon Commission Report will provide information and recommendations for both the child and adult service delivery systems.

### **Children's Services**

Mental disorders in children must be considered within the context of a child's development. It is critical to identify and understand typical child development and the factors that disrupt this process. It is also important to recognize that family, peers, school, and community play an integral role in a child's development, because, as stated in the Surgeon General's report:

"...psychopathology in childhood arises from the complex, multi-layered interactions of specific characteristics of the child (including biological, psychological, and genetic factors), his or her environment (including parent, sibling, and family relations, peer and neighborhood factors, school and community factors, and the larger social-cultural context), and the specific manner in which these factors interact with and shape each other over the course of development."<sup>20</sup>

National prevalence studies suggest that 11 percent of children ages 9-17 have significant mental health impairment. In Connecticut, this means that at least 82,500 children need mental health services as noted elsewhere in this report. Other estimates of prevalence are even higher. Many of these youth receive care via private insurance and private service providers. However, according to a recent study of children's behavioral health<sup>21</sup>, there are 184,000 children enrolled in the state's HUSKY programs (Title XIX and Title XXI). Consistent with the national prevalence data, of the youth enrolled in HUSKY, 22,300 (12 percent) use behavioral health services. Of these youth, 8,419 are children in the custody of DCF, and they account for 60 percent of all behavioral health expenditures.

It is not surprising that children involved with the child welfare and/or juvenile justice systems have significant mental health needs. National prevalence data suggest that between 60 percent and 73 percent of youth in public and private juvenile facilities have at least one diagnosable mental health disorder (Otto, Greenstein, Johnson & Friedman, 1992). In addition, there is compelling data to indicate that the proportionately high rates of physical and sexual abuse, poverty and educational barriers among youth in the child welfare and juvenile justice population give rise to serious mental health problems. These data support the need for a comprehensive and consolidated mental health system for children that coordinates mental health and substance abuse services with those of child welfare, juvenile justice and the probate courts.

Experts and policymakers across the nation agree that children with serious emotional disorders are best served when the service delivery systems are comprehensive, coordinated, family-focused and community-based. The recent study on children's behavioral health services in Connecticut found that services in the public sector have generally been fragmented, inadequate, and over-reliant on out-of-home care. There are multiple funding streams and multiple entry

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<sup>20</sup> Mental Health: A Report to the Surgeon General (U.S. Department of Health and Human Services), p.127.

<sup>21</sup> "Delivering and Financing Children's Behavioral Health Services in CT" (The Child Health and Development Institute of Connecticut (2000)).

points into services. As a result, many children who need services do not receive them, or receive them in inappropriate settings.

During recent years there have been a number of serious efforts to address problems with coordination, continuity and quality of care:

- ❑ Practice Standards – DCF has established practice standards for Extended Day Treatment, Outpatient Psychiatric Clinics for Children, Emergency Mobile Psychiatric Services, Sexual Offender Treatment Programs and Systems of Care.
- ❑ Local System of Care Collaboratives – Since 1997, DCF has assisted with the development of nineteen local system of care collaboratives. These collaboratives include schools, community service providers, families, advocacy groups, and other organizations concerned with the well being of children with complex emotional and/or behavioral needs.
- ❑ Continuum of Care Initiative – DCF has implemented a research demonstration project in which two Lead Service Agencies (LSA) are given a case rate to provide care and coordination for youth approved for residential treatment. The case rate can be used flexibly to provide community-based alternatives.
- ❑ Special Populations and Transitioning Youth Projects – These projects are a collaborative effort between DCF, DMHAS, DMR and OPM to provide services to young people “aging out” of the DCF system.

To address the problems in the child mental health system, significant planning efforts have been undertaken. Recommendations for restructuring the children's mental health system were presented in the report referenced above, and submitted to the Connecticut state legislature by the Department of Social Services earlier this year. Specifically, this report identifies the following system issues that must be addressed:

- ❑ Of the approximately \$207 million in public funds spent across five state agencies last year on children's behavioral health, only 30 percent was spent on community-based service delivery.
- ❑ There is a need to increase community-based supports and services to divert children and youth from unnecessarily entering more restrictive levels of care, or to reduce lengths of stay by assisting youth to reintegrate into community-based treatment settings.
- ❑ The existing Local System of Care model in Connecticut can serve as a basis for developing an excellent service system but needs to have adequate resources to address the complex needs of children and youth with serious emotional disturbances.
- ❑ Coordination and integration of service delivery and funding must be enhanced across all systems that serve children. In addition to DCF and DSS, the education and juvenile justice systems, DMHAS, and DMR must be encouraged to increase collaboration and form partnerships with the behavioral health service system for children.

- ❑ There must be supports to increase family involvement in service planning and service delivery decision-making.
- ❑ The service system must focus more attention on issues of cultural sensitivity and competence.
- ❑ There needs to be a stronger focus on quality and effectiveness of service delivery, with a well-developed management information system to support this work.

To address these concerns, the report recommends the following: a) local systems of care be expanded and enhanced to provide a richer array of community-based services for children; b) a carve out for children requiring more extensive behavioral health services be established, funded through a blended funding approach that combines DSS, DCF and potentially other dollars; and c) DSS and DCF together contract with a statewide administrative services entity to administer the funds, along with up to 10 regional Lead Service Agencies to contract with providers and provide services and administrative support required by local systems of care. The Managing Services Expert Panel fully supports these recommendations.

### **Adult Services**

Mental health disorders are often persistent, sometimes lasting for many years. Some disorders, such as bipolar disorder or early onset schizophrenia, may begin in childhood and persist through the adult years. Others may not begin until well into adulthood. Symptoms may be recurrent, involving cycles of acute illness followed by periods of relative stability. As a result, adults with mental health service needs, as with children, require a continuity of care, and an array of rehabilitative and supportive services. In order to achieve optimal outcomes, the adult service system must be organized, managed and financed in a manner that promotes access, addresses each client's unique needs, supports accountability and accepts the individuality of all people.

National prevalence studies suggest that of Connecticut adults, 135,000 are estimated to have a serious mental illness. The public mental health system provides services to the poorest of these, and typically the most disabled – and their numbers are increasing. The number of adults served by DMHAS has risen from 30,728 in FY1996 to 37,041 in FY1999, an increase of 20 percent over a four-year period. Providers statewide are facing significant increases in the number of adult clients with co-occurring disorders. At present, over 12 percent of DMHAS clients (over 4,300 people) are diagnosed with both a serious mental illness and a substance abuse disorder. Many others have been lost to the service system. It is estimated that as many as a third of homeless adults have a psychiatric disability.

The delivery of mental health care has, historically, occurred through independent practitioners and provider organizations, as well as through State-run treatment facilities and local mental health authorities. However, the number of private practitioners and hospitals providing treatment services to adults with serious mental illness is quickly eroding, as costs outrun insurance reimbursements and federal support. This places added stress on an already overburdened public mental health system.

Clinical and administrative responsibility for all public sector adult mental health clients is vested by DMHAS in a statewide network of local mental health authorities (LMHAs). Nine of these fifteen LMHAs are nonprofit organizations, and the other six are state operated. The LMHAs are charged with coordinating efforts among local service providers within their respective geographic areas. With inflation adjusted funding for community services essentially remaining flat since the last state hospital closed, the not-for-profit LMHAs have cut back on services, and many have limited or no resources to address basic needs. LMHAs across the state have had to focus more and more on "crisis triage" at the expense of early intervention and comprehensive services that promote recovery. As a result, the care of people with the most serious needs – those with co-occurring disorders, with other medical problems, with limited coping skills – is often shifted into other more expensive settings, such as prisons and nursing homes. Connecticut's network of shelters reports increasing numbers of residents with mental illness, many with co-occurring addictive disorders and many of whom were discharged from institutional care. A 1999 survey of nineteen Connecticut homeless shelters found that, over a six-month period, 723 people came to their shelters directly, or were recently discharged, from psychiatric hospitals or mental health/substance abuse treatment centers.<sup>22</sup> At present, approximately 2,300 adults with serious mental illness are in nursing homes. Since late 1996, no systematic assessment has been made to determine if some of these individuals could live in the community with proper supports.

For individuals with mental illness who get involved with the criminal justice system, there are additional struggles. Presently, approximately 12 percent of Connecticut's jail and prison population has a mental illness serious enough to warrant treatment. Many of these inmates were arrested for charges specifically related to their illness. Persons with psychiatric disabilities spend a longer time in prison than persons without mental illness, partly due to the lack of sentencing alternative programs that will accept them because of their special needs.<sup>23</sup> The Managing Services Expert Panel recommends expanding the current "Jail Diversion" programming to all geographic area courts in the state.

To address some of the issues within the adult system, a number of efforts have been undertaken. For example, the following programs and services have been developed:

- ❑ Supportive Housing Pilots Initiative (PILOTS), a statewide, DMHAS-led effort designed to produce 500 units of supportive housing over four years for families and individuals with mental illness and addictions who are facing homelessness.
- ❑ Jail Diversion teams
- ❑ "Bridge" Subsidy program (security deposit and rental assistance)
- ❑ Consumer advocates
- ❑ DMHAS pilot of three levels of case management

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<sup>22</sup> Survey conducted by Connecticut Coalition to End Homelessness for period October 1998 through March 1999.

<sup>23</sup> "The Costs and Effectiveness of Jail Diversion: A Report to the Joint Standing Committee of the General Assembly", DMHAS, 2/1/00.

DMHAS and DSS also recently collaborated on a report titled "A Medicaid Behavioral Health Partnership for Disabled Adults in CT". In summary, the report indicates that:

" People with dual eligibility (Medicare and Medicaid) who have chronic and/or specialized health care needs more likely than not will experience fragmented care and conflicting administrative practices and procedures. This occurs when both Medicare and Medicaid, through the use of complex systems of regulations and reimbursement strategies, attempt to shift cost to the other funding source. It is the consumer who becomes the victim of the resultant "ping pong" effect on service delivery. What is particularly challenging is the fact that the resultant fragmentation of care is imposed upon a particularly fragile population, those individuals having severe and persistent behavioral health needs."

The report recommends that DMHAS and DSS should collaborate in operating a managed care behavioral health program for certain Medicaid recipients (initially, only those in the Aged, Blind and Disabled category) by employing an approach similar to the one it currently uses with the DMHAS General Assistance Behavioral Health Program. This option is currently under review by the two departments and the Office of Policy and Management.

As detailed above, the consequences of mental health disorders in adults can be severe, including unemployment, poverty, and involvement with the criminal justice system and homelessness. Because of the chronicity of some mental illnesses, their impact on the individual's functioning in many of the basic domains of their lives, and the economic poverty common in the population, the public mental health system must address both a range of treatment and rehabilitation services and basic human needs including housing, employment, income assistance, and quality health care. All of these supports have been shown to be essential components to advance recovery and reduce recidivism. The Managing Services Expert Panel recommends significantly expanding the availability of non-clinical supports in the areas of housing, case management and employment through interagency approaches at the State and provider levels. All three supports are interconnected. Affordable housing provides a stable base for growth. Effective case management can help an individual develop the independent living skills needed to maintain successful tenancy in housing and sustain employment. And once in stable housing, many people with serious mental illness are able to work, if provided with appropriate supports. To be effective, employment supports for people with mental illness must include job training and placement, and also services not readily available through the existing workforce development system, such as job readiness, remedial and basic skills education, development of work experience, and job retention supports.

The Managing Services Expert Panel also supports the concept of locally managed systems of care, including a lead agency as the single point of accountability and coordination of services. However, these lead agencies must be adequately and equitably funded, and the same standards of care must be applied equally to both public and private providers.

## **Concerns Common to Adult and Children's Systems**

Given the Commission's focus on mental health needs across the life span, this Expert Panel was particularly concerned about points of intersection between the children's system and the adult system. These occur at two important junctures. One is at the time of transition from the children's service system to the adult service system. This occurs for youth who are "aging out" of the children's treatment system but are still in need of services and supports. The other is how best to meet the needs of families where both children and adults need mental health treatment services. How services are provided in a coordinated way that is most effective, easily accessible, and not disruptive for children or their families is a particular challenge that tests the effectiveness of the public systems.

## **Insufficient Resources**

Although effective management of care and integration of funding can help reduce system fragmentation and promote continuity, no amount of effort in this area can overcome service delivery problems caused by insufficient funding. The following are examples of the impact caused by unreasonably low compensation rates and inadequate funding in both the adult and children's systems:

- ❑ **Barriers to Care** – Providers are forced to restrict access or discontinue unprofitable services even when clients continue to need such care. Poor clients and those with the most serious disorders are more likely to be adversely affected as providers seek to restrict access to individuals who are more expensive to treat.
- ❑ **Inappropriate Treatment Settings** – Inadequate funding creates gridlock in all areas of the service system and forces people to remain unnecessarily in inappropriate settings that interfere with and delay recovery and increase costs.
- ❑ **Reduced Quality and Decreased Continuity of Care** – Inadequate funding makes it difficult for providers to recruit and retain qualified staff. Service quality declines as less experienced personnel comprise an increasingly larger percentage of the workforce. Staff turnover, caused when employers have problems paying competitive wages, disrupts established relationships between clinicians, or other service providers, and clients that are essential to effective service delivery. As providers seek to cut back costs, staff training and skill development suffers. Important training areas such as the cultural competency of staff are left unattended.
- ❑ **System-wide Impact** – Inadequate funding in one part of the service system creates stress throughout the system as other sectors struggle to compensate without the aid of essential service components.
- ❑ **Poor Client Outcomes** - Declining service quality and decreased availability result in undesirable consequences such as homelessness and incarceration of individuals who would have otherwise benefited from treatment.

- ❑ Unfunded Treatment by Private Insurance – Narrow definitions of medical necessity applied by private insurers and fiscal intermediaries for public payers arbitrarily restrict the provision of acute inpatient treatment and intensive community care for both children and adults. This theme was stated over and over by participants at public hearings held by the Blue Ribbon Commission. The outcome is that people in serious need are forced to seek services from an already overburdened public sector.

### **Need for Cultural Competence**

In the mental health field, service delivery that is based on mono-cultural and universal premises has not adequately addressed the needs of clients, or potential clients from diverse cultural groups. The existing mental health system of care often tends to alienate, confuse, or, in some instances, penalize persons with different cultural backgrounds. Clinical staff is unfamiliar with, and sometimes, even hostile toward manifestations of culture and lifestyle that differ from the mainstream perspective. Some members of the under-served ethnic and cultural groups do not receive needed mental health services because of institutional barriers to access. Such barriers include linguistic obstacles, socioeconomic influences, transportation issues and a variety of inflexible policies and procedures that do not accommodate individual differences.

Cultural competence research indicates that cultural issues impact the mental health service delivery system in many ways, including client level of trust, access, retention, recidivism, cost effectiveness and quality of care. Connecticut must adopt new approaches for addressing the rich cultural diversity of persons who need mental health services.

As noted earlier in this Blue Ribbon Commission Report (specifically Chapter 4: DMHAS Client Characteristics), cultural competence is a critical issue common to both the children and adult's mental health service delivery systems in CT. In the adult system, people of different cultures and ethnic groups are more likely to be seen in both inpatient and community-based programs. The overrepresentation of African Americans in inpatient settings is of particular concern and must be better understood. As mentioned earlier in this Expert Panel report, approximately 12 percent of prison inmates in CT have moderated to severe mental health issues. Of those, over half are Black or Hispanic. This issue, too, must be examined and better understood.

Given these system problems, there is no doubt that significant reform must occur. Toward that end, the Managing Services Expert Panel has identified five major areas, and recommendations within each, to guide service system development activities:

- ❑ Sufficient Funding, Integrated Across Service Systems, to Fully Support Comprehensive Community-Based Care
- ❑ Local Management of Services
- ❑ Development of Services for Young Adults Ages 18-21
- ❑ Ensuring Accountability for Services through Quality Improvement
- ❑ Supporting Professional Development through Better Training, Recruitment and Retention
- ❑ Supporting the Development of Cultural Competence

### **M. S. Panel Issue #1 - Sufficient Funding**

Integrated Across Service Systems, To Fully Support Comprehensive Community-Based Care

**Statement of the Issue** – Despite attempts to improve the service delivery system, inadequate and fragmented funding present formidable barriers to comprehensive, community-based care for children and adults. Inadequate funding restricts access, prevents the development of new services, reduces quality and continuity of care, and compromises client outcomes. It also reduces workforce effectiveness because providers are unable to recruit and retain competent staff with the knowledge, skills, and values to practice in a manner that will result in the best possible outcomes for those receiving services.

Funding fragmentation contributes to unnecessary administrative complexity and inefficiency at all levels of the system. In the children's system, funding comes from five different state agencies (DCF, DSS, DOE, DMHAS, DMR) and the Judicial Branch. Similar fragmentation occurs in the adult system. It is imperative that this Commission act to promote the elimination of these barriers.

Ensuring integrated and sufficient funding first requires an understanding of the breadth of funding needs. As the service delivery system moves to a community-based system of care, the spectrum of support for people with mental illness is necessarily broadened to extend beyond inpatient, outpatient and residential treatment. The community-based system of care emphasizes early intervention, clinical treatment and rehabilitation services in one's own community, enhancement and inclusion of family and other natural supports, and the basic supports people need to live and thrive in their homes and communities. These basic supports include income supports, housing, employment, education, transportation, primary health care, the help of both professionals and non-professionals such as family, friends and peers and non-clinical community services. The purpose of the community system of care is to enhance the ability of each individual to integrate successfully into the life of their family and community.

The demands of a community-based system of care bring challenges and opportunities. From a funding perspective, it requires that sufficient resources must be directed to the full spectrum of services and supports needed to support recovery over time. If too few resources are directed to *basic community supports*, the treatment system experiences gridlock. The result is that many people spend longer than necessary in emergency rooms and inpatient settings, or are discharged to shelters or other inappropriate settings for lack of alternatives. If too few resources are directed to *treatment*, many people do not have access to care or receive inadequate care, and as a result may end up homeless, incarcerated, or forced to rely on emergency rooms, detention centers, or out-of-state placements for care. The challenge is identifying sufficient resources now to ensure a balanced distribution of resources within the system of care at levels that meet consumer demand. The opportunity is that this investment in a recovery-centered, community-based system of care will ultimately result in reduced recidivism and decreased utilization of high cost services, and a more cost effective use of State resources. It also brings the opportunity to employ collaborative approaches that cross the traditional boundaries of State agencies, and to blend resources from different agencies and disparate funding streams.

The recommendations below are based on this concept of a balanced system of care that assures that every citizen of the state who has a mental illness will have access to services that will support and promote his or her treatment and recovery over the long term.

**M. S. Panel Recommendations #1.a-1.c – Ensure Funding Adequacy and Integrated Management of Funding Streams**

1.a. Increase financial support across the full spectrum of services for children and adults to fill gaps in the existing array of services and supports, and increase the Medicaid reimbursement rates and state agency contract rates, to be more reflective of costs of providing services, thus increasing the capacity to provide sufficient and appropriate community-based care. High priorities for services for adults include jail diversion, case management, housing, employment, transportation and income supports. High priorities for services for children and their families include care managers, family advocates, emergency mobile psychiatric services, in-home and school-based services, extended day treatment, crisis, mentoring, and respite services. Maximizing federal revenue and reducing recidivism and the inappropriate use of institutional care will result in a cost-effective use of state resources toward this effort. Time frame: Achieve full implementation over the next four years.

1.b. Integrate the management of multiple funding streams across state agencies where possible for children, and separately for adults, to support a more comprehensive, flexible service array that allows for individualized treatment planning, and is based on the specialized needs of the children, youth, and adults being served, and their families. Where full integration of funding is not practical, assure the coordination of the use of funding across the broad range of service systems that affect the lives of those with mental illness, including DMHAS, DSS, DCF, DECD, CHFA, DOE, DOC, Judicial Branch, Probate Courts, and DOL. Time frame: Identify opportunities and vehicle to accomplish integration within one year.

1.c. Move forward with the planning and implementation of a proposed behavioral health program for disabled adult Medicaid recipients. Similarly, move forward with the plans to implement a carve-out for children, as recommended in the report “Delivering and Financing Children’s Behavioral Health Services in Connecticut.” For families who will be receiving treatment from both the children’s and adult service systems, develop a plan for funding and service mechanisms to provide coordinated, family-centered care. Time frame: File and secure necessary approvals within one year.

**Proposed Enhancements** – Resources for adult and children’s services should be increased to support the following:

**Adult Services**

Jail Diversion<sup>24</sup> – Jail diversion programs must be implemented in all geographic area courts in the state. This, combined with wrap around supports below, will significantly reduce the number of people with mental illness in the criminal justice system.

<sup>24</sup> Funds were appropriated in the June 19, 2000 Special Session of the General Assembly to fund Jail Diversion programs in the remaining 11 lower court districts.

**Case Management** - Case management services, including peer support and assertive community treatment teams, must be expanded and available in all regions to assist persons with severe mental illness and people with co-occurring addictive disorders to negotiate the system and develop the skills and supports necessary to become as self-sufficient as possible. Such case management services must be recovery-based, individualized, flexible, and easily accessible by the consumer.

**Housing** - Provide sufficient funding for support services, rent subsidies and housing development costs to create 800 units of housing over the next four years through the Supportive Housing Pilots Initiative in order to expand housing and residential options for people who are homeless or at risk of homelessness. 500 units are already part of the Supportive Housing Pilots Initiative and 300 additional units are recommended, particularly in areas of the State with tight rental markets.

Provide rental assistance to additional individuals with mental illness and their families by expanding the Bridge Subsidy Program. This program “bridges” waiting list periods for community Section 8 subsidies. An individual on disability benefits currently must pay two-thirds of their income to afford a typical efficiency apartment in Connecticut, and waiting lists for Section 8 rental assistance exceed two years in most cases.

Establish an interagency working group, under the leadership of OPM, on housing for people with disabilities with the goal of 1) ensuring the success of the Supportive Housing Pilots Initiative and 2) developing a five-year plan and strategies for the financing and creation of additional units of affordable and supportive housing serving the needs of people with disabilities. Include on the taskforce private sector funders and intermediaries, consumers and family members, and non-profit agencies experienced in providing affordable and supportive housing.

**Employment** - Expand employment supports for people with mental illness, including job readiness, remedial and basic skills education, opportunities for development of work experience, career ladders and job retention supports. DMHAS should be an active participant in existing State interagency workforce development efforts.

**Transportation** – Expand transportation support for individuals with mental illness so that treatment, employment, education and other support services are more easily accessible.

**Income Supports** - Eliminate the State practice of reducing Aid to the Disabled benefits for people receiving Supplemental Security Income when they are granted a cost of living increase on their Social Security benefit. People with disabilities on SSI should receive the same cost of living increase that Social Security recipients receive. Currently, the State, rather than the consumer, receives the benefit of the cost of living increase through reduced Aid to the Disabled payments to consumers, even though consumers are confronted with increases in their living costs.

**Dual Diagnosis** – Develop integrated treatment and rehabilitation efforts for individuals with co-occurring mental illness and substance addiction.

## **Children's Services**

Regional Systems Coordinators - DCF System Coordinators must be functional in each region to organize and coordinate systems of care.

Care Managers - Care Managers must be available within systems of care to provide assistance to children and families. These Care Managers should have a caseload of no more than ten children.

Family Advocates - Family Advocate services must be increased across every region to provide supportive services and advocacy on behalf of children and families.

Emergency Mobile Psychiatric Services - A fully functional and adequately funded emergency mobile psychiatric program is essential to divert children and youth from hospital level care, to provide short-term intensive crisis management and stabilization, and to link children and families to longer-term services and supports.

In-home and School-based Services - In-home and school-based psychiatric and supportive services must be expanded and reimbursed. Such services reduce problems with transportation, and allow treatment to occur in more naturalistic settings.

Extended Day Treatment - Extended Day Treatment programs must be expanded. These programs provide an important treatment experience after school, so that children with serious emotional disturbance can remain in the community and in their homes.

Respite, Crisis Respite and Mentoring - Families often identify support services such as respite, crisis respite and mentoring as the most significant reason that children can remain in their home and community. These services must be created and supported.

Therapeutic Foster Care - Therapeutic foster care in community-based family settings need to be expanded to support children moving from intensive, expensive, hospital and residential settings who are not yet ready or able to return to their families.

## **Funding**

Recommended actions to provide sufficient funding for the above enhancements are as follows:

### **State Resources**

- ❑ Increase and sustain the State's investment in the community-based system of care to create the capacity necessary to ensure adequate and appropriate levels of care across the service continuum and to eliminate gridlock for children and adults.
- ❑ By August 1, 2000, convene an interagency taskforce to develop joint budget options for consideration by the Governor and legislature for the FY02-03 biennial budget. Such budget

options should recommend strategies to address the priority areas identified above.

- ❑ Establish a Community Mental Health Services Trust Fund to serve as a depository for funds received by the State from the sale and/or lease of Fairfield Hills and Norwich hospitals and other appropriations, such as state surplus, and to apply for and receive foundation and other private donations. Trust funds should be used to continue to build the infrastructure necessary for the community integration of people with mental illness and to pilot state of the art approaches that support recovery.
- ❑ Amend existing State regulations to allow grantee agencies to carry over and reinvest surplus funds for the expansion of services, provided outcomes and goals are achieved. Any efficiencies achieved in the service system by more recovery-focused services or by better management must be reinvested in service expansion.

#### Federal Resources

- ❑ Maximize the funds Connecticut can obtain from the federal government for mental health services and use these funds, in combination with state funds, to provide reimbursement that is more reflective of the cost of services and to expand services to address gaps in the mental health service systems for children and adults. All new federal revenue must be fully reinvested in the children's and adults community behavioral health systems.

#### Medicaid

- ❑ Maximize the use of optional Medicaid State Plan services, including rehabilitation services and targeted intensive case management services.
- ❑ Develop a plan to utilize Medicaid waivers to expand services to adults and children.
- ❑ Conduct an ongoing outreach initiative to enroll eligible individuals in Medicaid. This will ensure Federal reimbursement for services.

#### Private Insurance

- ❑ Undertake an in-depth study, co-chaired by the Office of Health Care Access and the Department of Insurance, and including consumer and family members, to document practices by health insurers related to their actual application of parity and conformance to Connecticut's health insurance mandates. This study should include a review of the viability of psychiatric services in general hospitals, and outline recommendations to assure the continuum of adequate private sector services to meet the needs of Connecticut's citizens. This study should also address administrative practices of both managed care companies and Medicare fiscal intermediaries which may lead to restrictions of appropriate treatment across the continuum of care.

**Expected Impact** – By implementing this recommendation adults, children and families will receive the care they need when they need it and where they need it for the intensity and duration

necessary to sustain recovery. Community services will be expanded, resulting in smoother transitions into and out of acute care and residential settings, and supporting adults and children to remain in their own homes, schools and communities while receiving the supports and services they need. Providers will be able to offer the amount and range of services necessary to meet the individual needs of their clients and communities and with appropriate staffing levels. A reduction will occur in the frequency and utilization of hospitals, nursing homes and prisons by individuals with mental illness.

### **M. S. Panel Issue #2 - Local Management of Services**

**Statement of the Issue** – Local communities, inclusive of providers and citizens, tend to be most familiar with the adults, children and families requiring mental health services. As such, the local community should have the capacity to make informed decisions related to the *system* of services being delivered. Additionally, access to mental health services should be user-friendly, and there should be a single point of responsibility and coordination of services.

For children and families, during the past 15 years, there has been a shift across the country to create a more comprehensive approach to coordinating and delivering services. This “systems of care” approach is designed to be community-based, coordinated, family-centered, culturally competent, and individualized, with new financing arrangements driving changes in the way services are organized. It is based on three main elements:

- ❑ Services must be driven by the needs and preferences of the child and family;
- ❑ Services must be managed within a multi-agency community-based collaborative environment and grounded in a strong community base; and
- ❑ Services and agencies must be responsive to the cultural backgrounds of the children served.

Research on the effectiveness of systems of care shows positive results for such outcomes as reducing the use of residential and out-of-state placements, and in achieving improvement in functional behavior. In addition, families are more satisfied in systems of care than in more traditional service delivery systems.

State legislation passed in 1997 (Public Law 97-272) adopted the national system of care approach by identifying the core values and guiding principles for Connecticut’s services for children and adolescents with serious emotional disturbance. The 1997 legislation directed DCF to implement individual system of care plans for children who have mental illness or are emotionally disturbed and are at risk of, or are in, an out-of-home placement primarily for mental health treatment. Over the last several years DCF has assisted nineteen community groups in establishing local system of care collaboratives that include schools, community service providers, families, advocacy groups, and other organizations concerned with the well being of children with complex emotional and/or behavioral needs. This approach can serve as the foundation upon which to build an expanded and enhanced, locally driven approach to treating children and their families, and can serve as a model for the adult service system as well.

**M. S. Panel Recommendations #2.a-2.b – Ensure Local Management of Services**

2.a. Build on the locally-based service systems of care approach grounded in the principles of family and consumer involvement, cultural competence, and interagency collaboration that includes private, non-profit, and public providers. In the children's system, establish regional lead agencies or organizations to work with one or more local systems of care to coordinate service delivery, planning, and policy for eligible populations in their geographic area.

2.b. Create financial and service mechanisms that support coordinated family-centered treatment when both children and adults within a family are in need of mental health services.

**Proposed Enhancements**

- ❑ DMHAS and DCF should support local efforts to establish locally based service systems. Each state agency should support their local systems of care by developing mechanisms to collect and manage data, pay claims, credential providers and accomplish other administrative tasks deemed appropriate by the local systems of care. As an example, DMHAS and DCF could each seek to hire an organization skilled at accomplishing these administrative tasks, and each agency could use data to manage and improve their respective service systems.
- ❑ Maximize the efficiency and quality of services by requiring the local systems of care to be linked directly to local advisory bodies.
- ❑ *Children's Services:* Support present efforts to implement recommendations identified in the report "Delivering and Financing Children's Behavioral Health Services in Connecticut."
- ❑ *Adult Services:* Evaluate and refine, as necessary, the current system of Local Mental Health Authorities (LMHAs) in order to maximize efficiency and client outcomes. Require that the same standards of care be applied equally to both public and private providers.

**Expected Impact** – By implementing this recommendation individuals and families will receive care that is managed and coordinated by a local entity. There will be a reduction in duplicated and overlapping services because there is a single entity responsible for coordinating their care.

**M. S. Panel Issue #3 - Development of Services for Young Adults**

Develop Services for Young Adults, Ages 18-21, Transitioning to the Adult Treatment System

**Statement of the Issue** – Youth with serious behavioral, cognitive, social, and emotional problems must not fall through the cracks due to lack of age-appropriate services as they age-out of the children's mental health system, nor should the differences between various state agencies result in the systematic failure to provide services to young adults in need of ongoing services. Children who received behavioral health services through the state HUSKY program are no longer entitled to services once they reach age 19. Some of these young people will become eligible for services through DMHAS. DCF projects that 45-50 children in their custody are in

need of DMHAS mental health transition services in any given month. Other children will not meet the eligibility criteria for DMHAS, one that is narrower than that of DCF. This is a population highly vulnerable to ending up in homeless shelters or in the criminal justice system.

Services in the adult system are often not developmentally appropriate for youth ages 18-21, and may not meet their full range of needs. Services are not tailored for the needs of youth with serious emotional disorders, and there are few services for those with dual diagnoses (either substance abuse/mental illness, or mental retardation/mental illness). Young people coming out of a highly structured, self-contained residential treatment environment, either in state or out-of-state have little preparation for independent living.

For those eligible for DMHAS services, the process of transition from services provided through DCF must be smooth, with young adults experiencing continuity in their treatment and in the financing that supports their care. The Special Populations Program, and the Transitional Services Project developed together by DCF and DMHAS, provide some promising models. Both programs provide developmentally appropriate residential, educational, vocational, clinical, and recreational services, and need to be supported and expanded. For those who will not be eligible for DMHAS services, but who need continued support services after leaving DCF's custody, further understanding of what is available, and what is needed should be explored.

As reported in the Technical Appendix to Delivering and Financing Behavioral Health Services to Children in Connecticut (2000):

“A system of care for children and youth with behavioral health needs must include the transition needs of youth who have been placed out of home, responding with step-down services that ease the transition. In addition, the child system of care must collaborate with adult service systems to ensure that services are appropriate and provided in an environment that is comfortable. It must be responsive to those youth who, while not placed out of home, have behavioral health problems that, if left untreated, will escalate and lead them to less than optimal outcomes. Finally, transition planning must begin early, by age 16 at least, in order to assure that children and youth stay in treatment and thus can achieve best outcomes.”

**M. S. Panel Recommendation #3 – Development of Services for Young Adults**

Develop a full system of age and developmentally appropriate services and supports to assure continuity of care for those youth approaching age 18, who are “aging out” of services available for children and youth but are still in need of some form of care. For those receiving services through DCF who will be eligible for services through DMHAS, assure a smooth transition in services and supports, and in the funding that provides for these services.

### **Proposed Enhancements**

- ❑ Eliminate the service gaps for youth ages 18-21 by specifying either DCF or DMHAS to be responsible for this population, with established mechanisms to work in full collaboration with the other agency.
- ❑ Develop a full array of age-appropriate mental health services and supports for all youth 18-21 with serious cognitive, social, emotional and/or behavioral problems, to assure access to appropriate services as they move from school-based and community-based services for youth to services available to them as adults.
- ❑ For all youth involved with the DCF system who need ongoing mental health services, develop treatment plans to be continued up to age 21, with Medicaid eligibility to be continued through this time period. Continuity with their primary therapist or care manager should be maintained as they move into the new system of adult services, to ease the transition.
- ❑ Support the development of services for youth not involved with the DCF system so that they have access to transition services appropriate to their age as they move from late adolescence into early adulthood.
- ❑ Conduct a study of the service needs of youth ages 16 and older in the custody of DCF, to further the understanding of their needs. Address the needs of those who are likely to be eligible for services in the public adult mental health system, as well as those not likely to meet eligibility criteria. Develop recommendations for community-based services and funding opportunities that will help address the needs of both groups. In addition, using a case study approach, determine what earlier interventions may have been helpful in preventing the development of more serious disorders, and develop recommendations for strengthening a system of early intervention services and supports for children and their families.

**Expected Impact** – This recommendation will increase the likelihood that young adults between the ages of 18-21 will be served appropriately. This will reduce future expenditures on more expensive levels of care, and will reduce subsequent unemployment and potential involvement with the criminal justice system.

### **M. S. Panel Issue #4 - Ensuring Accountability for Services**

Ensure accountability for services through quality improvement

**Statement of the Issue** – Connecticut has limited mechanisms in place to ensure the quality of clinical and administrative behavioral health services. Currently, Connecticut State agencies assure quality and accountability through provider licensure/certification, provider monitoring and audits, and the oversight of management services (MCO/ASO) contracts. In addition, health

plans credential providers, perform high volume provider audits; and conduct quality improvement projects. These mechanisms are insufficient and too narrow in scope to ensure continuous accountability for quality services and to promote continuous quality improvement on a system-wide basis. The mental health system must implement systematic strategies to reward effective and efficient clinical and administrative service delivery practices and processes. Particular attention must be paid to the cultural sensitivity and competence on the part of the provider agency and its staff.

**M. S. Panel Recommendation #4 – Ensure Accountability for Services**

Create a public mental health system that is accountable and effective by developing policy, regulatory, contractual, and financial mechanisms that encourage health care access and quality. Begin by developing clinical and administrative process and outcome measures and use performance on these measures as the basis for contracting and the application of financial incentives and disincentives.

**Proposed Enhancements**

- ❑ Develop and enforce standards of practice (via policy, regulation, and contracting) that reflect best practice guidelines and current scientific evidence. Monitor these standards through improved licensing and program review activities.
- ❑ Develop specific standards related to cultural sensitivity and cultural competence.
- ❑ Develop automated procedures for the collection, analysis and review of clinical and administrative process and outcome data. Performance data should be readily accessible to contracted administrative and clinical entities.
- ❑ Develop tools to facilitate performance comparison and evaluation, for example, by establishing provider performance profiles, national and local benchmarks, and performance targets.
- ❑ Ensure that meaningful consumer and family participation are built into every level of the accountability system. Include client-centered and family-centered process and outcome measures focused on short-term progress and long-term wellness. Ensure that measures incorporate and recognize incremental growth and, in some cases, the need for lifelong support. Clients and families should be partners in the review and evaluation of performance.

**Expected Impact** – By implementing this recommendation, policy, financing, and contracting mechanisms will reward administrative accountability (e.g., timely claims processing, accurate and timely reporting) and clinical accountability (e.g., ease of access, effective and efficient service delivery practices, optimal outcomes). Children, adults, and families will be satisfied with their participation in service planning and delivery and they will experience such services as timely, appropriate, coordinated, and up-to-date.

**M. S. Panel Issue #5 - Supporting Professional Development**

Supporting professional development through better training, recruitment, and retention.

**Statement of the Issue** – Better outcomes for those receiving services will not occur without well-trained staff or providers with the skills and know-how to provide effective treatment and supports. Increased funding and reorganization of how services are managed will not be sufficient to produce results without effective and well-trained staff and providers. There is increasing concern that training, especially at the pre-service level, bears little relation to the changing trend in service delivery, the demands of the actual work, and the needs of the clients being served. There are few examples of training programs that reflect current practice such as the involvement of parents and consumers, interdisciplinary collaboration, strengths-based assessment and intervention, wraparound service approaches, cultural competence, and the use of natural informal supports and resources. It is important that training systems in Connecticut are relevant to practice, and to assure that what is taught is allowed to transfer into the workplace. It is also important to assure that those in practice are competent in using the knowledge, skills, values, and attitudes that inform a community-based, system of care approach. The State needs to support the recruitment and retention of staff with these skills through adequate reimbursement that supports competitive wages and appropriate benefits.

**M. S. Panel Recommendation #5.a-5.b – Ensure Professional Development**

5.a. Develop a competency-based training plan for pre-service and in-service training across systems and at all levels for providers, state agency staff, and consumers, to translate the knowledge about effective interventions and approaches into practice throughout the adult and child mental health systems.

5.b. Support the recruitment and retention of a skilled workforce through providing sufficient funding to support competitive salaries and benefits.

**Proposed Enhancements**

- ❑ Establish linkages with universities and higher education facilities. Undergraduate and graduate curricula, and on-going training activities, must increase competence by focusing on systems of care philosophy, evidence based practice and cultural sensitivity.
- ❑ Ensure that people who use/have used mental health services, are an integral part of the training and education of the workforce.
- ❑ Establish contracted requirements for competency based evaluations of staff to assure core competencies are met (similar to JCAHO requirement).
- ❑ Create credentialing standards for specific services (e.g., crisis evaluations must be done by Masters prepared staff).

**Expected Impact** – Adults, children and families will receive services that are grounded in best practices that have been taught to staff providing the services.

Competent and committed staff is providing services without high rates of burnout or turnover.

The cultural background of clients will be acknowledged and respected and they will receive services that are culturally sensitive.

**M. S. Panel Issue #6 - Cultural Competence**

Support the development of cultural competence of all providers of mental health services statewide.

**Statement of the Issue** - Cultural competence research indicates that cultural issues impact the mental health service delivery system in many ways, including client level of trust, access, retention, recidivism, cost effectiveness and quality of care. Connecticut must adopt new approaches for addressing the rich cultural diversity of persons, who need mental health services.

As noted earlier in this Blue Ribbon Commission Report (specifically Chapter 4: DMHAS Client Characteristics), cultural competence is a critical issue common to both the children and adult's mental health service delivery systems in Connecticut. In the adult system, people of different cultures and ethnic groups are more likely to be seen in both inpatient and community-based programs. The overrepresentation of African Americans in inpatient settings is of particular concern and must be better understood. As mentioned earlier in this Expert Panel report, approximately 12 percent of prison inmates in Connecticut have moderated to severe mental health issues. Of those, over half are Black or Hispanic. This, too, must be better understood.

**M. S. Panel Recommendation #6 – Cultural Competence**

State agencies involved in the delivery of mental health services should incorporate principles of cultural competence into their organizational structures and policies and into the design, development, purchase and implementation of such services. State agencies should engage in high-level interagency collaboration to develop and implement cultural competence clinical standards, outcome measures, policies and procedures.

**Proposed Enhancements**

- ❑ Establish an interagency multicultural advisory council that will examine the issues related to percentages of persons of color with mental illness in inpatient settings and in prisons and design, implement, and monitor a unified cultural competence strategic plan;
- ❑ Identify a single point of responsibility within each agency to oversee the coordination of the multicultural advisory council;
- ❑ Build the strategic plan upon existing models.

**Expected Impact** – Some of the expected outcomes of improved level of cultural competence with state agencies involved in the delivery of mental health services are:

Improved outcomes for under-served population in the areas of access, quality of care, dropout rates and recidivism;

Increased cultural accommodation by providers as they address the ethnic/culture of staff, consumers, and family members;

Increased collaboration of state agencies which furthers the infusion and integration of cultural competence;

Increased number of culturally competent staff within state agencies and providers; and

Increased number of programs that reflect the cultural values and needs of client population.

## **Prevention**

Prevention means promoting good health. It is achieved by reducing those risk factors that are known or suspected of causing illness while encouraging those protective factors that are known or believed to promote health. Currently 19 percent of adults and 14-20 percent of children and adolescents suffer from mental-emotional disorders.

Mental health promotion involves taking actions in a deliberate and positive way to both build mental health and to counteract harmful circumstances before they can cause disorder or disability. Prevention is focused on both reducing vulnerability and enhancing wellness. Prevention activities strengthen one's ability to diminish or change or reduce negative stressors, and develop the ability to manage unavoidable stressors.

By the time people realize that they have a serious problem, it is often too late to maximally engage in prevention. As the first step in the continuum of care, prevention services help to blunt the onset and effects of future problems, and are an important stopgap to crisis. Prevention efforts work to reduce health care and criminal justice costs, victim losses and lost productivity. Studies have shown that prevention is a cost effective and affordable investment, generating more benefits for every dollar spent (Rand, 1999).

When using prevention comprehensively, policymakers can help to decrease violent behavior, aggression, hospital stays, long-term residential treatment and suicide. They can create better quality of life, safety and resilient communities. Laying the foundations for hope, long-term cost-savings, and community safety is no small matter.

### **The Parameters of Prevention**

The following points are recognized as critical in the field of prevention (Gulotta, 2000):

- ❑ Prevention is proactive it builds new coping resources and adaptation skills and promotes emotional health in individuals not yet diagnosed as ill.
- ❑ Prevention focuses on groups rather than a single person, to have the broadest effect on good outcomes.
- ❑ Prevention is a science; prevention activities are planned interventions that are rooted in theory or research.
- ❑ Prevention has a technology that includes specific prevention interventions used to fashion a healthier environment, such as, a) education, b) systems intervention, c) competency promotion, and d) natural care giving. These interventions have overlapping boundaries and effective prevention programs practice elements of at least three.

## **The Factors Facing Improving Contemporary Family Life, Learning and Safety**

In addition to early identification of mental health problems, many of which have a genetic and biological basis, there are many factors affecting contemporary family life, learning and safety. The following examples, across the lifecycle, are indicators of areas for focusing prevention strategies.

### Dramatic Changes in Family Life

Family life has changed dramatically over the past two decades. Family structure change (divorce, separation, and blended families), the increase in the percentage of mothers of young children who work outside the home, and the increase in the aging population have impacted families in major ways. For instance, single-parent households, divorce, poverty, and the lack of good quality affordable childcare and elder care are circumstances that contribute to family stress. These daily environmental stresses affect all families as well as the developmental outcomes of children and adults, particularly during different stages of life.

### Prenatal Care/Early Intervention

The stress associated with pregnancy and caring for a newborn can be overwhelming for any new parent. Developmental research informs us that supportive services to children and youth should begin at birth or even during the prenatal period. Quality prenatal health care, positive parent/child interaction, nurturance and appropriate stimulation are paramount to a young child's development and, if absent, may yield a profound and irreversible neurobiologically based set of social/emotional deficits. The problem of expectant mother's addicted to alcohol or other drugs raises significant risk issues and potential life-long harm for the unborn child.

### Divorce

Divorcing families with young children face significant challenges and risks. These families of divorce are under greater economic stress; the children spend more hours in day care, and are less likely to be cared for by their father when their mother is away (Whiteside, 1995). Furthermore, the children are at greater risk for long-term problems in social and emotional adjustment (Zill, Morrison, & Coiro, 1993): they are less able to realistically appraise reasons for the divorce and consequently blame themselves more readily, and are anxious about abandonment, and are less likely to utilize the protective resources of other people (Hetherington, Bridges, and Insabella, 1998). These families are among the most frequent users of court-related family services in Connecticut.

### Domestic Violence, Aggression and Safety

Family violence represents a significant threat to the health and mental health of all family members. Approximately one in three women will experience violence at the hands of a partner sometime in her life and as many as 1.8 million women per year sustain a severe or life-threatening assault from a partner (Straus et al, 1990). Family violence has been found to be a leading cause of women's emergency room visits (Grisso et al., 1991). Many victims of family violence also suffer from a variety of psychiatric disorders, including substance abuse, anxiety, post-traumatic stress disorder, and suicide attempts (Stark & Flitcraft, 1996), and for a majority of battered women, the onset of these psychiatric difficulties appears to occur after the onset of

battering. Victims of family violence and trauma are over represented among consumers of mental health services (Di Palma, 1997).

Among children, bullying is a common and potentially damaging form of violence. Studies suggest that chronically victimized students may, as adults, be at increased risk for depression, poor self-esteem and other mental health problems including schizophrenia. Not only does bullying hurt the victim and perpetrator, it also hurts the safety of a neighborhood and learning in a school. Research findings now clearly link bullying to later delinquent and criminal behavior. In a recent Connecticut study of city youth, half of the high school students knew someone who was murdered. Thirty seven percent had witnessed a shooting. In another survey, 20 percent of high school students reported being threatened with a gun, while 12 percent were the gun's target.

#### Women and Children Who Are Trauma Survivors

Considerable research documents that domestic violence, sexual assault and battering are common factors in the histories of women struggling with various forms of mental illness and addiction (Crane, et al, 1988, Carmen et al., 1984, Stark and Flitcraft, 1996). Women with co-occurring disorders reported a higher rate of trauma than those in the general population.

Additional studies indicate that the risk for children experiencing trauma is equally high (Barnet et al., 1997). Moreover, there is some evidence of an association between witnessing violence and subsequent emotional maladjustment, suggesting that mere exposure to violence without direct participation in the conflict, may result in low self-esteem and acting out behavior (Wolfe et al., 1985).

#### Older Adults

In response to the rapid growth of the older adult population, there is a need to address issues that face older adults and their families. In 2000, 25 million persons in the United States are 65 and older, approximately 13 percent of the population. By 2030, this number is expected to double to 70 million persons, approximately 20 percent of the population.

Older adults experience conditions such as depression, Alzheimer's disease, alcohol and drug misuse or abuse, anxiety, and late-life schizophrenia. If left undetected or untreated, these conditions can lead to complex, costly health problems later in life or can lead to premature death. Prevention and early detection are successful ways to improve mental health later in life.

#### Sexual Orientation and Family Life

Studies suggest that when compared to the population as a whole, lesbian, gay, bisexual, and transgender individuals experience higher levels of social isolation, substance abuse, depression, and suicidality across the life cycle, particularly at adolescence and again, in their final years. The question has been raised whether this increased level of distress can be attributed to the emotional effects of stigma; the perpetual risk of peer, family, and societal discovery and/or rejection; harassment, increased risk and incidence of violence and discrimination. In spite of the increased risks this population faces, few services exist to meet their needs.

## **Values Behind Primary Prevention**

Primary prevention policies and programs are based on the following core tenets and values that include high regard for diverting pain, reducing expense, ensuring citizen safety and quality of life:

- ❑ Mental health needs must receive the same priority, as physical health needs.
- ❑ Promoting mental health and preventing mental illness must be priorities.
- ❑ Crises can be averted when intervention occurs at the first sign of difficulty.
- ❑ Research-based prevention practices work best.
- ❑ Consumers must have easy access to prevention and be viewed as partners and leaders for their children and other family members.
- ❑ Families are powerful agents of good health.
- ❑ Leadership and capacity building skills are imperative tools for individuals, communities and health care systems.
- ❑ Mental health preventive interventions need to be designed and delivered in a manner that is sensitive to differences of ethnicity, age, race, gender and sexual orientation.
- ❑ Community assets need to be identified and supported, particularly in low-income neighborhoods.
- ❑ Community activism and state policy that supports prevention helps promote safe, healthy communities.

## **The Importance of Prevention and Health Promotion for Connecticut's Citizens**

With an estimated 135,000 residents afflicted by serious psychiatric disabilities, Connecticut is facing an epidemic of suffering that will continue to overburden the service capacity of the state. In the absence of adequate investment in prevention, the state will experience a continued problem with mental disorder incidences among children, youth and adults.

Despite knowledge gained from research in mental health prevention in the past two decades, preventive practices in the form of mental health promotion are rarely funded. What is lacking is the infusion of dollars to invest in prevention making it difficult to intervene before a mental health problem develops, or early in its course.

Promoting mental health requires societal and political will to make the concerted investment needed. Investing in prevention will not require a major financial burden. Rather, it will

necessitate the willingness of all citizenry, including helping professionals, teachers and clergy to educate themselves about risk and protective factors, confront stigma associated with accessing services and advocating for adequate prevention screening and early intervention services.

In the past, treating illness was given priority over personal health behaviors, as they were not viewed as a legitimate clinical issue. Today, however, research has helped resolve some of the uncertainties among clinicians and social workers about the effectiveness of preventive services, thus removing a major barrier to the delivery of appropriate preventive care. Other barriers to implementing preventive mental health care include: insufficient reimbursement for preventive interventions; provider uncertainty about how to deliver this component of care; lack of individual or provider interest in preventive services, and lack of organizational/system support to facilitate the delivery of a comprehensive continuum of preventive mental health care.

Despite these imperfections, Connecticut's state behavioral health system has a solid foundation for developing this critical component of practice.

The following factors contribute to Connecticut's readiness to implement a comprehensive statewide mental health prevention effort:

**Leadership** among state agency heads, Legislators, insurers, providers, and consumers who recognize the value prevention brings to substantially reducing incidence and severity of leading causes of death and disability associated with chronic mental illness.

**Vision and strategic planning** is in place to develop, mobilize and sustain a statewide innovative prevention agenda.

**Structure and organizational formats** integrating behavioral health care systems are emerging that present a blueprint for creating and implementing new preventive services.

**Framework and theoretical models** have been identified providing a comprehensive and multifaceted approach to wellness.

**Best Practice Models and Infrastructure Programs** (e.g., school based health centers, youth service bureaus, and community-based prevention organizations) have been identified, and in some cases piloted.

**Success in leveraging and matching federal and foundation funding** has placed Connecticut in the forefront of testing and replicating new research-based behavioral health prevention strategies and sharpening interagency and local collaboration.

### **Prevention Practice Framework**

Over the last twenty years, an array of best practice prevention programs have proliferated across the country. These interventions have evolved from several generations of programs, theoretical models, and well thought out approaches addressing individuals throughout the lifespan. Coupled with research studies across target populations and fields of practice (mental health,

substance abuse, violence, teen pregnancy, school failure) a generation of new knowledge and lessons learned about the impact and effectiveness of prevention has assisted planners and program developers creating unique and promising preventive interventions.

While there are many theoretical models that frame mental health practices, Connecticut has identified five core models which intersect and compliment each other, providing a comprehensive and multifaceted approach to promoting wellness. The prevention framework is based on theoretical best practices and research based interventions that include the following models: (1) the life-span development approach; (2) the transactional model; (3) the risk and protective factor model; (4) the capacity building model; and (5) the Institute of Medicine's model.

### Life Span Developmental Approach

A life span developmental approach to prevention has two essential defining characteristics. First, it must be developmentally comprehensive, considering the needs, tasks, transitions, demands, and stressors for the individual over his/her lifetime. These will vary depending on the developmental stage from early childhood to late adulthood. During each phase, there is potential for either positive developmental and psychological outcomes or the emergence of developmental delays, problem behaviors, or psychiatric disorders.

Second, the approach is grounded in an ecological perspective, that attempts to understand how individuals function and adapt as part of the many systems within which they live (family, day care, school, peer group, workplace, neighborhood, etc.), their relative influence and change over time as development proceeds.

### The Transactional Model

The transactional model describes mental-emotional disorders as rarely being attributed to a single specific cause, but rather develop from a complex interaction of biological, physiological, psychosocial, interpersonal and environmental factors that operate in the context of the individual, his or her family, communities, social institutions (e.g. schools) and social/peer groups.

This model asserts that potential causes of mental illness can include individual characteristics, environmental risk or a combination of the two. The model suggests that human behavior has links to a pre-disposed disorder, environmental factors or the interaction between an individual's condition and present risk factors.

### Risk and Protective Factor Model

A core theoretical framework for the field of prevention science is the notion of modifiable risk and protective factors. Risk factors consist of characteristics of both individuals and their environments that influence the likelihood of developing mental and/or addictive disorders or that contribute to increased levels of psychological symptoms and problem behaviors. A risk-focused approach to prevention is aimed at determining the factors that play an important role in

the formation of a given problem, and the processes through which the influence of these factors is transmitted.

Protective factors are “those factors that modify, ameliorate, or alter a person’s response to some environmental hazard that predisposes to a maladaptive outcome” (Rutter, 1985). Exposure to risk can be mitigated by a variety of individual (e.g., active coping strategies, sense of self-efficacy and personal control, social and cognitive skills) and environmental (e.g., availability of social support) characteristics that serve protective functions. A protective factor approach to prevention focuses on strengths and competencies and leads to an emphasis on interventions whose aims are competency promotion, mental health promotion, empowerment, and positive youth and family development. These approaches are strengths, rather than deficits-based.

Based on the knowledge derived from risk and protective factor research, preventive interventions are designed to eliminate or reduce risk factors and/or to mediate or moderate the effects of risk by enhancing protective factors. When research has identified causal links between risk and protective factors and negative (or positive) outcomes, these factors become the targets of intervention efforts.

### Capacity Building

The concept of capacity in mental health has traditionally been applied to individuals. Various concepts have a bearing on capacity including the notion of resiliency; defined as individual’s attributes that allow for an unusual level of stamina and the ability to overcome adversity. Sometimes resilience refers to individual protective factors. The attainment of positive outcomes despite high-risk situations is believed to be related in good part to resilience.

In Connecticut’s Behavior Health Prevention Model, capacity includes the individual, the family, community, and health system. Activities under this model include training, organizing, community leadership development, planning, enhancing efficiency and effective service implementation, interagency collaboration, coalition and network building.

### Institute of Medicine’s Prevention Model

The Institute of Medicine’s prevention model defines three levels of prevention: universal, selective and indicated. The following are examples of prevention approaches and programs:

*Universal Prevention Interventions* target all segments of the population with the goal of preventing the onset of a mental-emotional disorder. Examples include mentoring, parent support networks, adult caregivers, life skills training, and diversity and tolerance initiatives.

*Selected Prevention Interventions* target individuals/families who have known risk factors and/or who are demonstrating early indicators/warning signs of emotional problems. These programs are often focused on critical life transitions, crisis events, chronic stressors or health-related problems. Examples include: services targeted to abused children, respite care, employee assistance programs, bereavement, support groups, support groups for gay/lesbian/bi-sexual and trans-gendered youth and adults.

*Indicated Prevention Interventions* are targeted strategies designed to reverse, in a specific individual, an already initiated pathogenic sequence. These strategies require the availability of screening procedures to identify individuals with pre-clinical signs of emotional/behavioral disorders. Indicated prevention interventions are provided to specific individuals with special indices of dysfunction. Indicated prevention programs address risk factors associated with the individual, such as conduct disorder, alienation from parents, peers, and school. Brief counseling, screening and referral to supportive services, all fall under this strategy.

### **Points of Intervention**

Prevention and health promotion can help children, adults, and elders both emotionally and cognitively. Schools, workplaces, adult day care centers, youth service bureaus, community and health care centers all have the unique capacity to provide a comprehensive range of greatly needed mental health services for children, elders, and families. These services include prevention programs that can reduce the risk of exposure to violence, child abuse, sexually transmitted disease, suicide, substance use/abuse and other social problems.

The following table is a review of prevention programs based on the Institute of Medicine's continuum of care (e.g., universal, selected, indicated) that targets groups across the life-span with different risk conditions and protective resources. A more detailed description of these programs appears in Appendix H. Although most of these programs have not been evaluated, there is some empirical basis for predicting that further research could support some positive effects. Also noted (\*) are programs that have been evaluated and are found reasonably certain to reduce risk factors and increase protective factors in the kinds of social contexts in which they have been evaluated.

## Sample Preventive Interventions for Mental Health

Life Cycle Stage	Risk Factors	Protective Factors	Sample Best Practices/Programs *
<b>Prenatal</b>	<ul style="list-style-type: none"> <li>• Inadequate prenatal care</li> <li>• Inadequate training of OBGYN</li> </ul>	<ul style="list-style-type: none"> <li>• Maternal education</li> <li>• Good maternal diet and care</li> <li>• Adequate training of health care providers</li> </ul>	<ul style="list-style-type: none"> <li>• Healthy Families Initiative*</li> <li>• First Steps</li> <li>• Training on identification and referral of OBGYN</li> <li>• Training for Probate Courts dealing with drug addicted expectant mothers</li> </ul>
<b>Early Childhood</b> ( <i>Infancy to Kindergarten</i> )	<ul style="list-style-type: none"> <li>• Teenage parenthood</li> <li>• Pre-term delivery</li> <li>• Lack of attachment /bonding</li> <li>• Early onset of mental illness</li> <li>• Parental rejection</li> <li>• Family history of mental/emotional disorders</li> <li>• Disabilities</li> <li>• Poverty, economic deprivation</li> <li>• Child abuse or neglect</li> <li>• Economic deprivation</li> </ul>	<ul style="list-style-type: none"> <li>• Healthy parenting behaviors</li> <li>• Parent/child bonding</li> <li>• Early screening and detection</li> <li>• Public awareness</li> <li>• Natural/family community support systems</li> <li>• Social service interventions (food stamps, health care, housing)</li> <li>• Pre-school/ community linkages</li> </ul>	<ul style="list-style-type: none"> <li>• Birth to Three</li> <li>• Early intervention for pre-term infants</li> <li>• Parent/Child Interaction Training</li> <li>• The Child Development Project (CDP)*</li> <li>• Family Advocacy * Network (FAN Club)</li> <li>• Parent/Child Development Center Programs</li> <li>• Parent Leadership Training</li> <li>• The School Readiness Initiative</li> <li>• Children of Divorce Intervention Program</li> </ul>
<b>Latency Period</b> ( <i>Elementary – 8<sup>th</sup> grade</i> )	<ul style="list-style-type: none"> <li>• Alienation</li> <li>• Rebelliousness</li> <li>• Being harassed/bullied</li> <li>• Early school failure</li> <li>• Low school attendance</li> <li>• Child abuse or neglect</li> <li>• Economic deprivation</li> <li>• Early behavioral problems</li> <li>• Anti-social behavior</li> <li>• Poor impulse control</li> <li>• Marital conflict and separation</li> <li>• Disabilities</li> <li>• Stigma associated with non-traditional families</li> </ul>	<ul style="list-style-type: none"> <li>• Social skills</li> <li>• Family cohesion</li> <li>• Parent/child bonding</li> <li>• Better school achievement</li> <li>• School policy on harassment/bullying</li> <li>• Positive school climate</li> <li>• Early screening and detection</li> <li>• Mediation Programs</li> <li>• Respect for difference education</li> <li>• Natural/family supports</li> <li>• Social services</li> <li>• School/community linkages</li> </ul>	<ul style="list-style-type: none"> <li>• Assertiveness Training Programs</li> <li>• Family Resource Centers</li> <li>• Social Skills Training</li> <li>• Creating Lasting Connections*</li> <li>• School Based Health Clinics</li> <li>• Family Bereavement Program</li> <li>• The Collaborative Divorce Project</li> <li>• The Olweus Anti-bullying Program</li> <li>• The School Crisis Prevention and Response Initiative</li> <li>• Primary mental health</li> </ul>

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Life Cycle Stage	Risk Factors	Protective Factors	Sample Best Practices/Programs *
	<ul style="list-style-type: none"> <li>• Parental substance abuse</li> <li>• Parental mental illness</li> <li>• Parental domestic violence</li> <li>• Inappropriate/inconsistent parenting practices</li> </ul>	<ul style="list-style-type: none"> <li>• After school activities</li> <li>• Support groups</li> <li>• Parenting/family skills training</li> <li>• In school interventions</li> <li>• Tutoring/mentoring</li> <li>• Alternative activities/programs</li> <li>• Peer mentors/ peer counseling</li> </ul>	<ul style="list-style-type: none"> <li>• project*</li> <li>• Communities in Schools/Waterbury</li> <li>• Neighborhood Revitalization Zones</li> <li>• Expanded school mental health programs</li> <li>• School based prevention program</li> <li>• Mentoring*</li> <li>• Life skills training *</li> <li>• Reconnecting youth*</li> </ul>
<b>Adolescents/Young Adults</b> (including Transitional Youth)	<ul style="list-style-type: none"> <li>• Low commitment to education</li> <li>• Early drug use onset</li> <li>• Academic failure</li> <li>• Behavior problems</li> <li>• Peer rejection</li> <li>• Alienation from friends and family</li> <li>• Sexual minority status</li> <li>• Disabilities</li> <li>• Being harassed/bullied</li> <li>• Parental substance abuse</li> <li>• Parental mental illness</li> <li>• Parental domestic violence</li> <li>• Inappropriate/inconsistent parenting practices</li> </ul>	<ul style="list-style-type: none"> <li>• High commitment to education</li> <li>• Academic achievement</li> <li>• High coping/stress management skills</li> <li>• Peer acceptance</li> <li>• Greater attachment to friends and family</li> <li>• Diversity and tolerance initiatives</li> <li>• Community service opportunities</li> <li>• Positive school climate.</li> <li>• Parenting/child interaction</li> <li>• Consistent, appropriate parenting</li> <li>• Parenting skills</li> </ul>	<ul style="list-style-type: none"> <li>• Life Skills Training*</li> <li>• Positive Youth Development Program*</li> <li>• Mentoring programs,* e.g. Across Ages, Big Brothers/Big Sisters</li> <li>• Youth Oriented Policing/New Haven</li> <li>• Student Assistance Programs</li> <li>• Training for helping professionals on competency in sexual minority issues</li> <li>• Reconnecting Youth*</li> <li>• Strengthening Families Program*</li> </ul>
<b>Adults</b>	<ul style="list-style-type: none"> <li>• Couple relationship problems</li> <li>• Marital separation /divorce</li> <li>• Postpartum depression</li> <li>• School dropout</li> <li>• Economic hardships /joblessness</li> <li>• Child rearing problems</li> <li>• Occupational stress</li> <li>• Involuntary job loss</li> <li>• Immigrant minority status</li> <li>• Post traumatic stress</li> <li>• Caregiver burden</li> </ul>	<ul style="list-style-type: none"> <li>• Marital adjustment</li> <li>• Educational achievement</li> <li>• Rapid physical &amp; psychological recovery</li> <li>• Co-worker/supervisor support</li> <li>• Positive parenting</li> <li>• Stress Management</li> <li>• Family/social supports</li> <li>• Respite opportunities</li> <li>• Diversity and tolerance initiatives</li> </ul>	<ul style="list-style-type: none"> <li>• Separation and Divorce Program (University of Colorado)</li> <li>• Caregiver Support Program</li> <li>• Employee Assistance Programs (EAP)</li> <li>• 12-Step program</li> <li>• Vocational program</li> <li>• Strengthening Families Programs*</li> <li>• Training for helping professionals on competency in sexual minority issues</li> </ul>

REPORT OF THE GOVERNOR'S BLUE RIBBON COMMISSION ON MENTAL HEALTH

Life Cycle Stage	Risk Factors	Protective Factors	Sample Best Practices/Programs *
	<ul style="list-style-type: none"> <li>Disabilities</li> <li>Sexual minority status</li> </ul>		
<b>Seniors</b>	<ul style="list-style-type: none"> <li>Widowhood</li> <li>Bereavement</li> <li>Family isolation</li> <li>Depression</li> <li>Social Isolation</li> <li>Caregiver burden</li> <li>Poor health</li> <li>Disabilities</li> <li>Sexual minority status</li> <li>Grandparents raising grandchildren</li> </ul>	<ul style="list-style-type: none"> <li>Social adjustment</li> <li>Strong family/neighborhood attachment</li> <li>Involvement in social activities</li> <li>Respite opportunities</li> <li>Medical Care</li> <li>Diversity and tolerance initiatives</li> <li>Advocacy services/training for grandparents and skills training for children</li> </ul>	<ul style="list-style-type: none"> <li>Education for Primary Care Physicians (PCPs) in recognizing and treating mental health problems in seniors</li> <li>Depression Screening</li> <li>Intergenerational Programs/Across Ages*</li> <li>They Help Each Other Spiritually (THEOS)</li> <li>Widow to Widow</li> <li>Respite Programs</li> <li>Training for helping professionals on competency in sexual minority issues</li> <li>Grandparents raising grandchildren program</li> </ul>

\*These are Best Practice programs that have been evaluated using research methods or have used prevention principles to guide their development. The other programs have shown encouraging results.

The following two programs from the table illustrate best practices.

Healthy Families – The Healthy Families Initiative is a prevention program for all new parents. All families are linked to medical care to assure optimal health, timely immunizations and well childcare. The program also promotes positive parenting and child development. Families with multiple needs are offered home visiting services and may be connected to a range of services in the community. Nearly 60 percent of the mothers have been victims of severe forms of abusive and neglectful behavior as children – placing them at much greater risk of abusing and neglecting or mistreating their own children. A little more than one-half of the families had a history of crime, drug abuse or mental illness.

The Healthy Families Initiative that began as a pilot program five years ago has been significantly expanded across the state, due to increased funding. The program has been field tested, well researched and rigorously evaluated by the University of Hartford Center for Social Research. The program components have received exemplary status for ‘best practices’ by Office of Juvenile Justice and Delinquency Prevention and the Substance Abuse and Behavioral Health Division of the federal Department of Health and Human Services. A fifteen-year study of early home visiting with high-risk families showed long term benefits for both the adults and

children who participated in the program. The Healthy Families initiative is currently operating in twelve of the twenty-nine hospitals in Connecticut with four new programs scheduled to begin in September 2000.

Programs for Older Adults - Many older adults experience loss with aging, particularly the loss of spouse. About 800,000 older Americans are widowed each year. Bereavement is a risk factor for depression. Widows and widowers are at risk not only for depression, but also for alcohol and drug use/abuse, and social adjustment problems. One approach to preventing depression is through grief or bereavement counseling for persons who have lost a spouse. Grief counseling is considered an effective intervention in preventing depression among widows and widowers.

Best practice models for grief counseling include They Help Each Other Spiritually (THEOS) and Widow to Widow: A Mutual Health Program for the Widowed (Silverman, 1988). These are effective self-help peer groups for bereavement. Studies have found that widows and widowers who participated in THEOS showed improvements on health measures such as depression, anxiety, and self-esteem. While those who participated in Widow to Widow experienced fewer depressive symptoms.

Use of the THEOS and Widow-to-Widow models particularly in settings such as elderly housing complexes, senior centers, funeral homes, and churches would prevent isolation and promote health as an older adult goes through the bereavement process.

### **Prevention Panel Issue #1 – Integrate Primary Prevention into the State System**

Less than 10 percent of the state's budget goes toward prevention. Yet, unprecedented numbers of children and adults currently lack family and community supports, early learning opportunities and support services to enable them to develop educationally, personally, and socially or explore new options for health promotion and early intervention. While many mental health and prevention-related programs and services are offered through schools and public agencies, they are often under-funded, fragmented and may even compete with one another for funds.

For a comprehensive mental health service delivery system to be feasible and effective, early intervention and prevention must be part of the continuum of care. Prevention needs to become embedded in state policy with communities leading the implementation locally.

Local systems of care are critical to mental health promotion, intervention and treatment. Substantive planning must take into account broad social and neighborhood indicators as well as individual family circumstances. The policies, outcome measures, and goals of programs need to be linked to promote mental health in Connecticut.

Priorities in mental health have in the past been developed out of institutional mandate, with limited focus on coordination, consumer access or empirically driven evidence of value. Prevention performance benchmarks and outcome measures have not been well developed, and when present, differ across funding streams. There are multiple funding streams and a low rate

of evaluation. For example, effective prevention of drug abuse, violence, school failure, teen pregnancy, welfare dependence and crime all share common desired outcomes that can be impacted by early childhood programs, family strengthening, community or neighborhood strengthening, mentoring, school effectiveness and social support networks. It is recommended that state agencies create a system of services that deliberately aligns the use of resources with short and long term goals of improving the well being of children and families, and improving the quality of life in their communities.

A redirection of some of the current mental health resources towards prevention and community systems of care, as well as improved federal funds maximization could stretch resources for a proactive prevention focus on community mental health. The savings from a primary prevention strategy could be creatively directed, as needed, for the citizens of the state.

**Prevention Panel Recommendation #1 – Integrate Primary Prevention into the State System through Model Policy and Structural Changes which include:**

(a) Development of a comprehensive prevention mental health plan which spans the life cycle and is built on state-of-the-art prevention research and practices. (b) Investment in a primary prevention budget across departmental lines addressing target populations throughout the life cycle. All state departments should adjust and craft annual budgets, which address prevention as well as service need and crisis. In the first year, a significant percentage of each department's mental health budget should go towards prevention, to align state practices with federal trends. For the next five years, each department should continue this investment with an increasing percentage. (c) Development of a prevention impact assessment for state policies and budget expenditures. Each state department, as well as policy committees in the Legislature, should assess the impact of prevention planning and policy and should annually report the anticipated outcomes of the prevention policy to the Governor and legislative leadership. Impact statements should include outcomes in projected savings to the taxpayer and long-term benefits to the community. (d) Development of indicators and benchmarks to guide primary prevention planning and program implementation outcomes should be developed across the three branches of government. A committee to be selected by the Governor's Blue Ribbon Commission on Mental Health should establish these indicators. (e) Creation of training and education initiatives on prevention for pre-professional training programs, the established workforce, health systems, and the community. (f) The development of linkages between prevention initiatives, intervention and treatment programs.

**Proposed Enhancement** – This recommendation builds on an already existing interagency framework and is consistent with outcomes adopted by other related mental health focused initiatives in Connecticut, including the Alcohol and Drug Policy Council, Governor's Prevention Initiative for Youth and the state's youth violence prevention initiatives. These initiatives are highly coordinated and based on the research of Hawkins and Catalano, the Search Institute, National Institute of Mental Health, as well as a wide range of other studies that have produced comparable analyses of the factors that increase or decrease the risk that mental health problems will occur.

**Expected Impact** – Implementing this recommendation will encourage state agencies to work together more effectively and better coordinate services, policy, data, and benchmarks in primary prevention. There is a system of benchmark/indicators based on these risk/protective factors that has been established in Connecticut and nationally. DMHAS has created a baseline of benchmark data that can be used as the basis for further measures of outcomes. These benchmarks should be agreed to by all state agencies with each state agency collecting data on those that are most relevant to their targets/populations.

Coordination of planning will help prevention to become embedded with in state policy and programs. This, in turn will enable implementation of best practices and improve child and adult outcomes in mental health. Agency budgets will shift away from use of dollars for crisis. This will eventually cause significant savings to the public. For example, state agencies could explore the feasibility of redirecting a small portion of dollars from the Children's Health Insurance Program, the children's mental health block grant, and adult mental health block to support prevention programs. This will result in safer and stronger communities and increase their capacity to address life transitions, crisis events, and chronic situations. As prevention programs are implemented, more parents, teachers, peers, clergy and caregivers will be able to nurture with skill and confidence, and the quality of life will improve for the community at large.

#### **Prevention Panel Issue #2 – Best Practices in Prevention**

Best Practices in prevention should be made available throughout the state targeting neighborhoods and supporting community leadership. Preventive interventions must be undertaken in a wide range of community settings and through collaborations/coalitions with key community stakeholders. This increases the likelihood that interventions will foster change at group, organizational and the community will sustain community levels, as well as individual levels, and those program efforts for longer periods of time.

Understanding where people live, their assets and supports provides a blueprint for long-term systemic change. Programs and policies geared to working with the dynamics of neighborhoods and local municipal functions will help mobilize the entire community to take responsibility for children and adults and build the broad support systems and services necessary for healthy families and communities.

Connecticut must make the financial investment and commitment to bring the best prevention practices to families throughout the state who want and need them. We also need to increase the use of research tested prevention programs for at-risk children and adults.

**Prevention Panel Recommendation #2 – Establish Best Practice Primary Prevention Programs**

(a) Implement and bring to scale where possible, best practice primary prevention programs that have good health outcomes and cost savings, which are consonant with state policy for targeted populations and communities throughout the state. (b) Create Prevention Community Incentive Grants where communities assess needs, gaps, assets and define primary prevention strategies and implementation plans based on research-based practice, model policy and public will.

**Proposed Enhancements**

The State should use incentive grants to establish model prevention programs that target schools, families, and neighborhoods. Communities seeking these grants would need to justify methods, research, standards and demonstrate broad as well as expert community participation. Programs and services should be provided in a manner that respect life-span issues, ethnic and cultural diversity, sexual orientation, language differences, and the unique nature of specific disabilities and risk factors.

In order to realize the benefit of this recommendation, Connecticut should launch a knowledge dissemination and application initiative to establish best practice programs throughout the state. Agencies should commit themselves to identifying known and proven preventive interventions aimed at ameliorating emotional/behavioral distress. Through a concentrated effort across agencies, providers and communities, specific prevention strategies that have documented proof of viability should be highlighted e.g., educational interventions that teach mood enhancement skills such as (the San Francisco Depression Prevention Project).

**Expected Impact** - Prevention Community Incentive Grants will allow communities to identify their own needs and take ownership for the interventions utilized.

By supporting best practice programs, children and adults will show less at-risk behavior including depression, suicide, school/work failure, and child abuse. Proven primary prevention programs will decrease mental health problems, diminish safety concerns in communities, save dollars for the state and town and enhance the quality of life of all citizens. Communities will be empowered to focus on promoting wellness including equipping individuals, families and communities with proven skills and knowledge to help them cope with life challenges and strengthen individual and collective helping abilities for the common good.

**Prevention Panel Issue #3 – Promote Mental Health as Way of Life**

Mental Health should be promoted as a way of life, not just an intervention. Mental health promotion is the process of enhancing the capacity of individuals to take control over their lives as a means of improving their mental health, while simultaneously strengthening the communities' ability to support its members. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for equity and personal dignity.

Mental health promotion involves exploration of the paths to good mental health, which include enhancing individual capacity as well as improving the external environment. Mental health promotion strategies include the development of public policy, reorienting services, strengthening the individual and community skills, supportive environments and public participation. Mental health promotion is about quality of life, optimal development of abilities and health attitudes. It is a value, a way of life and large-scale strategy rather than an intervention against risk factors or illness.

The World Health Organization over 40 years ago defined health as “a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.” Health is a state of well being associated with not only the physical capacity but also the resources available to successfully handle life’s challenges. Mental health promotion bolsters and supports individual and community well being. It focuses on factors, which influence health, rather than risk factors.

**Prevention Panel Recommendation #3 – Create a Prevention Strategy Committee**

Create a Prevention Strategy Committee of the Mental Health Policy Council to elevate, advance, and sustain the visibility of mental health promotion as an integral aspect of policy, research and health promotion.

**Proposed Enhancement**

This recommendation will serve to disseminate information on best practices and promising approaches to prevention, policies and actions that will elevate prevention where it will be viewed as equally important to treating mental illness. Implementing this recommendation will: a) summarize current information and encourage further research on factors that influence mental health and the linkages between them; b) clarify concepts and develop definitions that distinguish mental health promotion from mental illness and disease prevention; c) influence the integration for a mental health promotion approach in research related to health, social and economic development; d) influence the incorporation of mental health promotion strategy into program development such as community involvement, professional education programs; e) enhance existing state agency infrastructure to advance and support the recommendations set forth in the Governor’s Blue Ribbon Task Force Report; and foster interdepartmental planning, coordination and funding initiatives.

**Expected Impact** – Connecticut will maximize collaboration of state agencies, academic, private and community partners in producing and offering conceptual models and expertise in the area of mental health promotion. A preventive mental health agenda will lead to an increase in model public policy, reorientation of services, strengthening of skills in the individual and community, supportive environments and public participation. Substantive mental health promotion, woven into policy, public education and service delivery, can improve resilience, self-efficacy and coping skills of both the individual and community.

## Treatment and Intervention

### Introduction

Recent exciting scientific advances have made mental illnesses eminently treatable and have enhanced our ability to offer humane, informed, and *effective* care. Nevertheless, we are unable to deliver these treatments to the people most in need. Connecticut, like much of the nation, faces many of the barriers that prevent individuals with mental illness and substance abuse disorders from receiving fully the benefits of improved treatments. Some of these challenges are; overcoming stigma; making an effective transition from an inpatient-based to a community-based system of care; having care distributed across both public and private sectors; finding ways to integrate disparate funding streams; overcoming the discrepancy between care that research suggests is “best” and care as typically delivered in the real world; addressing the increased prevalence of co-occurring mental illness and substance use; making treatment responsive to cultural, ethnic, and linguistic differences; expanding services to respond to the increasing number of elderly individuals needing mental health treatment; providing specialized treatment for specific disorders; and delivering effective treatment services for children and adolescents.

It is now known that major depression, in comparison to cancer, accounts for a larger share of the societal burden of lost productivity associated with illness. It also is known that existing treatments are more effective in bringing about recovery from depression than from many of the chronic physical illnesses. Yet most people who experience a diagnosable mental disorder, including depression, will neither seek nor receive appropriate treatment. With a longer duration of untreated illness comes increased risk for the morbidity and mortality associated with mental illness.

Given the unique treatment needs of children and adolescents, the Treatment and Intervention Panel explored the benefits and risks of separating into adult and child subgroups. The Panel recognized that childhood and adolescence are characterized by unique transitional changes and significant developmental demands, thereby constituting a time of increased risk, prior to full-blown emergence, for a majority of mental disorders. The Panel also noted that treatment approaches for children are different from those for adults. Additionally, in Connecticut, the organization, delivery, and management of treatment services for adults and children also are distinct and separate. The coordination of services between adults and youth, as has been noted previously in this report, is consequently made more complicated by differences in funding streams and treatment providers. The adult and child subgroups of the Treatment and Intervention Panel agreed that their differences in focus were substantial enough to warrant framing their discussions separately. For the purpose of clarification, both subgroups understand their scope to include not only traditional treatment services such as psychopharmacology and psychotherapy, but also those interventions at the core of community-based systems of care such as outreach; case management; crisis intervention; residential, vocational, and psychosocial rehabilitation and supports; service advocacy; and community development strategies.

## **TREATMENT AND INTERVENTION: ADULT MENTAL HEALTH**

Connecticut has been involved in shifting the primary locus of care from institutional settings to a community-based system of care because of advances in treatment and the recognition of the importance to provide care in the least restrictive environment. This shift has placed tremendous strain on both public and private facilities as they struggle to keep pace with the increased demand for community services. At the same time, the mental health care system is a complex and multi-faceted structure that can be overwhelming to navigate even for the most informed consumer. Treatment services are delivered by an array of providers that includes state-operated and private non-profit hospitals and clinics, general hospitals with psychiatric treatment services, private agencies, and individual providers and group practices. While mental health services are organized through a network of local mental health authorities (LMHAs), substance abuse services are funded directly through DMHAS contracts with private non-profit agencies and through a fee-for-service payment mechanism established recently as part of the General Assistance Behavioral Health Program.

Many who seek treatment are bewildered by this maze of paths. Others in need of care are stymied initially, and throughout the course of treatment, by the lack of information about where to seek effective and affordable services. In both the public and private systems there are multiple portals of entry that cut across DMHAS and other state agencies such as DCF, the Department of Social Services, Department of Correction, and the Court Services Support Division. Once successful in entering the system, individuals must move among agencies, with treatment often poorly coordinated by disparate providers. Public hearings have identified these problems of access to treatment and information is pervasive throughout the system.

Through the combination of state-operated and private non-profit LMHAs, regions aim to provide a full spectrum of services. However, political and fiscal realities are such that services are not always available or accessible in a timely fashion. While urban areas may have a full spectrum of care, waiting lists pose a barrier to recovery when the most appropriate service is not delivered to the consumer at the most opportune time. Whole segments of the population confront difficulties accessing care due to linguistic, ethnic, or cultural problems. Individuals in rural areas may have to travel long distances to obtain needed services. Not only does the geographical distance present a hardship for clients and loved ones in such cases, but transportation and staff costs also increase for the provider who may be responsible for connecting the client with the service. Even when agencies do have a full complement of traditional mental health services, they may have difficulty treating the number of individuals with co-occurring conditions or special needs, or following treatment protocols applicable to individuals with a specific clinical profile.

Additional obstacles to receiving essential services are evident in the difficulty inpatient facilities face in discharging individuals ready to return to the community. In the case of certain special populations, these impediments to care may be even more complicated. For example, Connecticut faces a growing number of elderly individuals with mental disorders that include depression, anxiety, and Alzheimer's disease. The highest rate of suicide is found among older males. As noted in the Surgeon General's report: "As the life expectancy of Americans continues to extend, the sheer number – although not necessarily the proportion – of persons experiencing mental disorders in later life will expand, confronting our society with

unprecedented challenges in organizing, financing, and delivering effective mental health services for this population.”

Another formidable task for Connecticut is the challenge posed by the large population of individuals with co-occurring psychiatric and substance use disorders. As many as half of all persons with serious mental illness develop alcohol or other drug abuse problems at some point in their lifetime. Over the past several years, the state has seen an increase in the number of individuals with co-occurring disorders whom it serves. Connecticut also has witnessed an increase in critical incidents that are related to the combination of mental illness and substance abuse. As a result, the state will need to continue developing an integrated treatment approach that combines interventions, by the same providers, directed simultaneously to both conditions. The effectiveness of such a treatment approach has now been demonstrated by over ten years of national research.

Special consideration needs to be given to the identification and treatment of trauma. Severe trauma and domestic violence may have long-lasting impact. Traumatized individuals include those who have experienced parental death, domestic violence, and geographic dislocations as in the case of refugees. In recent years there has been an increased effort to identify child abuse and domestic violence cases in Connecticut that has overwhelmed the community resources developed to address these problems. These resources will need to be enhanced to enable the community service system to meet the demands that this increase has imposed on the system.

Over the past decade, both nationally and locally, there has been an increase in the number of people with mental illness becoming involved in the criminal justice system. In addition, there are many more offenders being treated by DMHAS including those who are being supervised in the community under the auspices of probation, parole, and other community criminal justice programs.

The criminal justice system involves multiple state agencies with varying goals and responsibilities in the processing and disposition of criminal defendants. Continuity of effective care in treatment for people with mental illness in the criminal justice system poses unique challenges for the different agencies to provide cooperatively a unified system of care.

In addition to the needs of special populations, the dynamics of financing mental health services have influenced availability of, and access to, care across the nation. Managed care has found its way into publicly-funded health care, with national managed Medicaid enrollees rising from 9 to 48 percent between 1988 and 1997. Many of the tools initially developed by managed care were designed to address a perceived lack of clarity and accountability in the treatment process and outcome of mental health care. In practice, however, these tools have come to be used instead to emphasize cost containment over quality of care. Nonetheless, such tools as utilization review and management, outcomes monitoring, and the development of clinical pathways (a set of predetermined activities designed to address a particular disorder) can be useful in efforts to more equitable and effectively allocate the scarce resources available to fund mental health services. These advances in practice management technology, along with the updated training and skill development needed to implement them, will now need to be transmitted to all elements of the service delivery system across the state.

The consumer, recovery, and family support movements have provided a positive and hopeful influence on the nature of services to be offered. The voices of consumers, advocates, persons in recovery, and their loved ones have been eloquent in demanding a system that is responsive to their needs and aspirations. A recovery paradigm emphasizes the strengths and life goals that a client brings to the treatment and rehabilitation enterprise, rather than focusing only on the amelioration of symptoms. Through a collaborative partnership among the individual, his or her significant others, and health care providers, the aims of a recovery-oriented system of mental health services accent the following: bringing about reductions in the signs and symptoms of the disorder; minimizing the disruption of the individual's on-going pursuits; and enhancing daily functioning to enable the person's achievement of the normative life goals of participating in meaningful activities, reciprocal caring relationships, and the on-going rhythms of community life. Only recently established as a core vision, the state has many challenges to overcome in implementing the values of a recovery paradigm throughout the community-based service system.

## **Key Issues and Recommendations For Adult Mental Health**

### **T/I Panel Issue #1 – Treatment and Policy**

Currently, Connecticut lacks a mechanism for the development of clinical policies that could help the state move toward its goal of facilitating the recovery of individuals with mental illness.

**Background** – Although DMHAS has responsibility for setting policy, specific recommendations regarding treatment and interventions have not traditionally incorporated the considerations of a variety of concerned parties in a structured and planned manner. The result is that few clinical policies, when initially advanced by DMHAS leadership, reflect concordance among different constituencies. Whenever possible, it is desirable that policy reflect interactive collaboration among consumers, providers, legislators, advocates, and agency managers.

### **T/I Panel Recommendation #1 – Establish a Treatment Advisory Committee**

The Mental Health Policy Council vehicle referenced elsewhere in this report should incorporate a Treatment Advisory Committee comprised of key constituency groups. Constituents should include, but not be limited to, DMHAS, DCF, DOC, and other state agency leadership, persons in recovery, providers, legislators, family members, community representatives, and professional society representatives. These stakeholders would be charged with identifying innovations in treatment and intervention and making recommendations about the possible incorporation of these developments into everyday use. With assistance from academic researchers in public and private universities and colleges and other human service agencies, the Treatment Advisory Committee would focus on interventions and populations of high policy relevance. These stakeholders would identify areas in which information is needed to help shape policy, and the Committee would help to provide and disseminate this information through multiple mechanisms, including: (1) Consulting individuals in recovery and their families to assess their needs and preferences; (2) reviewing the literature and surveying other state behavioral health entities with regard to best practices in the area in question; (3) alerting DMHAS and relevant agencies of behavioral health care of important developments in the treatment of behavioral

health disorders; and (4) providing advice and technical assistance in disseminating information about, and promoting the adoption of, best practices.

## **T/I Panel Issue #2 – System of Care**

Lack of access to and availability of basic service elements linked comprehensively in an integrated system of care in some parts of Connecticut undermine the recovery of some individuals with serious mental illness.

**Background** – While the panel recognizes that a comprehensive system of care must include immediate access to quality inpatient care, this recommendation focuses on the continued development of community-based services. It acknowledges state and national trends toward treatment in the least restrictive setting, as well as the chronic problem of waiting lists for community programs. Significant gaps in this system exist for many individuals who have moderate to severe disabilities due to: a lack of access to certain services in regions that do not have a full continuum of care; a lack of access to available services due to waiting lists, lack of transportation, or other barriers; a lack of coordination and integration of services offered; and a lack of differentiation in services based on such factors as age, gender, geographical location, culture, race, ethnicity, sexual orientation, religion, language, co-morbid conditions, and clinical profile.

Local community-based systems of care should be expanded to include clinical and rehabilitative care that provides specialty services requiring particular expertise or more intensive resources. By way of example, specialized treatment approaches are essential for those individuals diagnosed with mental illness and substance abuse disorders, individuals who have experienced trauma; elderly individuals needing accurate identification of symptoms and appropriate treatment; those individuals with distinct cultural or linguistic needs; individuals diagnosed with severe and pervasive impairment in several areas of their psychological or neurological development. These changes are essential if treatment is to expand beyond the one-size-fits-all mentality.

Despite the availability of effective treatments, and partly as a result of stigma, many individuals who develop a severe mental illness are not identified at a point early enough in the course of illness when treatment could prevent the unnecessary loss of residential, vocational, educational, and social involvement. In fact, the average time a person will suffer with an undiagnosed severe mental illness prior to receiving appropriate psychiatric care is currently over two years. During this period, significant damage can be done to the person's life, including the severing of ties to normative life pursuits such as work, school, and relationships. A comprehensive system of care therefore recognizes that early identification and intervention is key to achieving the full potential of a recovery vision of self-determination and independence.

At the other end of the developmental spectrum, attention needs to be paid to the increasing number and needs of the aging population. As noted in the Surgeon General's report, "disability due to mental illness in individuals over 65 years old will become a major public health problem

in the near future because of demographic changes.” Mental health issues affecting older adults tend to be lost at the juncture between the aging and mental health fields, each believing the other better equipped to address the problems. It is imperative to augment collaboration and cooperation between agencies and treatment levels to address these concerns.

**T/I Panel Recommendation #2.a - 2.b – Assess and Expand the System of Care**

2.a. DMHAS should assess presently existing needs and, based on identified service gaps and critical local waiting lists for services, develop a plan to expand the community-based system of care for individuals with serious mental illness through public and private partnerships that address a full spectrum of services. Key links in the further evolution of this system will include, but not be limited to:

- ❑ In-home services
- ❑ Co-occurring disorder services
- ❑ Affordable housing and residential support services across the life span with a particular focus on the elderly
- ❑ Assistance in obtaining and maintaining employment
- ❑ Intensive outpatient services
- ❑ Services for individuals who have experienced trauma
- ❑ Community outreach services to settings such as nursing homes
- ❑ Coordination of primary medical and dental care

2.b. DMHAS, DCF, DOE, local school systems, probate, juvenile, family relations and criminal courts, and other relevant agencies should encourage the identification of adolescents and young adults showing early signs of severe mental illness. Interventions should focus on containing and reducing the signs and symptoms of disorder and on preserving the person's involvement in normative life tasks such as school, work, and social relationships.

2.c. DMHAS must work to produce a coherently integrated system of mental health and substance abuse services.

**T/I Panel Issue #3 – Quality of Services**

It is difficult to keep the quality of practice on the front lines at the highest level across the state. While an array of clinical and rehabilitative services might be available in a particular region, care actually delivered by providers in that region may or may not reflect the field's best practices.

**Background** – All too often, treatment practices have been linked to the historical distribution of resources or based on habit rather than on evidence of an intervention's effectiveness. Individual agencies are not engaged in any formal dialogue about other, more effective practices. Staff training and skill development do not keep pace with advances in the field, and there is little knowledge transfer between the state's academic institutions and the front line staff who provide the majority of care. Finally, there is no standard of care incorporating a “best practices” approach and no mechanism for the dissemination of such information.

Just as linkage and communication systems can and do fail to follow an individual between agencies and various levels of care, treatment advances and specialized interventions are not translated into standard treatment protocols. Institutionalizing exposure to new information as well as enhancing training and skill development are avenues toward standardizing quality across state and private non-profit agencies in urban and rural areas. By way of example, new practice protocols on the treatment of bipolar disorder recently have been published. The ability to disseminate such information routinely would assure that all of Connecticut's citizens have access to state-of-the-art services regardless of financial or geographic circumstances.

**T/I Panel Recommendation #3 – Ensure Quality of Services**

The State of Connecticut should ensure that treatments and interventions employed in clinical and rehabilitative practice, as well as strategies for community integration, attain and maintain a standard of quality that is consistent across the regions and informed by current clinical research and the consumer/recovery and family support movements. The practices of frontline clinicians and rehabilitation specialists should be monitored periodically and staff should be informed of innovations in clinical and rehabilitative practice and emerging strategies for improvement of the service system. Specific areas in which there currently are pressing needs for an infusion of new and more effective interventions are: pharmacotherapy; risk assessment and management; housing, vocational, and social supports; disorder-specific treatments; neurocognitive assessment and rehabilitation; and comprehensive approaches to multiple-need populations (e.g., persons with co-occurring conditions) and cultural competency. The Mental Health Policy Council mechanism recommended above will facilitate implementation of this recommendation, as will strengthened connections between DMHAS and the state's academic institutions.

**T/I Panel Issue #4 – Persons with Mental Illness in the Criminal Justice System**

Over the past decade, there has been an increase in the proportion of offenders in the criminal justice system that has a serious mental illness. These rates reflect a higher percentage of the occurrence of mental illness than in the general population. The criminal justice system is a complex administrative structure that involves multiple state agencies and requires a high level of coordination. The lack of a comprehensive treatment system that provides for continuity of care as a person travels through the criminal justice system is detrimental to both the provision of quality treatment and the promotion of public safety.

**Background** – From the point of arrest through pre-trial services and the post-sentencing process, either in the community or an institution, the array of services available within the criminal justice system has not kept pace with those available in the community. Diversion services are not offered in 11 lower courts and post-sentencing alternatives are not available at all in many areas of the state.

Early identification of offenders with co-occurring disorders is critical for successful diversion of nonviolent offenders. Diverting individuals with mental illness out of the criminal justice system, where appropriate, should be a primary consideration. Currently, this identification does not begin until arraignment or post-arraignment. The ability to enhance this identification at the

point of arrest and lockup would facilitate diversion into the mental health system or promote continuity of care as an offender is processed through the system. Alternatives to incarceration in both pre and post-adjudication stages are limited due to the lack of a comprehensive service system for the offender with mental illness and those with co-occurring disorders. Currently, mental health diversion programs only exist in half of the court districts; no universal mental health and co-occurring substance abuse screening tool is used by all agencies; and community criminal justice programs are not designed for offenders with psychiatric disabilities.

Institution-based treatment for offenders with mental illness in both the Department of Correction and DMHAS has improved over the past few decades. However, attention needs to be paid by all to ensure that the capacity and quality of such services continue toward the goal of eventual community treatment for such offenders without threatening community safety.

While offenders are in the criminal justice system, they enter and exit the mental health system at various points, therefore, DMHAS needs to develop a system of care for those with mental illness in collaboration with other agencies (Department of Correction, Judicial Branch's Court Supported Services Division, Board of Parole, Department of Children & Families, Department of Mental Retardation, Department of Labor, Department of Social Service, Psychiatric Security Review Board and Department of Education).

**T/I Panel Recommendation #4 – Address Needs of People with Mental Illness in Criminal Justice System**

4.a. Forensic community treatment system: A spectrum of programs jointly developed by DMHAS, the Department of Correction, and the Judicial Branch should be initiated for the treatment of offenders diagnosed with mental illness and/or substance use disorders in the community. These community services should be systematically linked to mental health services provided in criminal justice settings. These services should emphasize diversion from the criminal justice system and release from confinement. In order for this community system of care to be effective, the mental health criminal justice diversion programs should be expanded to cover all lower court districts. The community care system should develop linkages with other agencies to ensure that essential supportive services such as housing, employment, and vocational services are provided, and that treatment is based on a risk management model with specialized forensic case management and monitoring, and specialized treatment services. This community care program should be accessible from all geographical areas. The goal of this model should be to incorporate both the goals of high quality mental health services and reduction of criminal recidivism.

4.b. Co-occurring disorders: As co-occurring disorders (mental illness and substance abuse/dependence) are over-represented in the criminal justice system, screening and identifying these individuals at the earliest possible stage is paramount. Toward that end, the panel recommends the implementation of a universal screening tool and pre-service and in-service training (as appropriate) in mental health and substance abuse recognition/triaging for those professionals involved in all stages of the process (e.g.: Police, Prosecutors, Defenders, Judges, Clinicians, Custody personnel). The intent is to emphasize recognition and triaging of individuals who require treatment for co-occurring disorders, as the first step in the development of an array of

specialty services targeting co-occurring disorders.

4.c. Need for expanded high-intensity settings: Inpatient settings for the criminal justice population are necessary treatment options for some offenders. The demand for high intensity bed capacity has risen and is expected to persist. Collaboration between DMHAS, DOC, DCF, the Probate Courts and Judicial Branch, and other agencies will need to focus on developing community services for the subgroup of offenders with mental illness who pose a significant risk to public safety, but who may be able, with specialized services, to be managed safely in the community. At the same time, DMHAS needs to increase its bed capacity at the Whiting Forensic Division at Connecticut Valley Hospital.

## **Treatment and Intervention: Children's Mental Health**

Despite many challenges, there are a number of areas of the success in treatment and intervention that provide promising prototypes for the development of a truly functional system of mental health services for Connecticut's children. In many communities, developing systems of care have brought together families, community representatives, and professionals in a collaborative effort to increase the quality of services for children. The development of the DSS task force report, as required by the legislature, represents an additional example of collaboration between State agencies, communities, and families with the goal of improving Connecticut's mental health system for children. Other efforts to improve the quality of mental health services for children include:

- ❑ The initiation of two continuum of care projects by DCF
- ❑ The joint Transition Services Program operated by DMHAS and DCF
- ❑ The Community Policing Project in New Haven
- ❑ The "Self-Determination" model sponsored by the Department of Mental Retardation
- ❑ The proliferation of School-based Health Clinics
- ❑ The establishment and operation of 24-hour mobile psychiatric response units
- ❑ The development of respite services for families and care givers
- ❑ Extended day programs
- ❑ The Husky B service delivery models
- ❑ The collaboration between the Court Support Services Division and DCF to provide acute psychiatric hospital care to the juvenile justice population

These and other numerous programs are indicators of the increased commitment to children's mental health.

In spite of these accomplishments, there is a gap between the mental health services that are available and those that could be available to meet the needs of Connecticut's children and youth. Factors contributing to this gap include, first, unequal and inconsistent access to care that varies depending on wealth and geographic location and, second, a shortage of qualified and culturally competent service providers. There are a number of other barriers, including:

- ❑ Not enough attention is paid to prevention and early intervention.

- ❑ Not enough professionals have been trained to meet the diverse and challenging needs of children, particularly those requiring a broad spectrum of interventions.
- ❑ Out-of-state residential placements, used for too many children, drain resources that could go into the development of community-based mental health treatment.
- ❑ Funding for effective treatment and wraparound services is difficult to access and often inadequate.
- ❑ The insurance industry imposes overly restrictive criteria (“medical necessity”) before authorizing payment for services; furthermore, it focuses on the immediate reduction of symptoms while ignoring psychosocial stressors, developmental realities, and the need for a longer-term perspective.
- ❑ State agencies, local schools, and community providers do not coordinate their efforts and are reluctant to take responsibility for addressing mental health problems because of the attendant financial burden of doing so.
- ❑ Families and consumers are often not included in treatment planning and policymaking.
- ❑ State agencies responsible for developing policy often lack cultural and linguistic sensitivity and competence.
- ❑ The residential placement of children out of state often severs bonds and tears families apart.
- ❑ The definition of mental health treatment is so narrow that it excludes the prevention-oriented building of skills and other outpatient interventions that significantly contribute to positive outcomes.

To address the current and long-term mental health needs of children, Connecticut needs a strong and comprehensive community-based system that encompasses not only therapy but also psychosocial supports and preventive services, which though often not currently reimbursable are medically necessary. Providers need to recognize and respect the importance of the family, the community, in the school. It is imperative that families are actively included in all aspects of planning and treatment. The mental health system must focus on the current situation of the individual and the family, must accommodate their capabilities and needs as these change with time, and must rely on approaches and practices of proven efficacy.

Treatment must be particularly sensitive to the notion that transitions challenge children. Youngsters at certain times—for example, when they move from early childhood to preschool or from the teens to early adulthood—change in ways that make them especially vulnerable. At present, services are disjointed and tend not to follow children across developmental phases.

Thorough assessment should always precede intervention and treatment. An effective mental health system must respect the time sensitivity of each child’s development and the need for sustained, ongoing emotional attachments.

The mental health community can impart basic knowledge and skills that importantly increase competency, ability, and resilience and are therefore vital to healthy growth and development. Treatment should be understood to encompass a broad range of interventions that contribute to the emotional well being of a child, not narrowly confined to the medically defined interventions.

## **KEY ISSUES AND RECOMMENDATIONS FOR CHILDREN'S MENTAL HEALTH**

### **T/I Panel Issue #5 – The Problem of Fragmented Care**

**Background** – The many barriers to timely access of adequate outpatient evaluation and treatment include long waiting lists, service gaps, irrationally prescribed and inappropriate combinations of medication, and providers who are overburdened, inadequately supervised, and/or unaware of best practice treatments. In addition, reimbursement practices reward piecemeal, discontinuous care that focuses narrowly on acute symptoms and on the short-term (Burns et al., 1999).

Currently most outpatient psychiatric care comes from mental health providers who feel overwhelmed by the numbers of children and families needing services and who are hampered by insurance funding that is both inadequate and administratively cumbersome. In addition, general medical practitioners who have not been trained in the treatment and assessment of psychiatric disorders may render care.

The combination of an inadequate reimbursement structure, delayed payment, too much paperwork, and excessive denial of claims means that many practitioners lose money for each hour of service they provide. The ongoing financial loss prevents clinics from hiring and keeping enough child psychiatrists and other professionals on their staffs. The many and varied obstacles undermine operations with the result that many private providers refuse to accept any type of managed care insurance. Therefore, the mental health needs of children, especially those from economically disadvantaged families, are not being met.

In public education a different set of factors keep schools from providing needed mental health services. A major dilemma is the common practice of allocating the limited services of school mental health professionals for special education students only. Not all students with mental health needs will qualify for special education due to strict requirements of the federal law. Other at-risk students who have mental health needs that do not directly impact educational performance are unable to receive services. When mental health services are only available to those in special education it creates pressure to label students inappropriately. In the process, a disproportionate amount of services are invested in the evaluation and eligibility process.

The many constraints, together with the inadequate fee structure of managed care, discourage social workers or clinicians, schools, other health care providers, the juvenile justice system, and the various other key players from collaborating on the flexible delivery of services. Rather than promoting cooperation, the current system of funding pits the various providers against one another as each seeks to avoid being saddled with the full cost of intervention.

The current unequal access to care must be rectified by a system of treatment that meets best practice standards (American Academy of Child and Adolescent Psychiatry, 1997). The system should deliver adequate services when they are needed for as long as is necessary to achieve results. Such services should be provided by culturally and linguistically competent practitioners who use professional best practices in stable therapeutic relationships that provide the maximum continuity of care. Finally, the system should seek not only to alleviate the client's symptoms

but also to develop and maintain the client's adaptive capacity. Every community in the State of Connecticut must provide a point of entry to children and families with mental health needs. In response, a mental health infrastructure must be established in each Catchment area to provide needed services through a web of interconnected clinics along a continuum of care model.

Core mental health services must be available which include psychosocial, psychiatric, psychological and related evaluations plus all the modalities of treatment (individual, group, family, psychiatric, etc.).

A second tier of services should target specific areas of the child's and family's life, especially for children, already using the mental health system who are at risk for out of home placement or more serious pathology. These services might include extended day treatment, respite services, in-home treatment, emergency mobile ambulatory services, mentoring and school interventions. An extension of these services should include approaches that strengthen the family unit such as parent aide services, family resource centers, parenting education such as the training provided to foster parents, behavior management training, and family advocacy.

A third tier of services is required for children whose removal from home is necessary to receive specialized services. These services may include small group congregate living, residential services and inpatient treatment.

**T/I Panel Recommendation # 5 – Ensure Quality System of Outpatient Psychiatric Evaluation and Care**

Connecticut should develop and implement a quality, culturally competent, comprehensive system of outpatient psychiatric evaluation and care. This system should be designed to provide equal access and comprehensive treatment based upon an assessment that is not limited to diagnostic criteria, but also includes evaluation of functional impairment. Staff training according to professional best practice standards, and new means of funding are crucial to the development of this new system.

**Proposed Enhancement**

A legislatively mandated task force—involving the Departments of Social Services (DSS), Children and Families (DCF), Education (DOE), Mental Retardation (DMR), and Mental Health and Addiction Services (DMHAS) and representatives from probate, juvenile, family-relations and criminal courts, providers, and families—should be convened to study the issues and to make specific recommendations for improvement of the outpatient system.

The task force should be modeled on the DSS task force and should recommend to the appropriate state agencies and the legislature ways of eliminating from the funding process inadequate fee structures and cumbersome administrative procedures. In particular, the recommendations should propose new financial incentives that will promote teamwork among the various service providers. Possible recommendations might include that:

- ❑ Outpatient funding permit reimbursement for preventative and early intervention strategies such as school-based clinics in order to strengthen treatment efforts in the educational setting, collaboration with primary care physicians, early head start, etc.
- ❑ Outpatient therapists in partnership with a child and family, determine the frequency and duration of outpatient treatment without artificial limitations established by managed-care
- ❑ Authorization for initial treatment be sufficient to provide care without having to justify services every five visits, or so thereby minimizing paperwork and increasing the potential for planned discharge.
- ❑ All federally mandated services under Medicaid be available and reimbursed for children's outpatient care such as case management and psychological testing, without superfluous justification.
- ❑ Medication not be overly recommended by managed care providers to children simply to reduce symptoms at the cost of ignoring psychosocial stressors, development realities, and need for long-term treatment.
- ❑ Outpatient clinics have the necessary psychiatric staff to treat children as well as culturally competent staff to work with the increasing ethnic minority populations.
- ❑ The state develops and maintains an outpatient behavioral health delivery system infrastructure that is accessible to families within their respective communities.

**Expected Impact** – In a newly integrated service model, schools and pediatric providers in the community will, through a flexible continuum of services, identify the mental health needs of children and adolescents in a timely manner. Well-trained practitioners working in unison will then be able to offer early treatment. Providers will be able to hire and retain sufficient staff with the necessary training to furnish outpatient services conforming to accepted principles of care. With adequate funding and staffing, child guidance clinics will be ready and financially able to offer services embodying practices known nationwide to be the best, the most up-to-date, and the most effective. Private practitioners will resume accepting insurance reimbursement, so that there is an increase in the total number of providers and more equal access to critical services.

#### **T/I Panel Issue #6 – Gridlock in the Delivery of Acute Care Services for Children**

**Background** – During the past five years, the system for delivering care to the most seriously disturbed children throughout the state has virtually ground to a halt. Those who do not need extended acute inpatient stays remain hospitalized for months because there is nowhere else to place them, either in institutions or in the community. This inappropriate use of resources means that individuals who do need acute care are denied timely treatment. In addition, children with critical needs often receive inadequate evaluation in crowded emergency rooms and outpatient clinics. At the same time, some individuals remain in residential programs, both within the state and outside, long after their need for such restrictive settings has passed.

**T/I Panel Recommendation #6 – Eliminate Gridlock in Acute Care Delivery**

Connecticut State agencies, private providers, and families should join forces to create an integrated system of comprehensive, community-based care with seamless connections for severely disturbed children. Children must be able to move back into the community as soon, as is clinically appropriate.

**Proposed Enhancements**

- The recommendations of the recent DSS task force report on children's mental health services should serve as a model for the development of a system. Such a system would include, at a minimum, acute and sub-acute residential programs, community living facilities, group living, therapeutic foster care, special education, extended day treatment, respite, mentoring, in-home psychiatric care, intensive outpatient treatment, housing, recreation, and court/probation services. The system must be guided by consumer experience; must be informed by advanced clinical knowledge and valid, reliable outcome data; and must employ service technologies supported by scientific research and lessons learned elsewhere in the nation.
- The proposed coordinating Mental Health Policy Council should have a children's treatment and intervention sub-panel which would meet monthly, issue an annual report and the legislature, and would propose legislative remedies for institutional problems. This council would place on its agenda real, complex cases that highlight major problems in the delivery of care. Family members would participate in deliberations as the council worked to identify the remedial actions appropriate under the mandates of the various departments and council members. The sub-panel, as part of the coordinating vehicle, would consist of senior representatives from DSS, DMHAS, DCF, DMR, DOE, the Department of Correction (DOC), the Department of Public Health (DPH), the Office of Policy and Management (OPM), the Court Support Services Division (CSSD), community service providers, families and consumers, and representative local education agencies.
- The legislature should create a system-of-care forum as a venue in which stakeholders could engage in dispute resolution, collaboration, and the clarification of expectations in cases of interagency and interprovider disagreements. This forum should be an expanded version of the three-tiered structure of the DCF system of care, which includes all of the departments represented in the Coordinating Council. The system of care would refer problematic cases for consideration by the coordinating vehicle.

**Expected Impact** – Children and families will be better able to access appropriate and timely services in their own communities. These services will more fully accommodate the needs, wishes, goals, capabilities, and culture of the child and the family. As more stakeholders sit down at the conference table, problems within the system of care will be identified and solved before major barriers have a chance to develop.

## **T/I Panel Issue #7 – The Needs of Youth Transitioning Into The Adult System**

**Background** – Appropriate interventions can exert a profound effect on the lives of adolescents with mental health needs and on their ability to be independent and productive adults. Many individuals are not making the transition into adulthood successfully. Rather, they are ending up in jails, in psychiatric hospitals, on the streets, or idle at home, with neither gainful employment nor hope for the future.

The tasks of completing school, starting to live independently, and getting a job are difficult at best for young people without mental health needs. The developmental challenges can be insurmountable for troubled youth. The number of individuals in Connecticut with serious emotional disturbance (SED) who drop out of school has increased since the mid-1990s (Breetz, 2000). Such youth have a graduation rate lower than the state average and lower than that of youth with other disabilities. Although youngsters with an emerging mental illness may graduate from high school and enroll in college, many of them ultimately drop out as their illness becomes debilitating. Lack of education means poor employment prospects; continuing mental health problems mean higher than average rates of substance abuse and place the individual at increased risk for suicide.

The developmental challenges confronting transitioning youth are complicated by the lack of age-appropriate services targeted at helping this population prepare for adulthood. The problems are exacerbated by the fragmentation of services, the lack of continuity of care for each individual, narrow mandates that restrict access, and negative incentives embedded in the system.

Many transitioning youth have nowhere to turn for help. DCF has traditionally focused on young children; DMHAS, on adults with serious and persistent mental illness. Youth in transition may find themselves ineligible for DMHAS services because their illness is not yet “persistent” or because its cause is subject to a variety of interpretations.

### **T/I Panel Recommendation # 7 – Expand and Refine the Program for Transitioning of Youth to Adult System**

At present DCF and DMHAS are in the process of implementing a program for the orderly and appropriate transition of thirty SED youth from DCF to the adult mental health system. The DCF/DMHAS Treatment and Intervention Workgroup should be used to create a model for generating ways to transition individuals with serious needs from one system to the other and for ongoing collaboration among agencies, including DOE, juvenile court, DOC, and DSS. In addition, DCF-involved youth who do not bear the SED label and young adults who have not been involved with DCF should be able to access services. The model should take as its point of departure the work of a consensus-building project conducted in the state to ensure the provision of an exemplary program for these youth.

## **Proposed Enhancement**

Youth in transition with mental health needs would have access to exemplary programs with essential elements in five areas: transition services, outreach and education, clinical services (including early intervention for emerging mental illness), service attributes, and service improvement.

- ❑ Transition services would include employment services, education support services, independent living services, socialization/recreation services, and transition facilitation (case managers). Emphasis should be directed at transitioning the youth into adulthood, not only into the adult mental health system.
- ❑ Outreach and education should encompass public education on early intervention that is targeted not only at parents, family physicians, ministers, and teachers but also at young people, who frequently know little about mental illness and less about the effectiveness of treatment and recent improvements in outcome. The information supplied should describe the various child and adult service providers and the state services for which individuals may be eligible.
- ❑ Clinical services would include mental health assessment and treatment. An accurate diagnosis reached through the use of objective criteria, and appropriate medications are essential for positive outcomes. Treatment should be based on strengths and should be provided using a team approach that incorporates all elements of transitional services.
- ❑ Services should have several important attributes. To promote voluntary engagement—essential for youth over the age of sixteen--programs must be age appropriate and appealing. Families must be involved; the model of parent involvement is frequently cited as the ideal starting point for intervention and one that can lead to the empowerment of youth. By the same token, youth should participate in making decisions about services and recovery. Mentors and peer supports can provide positive role models for independent living.
- ❑ To ensure the continuous improvement of services, providers must be trained in adolescent mental health needs, substance abuse, and other issues affecting this population. Extensive evaluation with a focus on outcomes is a prerequisite for program effectiveness.

**Expected Impact** – The transition to adulthood is a pivotal stage of development. Effective intervention will profoundly alter the lives of troubled youth. The aforementioned programs will reduce unemployment, lack of education, social isolation, and homelessness. Early intervention and treatment will lessen the impact of mental illness and will minimize disability. Interventions aimed to prevent problems that frequently accompany mental illness, such as substance abuse, will reduce the incidence of co-occurring disorders.

Collaboration among all state service delivery systems will eliminate barriers that currently exist. The end result will be more appropriate utilization of community mental health services and reduced reliance on hospitalization and incarceration.

## **Summary of Treatment/Intervention Issues for Children and Families**

Mental illness has many roots and many faces. It may originate from genetics pre-disposition, perinatal or prenatal conditions, in early childhood, in adolescence, or in any phase of adulthood.

It may be a onetime, temporary condition, an episodic problem, or an unremitting struggle that lasts a lifetime. A whole family can be affected by the illness of one member, or a single individual may suffer the effects of disease in silence. No one is exempt from mental illness by virtue of economic status, culture, or gender. All lives are subject to developmental changes, social demands, diverse cultural expectations, and shifting personal needs. An individual's psychological adaptability does not always keep pace with life events, and mental illness may result.

A comprehensive mental health system must reach out globally. It should begin with the expectant mother and continue through old age, responding to all individuals with well-funded programs, utilizing current technologies and research. Services should be consumer- and family-centered that are individualized and flexible, reflecting the unique needs, expressed preferences, and active participation of the child or adolescent and the family.

## CHAPTER VIII – CONCLUSION

The Governor's Blue Ribbon Commission on Mental Health represents an historic opportunity to improve the quality of life for all citizens in Connecticut. It has been 18 years since the state last embarked upon such a study. During this time many improvements have been made in services available to children, families and adults with emotional and mental disorders. Yet, it is clear that there are changing needs which Connecticut must meet.

As the Blue Ribbon Commission formulated its recommendations it sought the ideas, opinions and personal experiences of Connecticut residents. Six public hearings were held throughout the state and public comment was taken during the April 2000 Commission meeting. Over 600 people attended these meeting and approximately 200 citizens presented testimony. The passion of those who spoke was unmistakable. Vivid personal accounts of how mental illness has affected the lives of so many Connecticut families left an indelible memory for those present. Many were tales of frustration, anguish and pain, but there were also stories of struggle and triumph over mental illness. It is in the spirit of struggle and hope that the Blue Ribbon Commission on Mental Health submits this report.

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APPENDICES