

VERBATIM PROCEEDINGS

TOWN HALL MEETING

RE:

MENTAL HEALTH TRANSFORMATION

OCTOBER 26, 2006

UNIVERSITY OF CONNECTICUT HEALTH CENTER
LOW LEARNING CENTER

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1 . . .Verbatim proceedings of the Town Hall
2 Meeting re: Mental Health Transformation, held October
3 26, 2006, at 4:30 P.M., at the University of Connecticut
4 Health Center, Low Learning Center. . .

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10 CHAIRPERSON PAT REHMER: -- or comment and
11 hand it to a moderator, who will be glad to read it for
12 you. And that's true for all of the sites that we're
13 broadcasting to.

14 A tape of this meeting will also be
15 archived on the web for those who are unable to view this
16 presentation live.

17 Just the format for today. We're going to
18 begin with opening remarks by Commissioner Kirk, the
19 Commissioner of the Department of Mental Health and
20 Addiction Services, followed by a 15 to 20-minute
21 presentation of our progress over the past year, and then
22 really open up for discussion for about an hour and 15
23 minutes where we want to talk with all of you via the web,
24 via the other sites, about what the vision as we move

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1 forward should look like.

2 The formal meeting will end at 6:15. And
3 those in remote sites up here, we'd be glad to stay for
4 about 15 minutes after that and continue the discussion.

5 During the discussion part of the meeting,
6 we ask that you limit your questions or comments to about
7 two or three minutes so that we give people time, equal
8 time, across the web and, again, at the other sites.

9 The moderators will assist us off-site in
10 maintaining the flow of the meeting.

11 And for those of you participating on the
12 web, if you look right above my head, there's a box that
13 says "Ask". If you click on that box, you can type in any
14 questions or comments that you have. And we will then
15 read them here during the course of the discussion.

16 At the end of this presentation, we ask
17 that you fill out evaluation forms. And there's a couple
18 of reasons for that. One is that this is the first time
19 we're using this format. We want to know how it works for
20 people. So if you're at one of the community college
21 sites or here, there are evaluation forms in the back of
22 the room. If you're on the web, if you return to the
23 transformation website, you will see an evaluation form on
24 there. You can fill it out electronically and send it to

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1 us.

2 Yes?

3 (QUESTION FROM AUDIENCE): I have a
4 question. What's the "Ask" button?

5 CHAIRPERSON REHMER: That was for people
6 who are -- the question was what was -- what was the "Ask"
7 button that I referenced before. That's for people who
8 are at home on their computers or off-site. Okay?

9 Any other questions before we -- okay.

10 Let me introduce Commissioner Kirk, who is going to make
11 opening comments.

12 COMMISSIONER THOMAS KIRK: Good afternoon.
13 My name is Tom Kirk. I'm the Commissioner of the State
14 Department of Mental Health and Addiction Services. I'd
15 like to welcome you to the state's first electronic town
16 hall meeting.

17 Let me give you a little bit of background
18 before we actually move further into the program. 2003,
19 at the federal level, there was established something
20 known as the Freedom Commission. And the Freedom
21 Commission was directed to review mental health services
22 throughout the country and to identify those areas, gaps,
23 barriers and so on, that, frankly, represented faults in
24 the system and that would -- and addressing them would

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1 result in a much more effective system of care.

2 Let me read you the vision statement that
3 was identified by the Freedom Commission. "We envision a
4 future when everyone with a mental illness will recover, a
5 future when mental illnesses can be prevented or cured, a
6 future when mental illnesses are detected early and a
7 future when everyone with a mental illness at any stage of
8 life has access to effective treatment and support
9 essential to living, working, learning and participating
10 fully in the community." That's the vision that emerged
11 from the Freedom Commission.

12 Subsequent to the findings being released
13 by the Freedom Commission, they came to one basic
14 conclusion. They said that they saw the flaws in the
15 mental health system across the country were so great in
16 terms of fragmentation that incremental change in the
17 system was not going to get us to where we want to go in
18 terms of this vision.

19 Their conclusion was there needed to be a
20 full, true transformation of the mental health system to
21 realize the vision that they identified.

22 Where does that bring us to today?
23 Subsequent to the release of the Freedom Commission
24 report, the federal authorities said that we would fund

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1 several states to move on this particular initiative to
2 transform the mental health systems in their particular
3 states.

4 Those applications, the applications to go
5 after this particular grant, were initiated through the
6 Governor's Office where Governor Rell directed DMHAS, as
7 well as 14 other state agencies, to apply for this
8 particular grant award and to truly transform the mental
9 health service system in the state of Connecticut. And we
10 thank the Governor for giving that -- giving us that
11 opportunity because, when the long and short of it came
12 about, only seven states in the nation were awarded this
13 transformation grant to move the system. So we are in a,
14 if you will, a catbird seat to try to move the system.

15 Subsequent to that, the National Alliance
16 on Mental Illness reviewed each of the states around the
17 same time. States across the country received a "D"
18 rating relative to the mental health system. Connecticut
19 and Ohio were the two highest states in the nation. They
20 both got B's. We understand -- we accept the fact that
21 that's a baseline. It's not where it is we want to be.
22 And to realize the vision of the Freedom Commission and to
23 realize what we want to do to help all people with
24 psychiatric disability to recover, we understand that

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1 major, major changes have to occur.

2 One of the things that was learned is that
3 when all is said and done, the people who experience the
4 system, the families, the individuals, families and others
5 in Connecticut, they're the ones who we can best learn
6 from.

7 And so our primary purpose today of having
8 these town meetings is to hear from you all over the state
9 of Connecticut, not just persons who are most directly
10 involved with the system but all people in the state of
11 Connecticut. What do you suggest? What do you see as the
12 major barrier? What are your recommendations to help us
13 to achieve the vision that was put into place or
14 identified by the Freedom Commission?

15 What I would like to do is indicate the
16 fact that one of the recommendations that came from the
17 Freedom Commission -- there were six. One of them was,
18 the sixth one, technologies used to access mental health
19 care information. Let me read it again. Technologies
20 used to access mental health care information.

21 Isn't it fitting that today we're having
22 town meetings across the state based upon the technology?
23 Who helped us to have this technology and to move on this
24 particular format? There are many individuals and

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1 agencies that have assisted and organized this town hall
2 meeting. I would like to specifically thank the community
3 colleges who are hosting today's meeting. I would also
4 like to thank the moderators at each of the community
5 colleges. A special thanks to UConn Health Center here in
6 Farmington for helping with the innovative technology that
7 is making this meeting possible.

8 So when all is said and done, when we
9 finish this two hours, what my professional and personal
10 hope is that we hear from as many people in Connecticut as
11 possible, help us to identify what it is we need to do to
12 truly transform the mental health system so that it
13 reaches the goals and opportunities and challenges that
14 were evidenced or articulated by the Freedom Commission's
15 vision statement.

16 And now I'd like to turn it back to Deputy
17 Commissioner Pat Rehmer, who is Deputy Commissioner within
18 the Department of Mental Health and Addiction Services and
19 who is the Project Director or the Director of the whole
20 transformation initiative, chairperson.

21 Deputy Commissioner Rehmer?

22 CHAIRPERSON REHMER: Thank you,
23 Commissioner.

24 Okay. We're going to start by going

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1 through a brief PowerPoint presentation so that you have
2 some sense again of where we've been for the last year in
3 terms of this process and then open it up for discussion
4 about where you think we ought to go in terms of continued
5 work.

6 The mental health grant required signature
7 from other state agencies and their agreement to
8 participate with us in this process. This grant, as the
9 Commissioner said, is a grant held by the Governor's
10 Office. And while we are the lead agency on it, the
11 cooperation of these 14 other state agencies and the
12 judicial branch has been imperative in moving this process
13 along.

14 What do we mean when we talk about
15 transformation? Transformation really is about change.
16 The results of a transformed system, we hope, will be
17 enhanced mental and physical health and well being of the
18 state's citizens, increased productivity of the workforce
19 and a life in the community for everyone.

20 This is the vision that we are working
21 with now. We want to spend the next couple of hours with
22 you talking about how we came to this vision, discussing
23 with you how we will achieve a shared vision and hearing
24 what your thoughts and ideas are about the direction that

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1 the vision should take to achieve a truly transformed
2 mental health system.

3 The partners in this process, the state
4 agencies clearly are key. Individuals in recovery need to
5 be involved at every step of this process. Family
6 members, schools, community members, private providers.
7 The list really goes on and on. And these are the people
8 that we need to be involved in this process.

9 Why is change in the mental health system
10 necessary? These findings actually came out of the New
11 Freedom Commission report that Commissioner Kirk mentioned
12 in 2003. The first finding was that mental health care
13 across the nation is fragmented.

14 We know in the state of Connecticut, for
15 example, that we have very limited ability to share data
16 across state agencies. So if you're receiving services in
17 one of the state agencies and move to another state agency
18 to receive services, our ability to share information or
19 data about that is extremely limited, resulted in
20 fragmented care often.

21 The focus is on managing the disabilities.
22 Again, this is not news to us. We really need to take a
23 more holistic approach, start to talk about strength-based
24 treatment instead of looking at people and identifying

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1 them either by diagnosis or functioning level.

2 The third is that access to care may be
3 limited by stigma or other barriers. We know that this is
4 true. We know that access can be a problem in
5 Connecticut. There are many, many reasons for that. I
6 hear about access issues in the public behavioral health
7 system as well as often get phone calls from family
8 members who may be involved in the private system that
9 have difficulty accessing care as well.

10 We need to address that issue. We need to
11 address stigma and the kinds of barriers people find in
12 the system because of the stigma they experience.

13 Mental illness is often detected too late.
14 We know that if we can detect mental illnesses earlier, we
15 may have a better chance of impacting on them with a more
16 positive outcome.

17 We hear often from school teachers that
18 they may be able to identify young children who are
19 beginning to exhibit what could be symptoms of mental
20 illness, but they really don't know what to do with that
21 child, where to go for help with that child or how to
22 access treatment.

23 We know that evidence-based practices are
24 slow to be adopted. The Institute of Medicine released a

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1 report in 2001 that indicated it takes 17 years from the
2 time we determine that an evidence-based practice has
3 worked well for individuals to the time that it's actually
4 implemented in the system. That clearly is way too long
5 of a wait.

6 The tools that we use for change may
7 differ. What -- how we reach transformation may differ in
8 different areas. Transformation challenges us to look at
9 how we work and how we think. This is a not a new
10 challenge. It's the challenge of saying we're not going
11 to do things the same way. It's not going to be business
12 as usual.

13 And we really have to consider how we are
14 going to work differently and how we are going to think
15 differently. What does that mean? Different means that
16 we include those who we serve in the development and
17 provision of services, work with other agencies that serve
18 common people and that we design services to meet unique
19 age, gender, race and needs of those people.

20 Again, involvement of individuals in
21 recovery, youth, the family of individual in recovery and
22 the families of youth is critical. Involvement of the
23 state agencies that provide these services, the public
24 non-profit agencies that provide these services is equally

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1 important.

2 Connecticut's tool for change is the
3 mental health transformation state incentive grant. This
4 is a 13.7-million-dollar grant awarded for five years to
5 the state. It focuses on the New Freedom goals.
6 Commissioner Kirk read the vision from the New Freedom
7 report, as well as the last goal. But let me just speak
8 to you about what the goals are because they're really
9 critical in terms of the work we're doing and how we
10 decided to organize it.

11 The first goal is that people will
12 understand that mental health is essential to overall
13 health.

14 The second goal is that mental health care
15 will be consumer and family-driven.

16 The third goal is that disparities in
17 mental health will be eliminated.

18 The fourth, early mental health screening,
19 assessment and referral to services will be provided.

20 The fifth, excellent mental health care
21 supported by research will be delivered.

22 And the sixth, technology will be used to
23 increase access to care and information.

24 So, again, the focus of our work is on

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1 these six goals.

2 Another critical component of the grant is
3 that we must take a life span approach. This grant is
4 intended to meet the needs of all citizens of Connecticut
5 across the life span from birth to older age. We can't
6 focus on one population. We can't focus on one age group.
7 We have to look at the service system and what we're doing
8 across the life span.

9 There's a cross-system orientation to
10 reduce fragmentation. That's the involvement I talked
11 about earlier of the 14 state agencies and the judicial
12 branch. We have to start to align our service system and
13 ensure that the services that we're providing are less
14 fragmented.

15 The funding through this grant is to be
16 used for infrastructure. That was the -- the one thing
17 that I think I experience people having difficulty
18 understanding and perhaps the most question about.

19 Infrastructure as we're talking about it
20 here, what is it and what is it not? The "is not" is
21 actually much easier to understand. It's not services and
22 it's not programs. We can't take the money that's
23 associated with this grant and use it to bring up new
24 programs or to provide new services.

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1 And that, when the senior leadership from
2 SAMHSA came in to give us this award, we had discussion
3 with them about why that decision was made. And what they
4 said to us actually made a lot of sense to me. What they
5 said to us is as the mental health system has gone through
6 decreased funding across the nation over the last five to
7 ten years, the infrastructure has been where the funding
8 in many ways has taken a big hit.

9 Sometimes, if you need to go to the
10 legislature and say, "We need to bring up this service" or
11 "We need to bring up this program" for a specific
12 population or a specific reason, the legislature can hear
13 that and can at least entertain the idea of giving you
14 money through the state budget to do that.

15 It's less likely, especially when times
16 are lean, that they are going to fund infrastructure.
17 They're not going to be able to hear as much that "We need
18 money to look at policy development" or "We need money to
19 look at technology to support the system" or that we need
20 to develop our workforce.

21 Workforce development. One of the things
22 that we know is that the workforce in Connecticut is aging
23 and that the workforce specifically in behavioral health
24 not only is aging but people coming into workforce are

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1 expressing less of an interest in being involved in mental
2 health. That will be a problem as the system evolves.

3 So what are some of the things that can be
4 funded through this grant? And let me also say that
5 everything that we -- all the work that we do in this
6 grant does not have to cost us money. We believe there
7 are some things that will be no cost to the system that
8 will develop because of better working relationships
9 through state agencies, increased conversation with people
10 in recovery and their families.

11 We can look at policies. We can look at
12 policies on access across agencies. We can look at a more
13 consistent approach through policies. We can look at many
14 different policies that look very different at this time,
15 depending on where you get your care.

16 Strategic planning. Thinking about
17 involving consumers and their families more as we move
18 into strategic planning and ensure that they're at the
19 tables when we're doing this.

20 Development of networks. We had recent
21 dialogue with individuals who are interested in developing
22 a consumer network. We need more emphasis on family
23 networks. How do we think about developing networks in
24 the state?

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1 Workforce development. As I mentioned
2 earlier, we know the workforce is decreasing and aging.
3 We need to be very cognizant of what the needs of that
4 workforce are. We can look at training and education. We
5 can look at peer workforce development.

6 And communication activities.
7 Specifically focusing on things like stigma to really
8 begin to break down the barriers. Maybe a campaign that
9 can do that.

10 The vision for change may look different
11 for all of us. We may have different ideas about what the
12 vision should look like. And, in fact, the vision for
13 this project may change every year.

14 One of the things that we had lots of
15 conversation with SAMHSA, the Substance Abuse and Mental
16 Health agency at the federal level, about is the idea that
17 this has got to be a really dynamic process. We need to
18 be able to set goals and think about activities that may
19 need to change as you tell us that that's not the
20 direction perhaps we need to go in or we need to do a
21 little course correction.

22 Remember, that's why we're here today; to
23 hear and to have discussion with you about what the vision
24 for the system is like.

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1 Connecticut's vision for change includes
2 involving individuals in recovery, youth and their
3 families. It includes involving interagency coordination
4 and collaboration and addressing the needs of all
5 citizens, public and private, across all ages and across
6 all cultures.

7 In order for change to occur we must agree
8 that change is needed. We are going to have to work
9 actively to make change happen. And we must be as willing
10 to try new approaches as we expect others to be in
11 changing theirs.

12 The change process. What have we spent
13 the last year doing? The Oversight Committee is the
14 committee that has responsibility for approving the
15 recommendations and ultimately the expenditures for this
16 grant. The Oversight Committee includes consumers, family
17 members, state agencies, advocacy agencies and other key
18 stakeholders. It's a large group, probably not large
19 enough. But we need a body to really look at the process
20 and help us make decisions.

21 There are seven work groups that worked on
22 the goals of the New Freedom Commission. So each work
23 group was assigned a goal, one through six, and a seventh
24 goal of workforce development because, again, we feel it's

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1 a critical component of the transformation.

2 There are over 150 individuals involved in
3 those groups. On average, 48 percent of the individuals
4 who participated in those -- in that process were people
5 that disclosed that they were in recovery or family
6 members of people in recovery. They've put a lot of time
7 and energy. And I want to be very respectful of the work
8 that they've done and the recommendations that have come
9 out of those groups.

10 Those recommendations were rated by the
11 Oversight Committee and they established seven initial
12 areas of focus for the coming year. In addition, a needs
13 assessment and resource inventory was conducted to try and
14 guide the work for the first year.

15 The needs assessment -- one of the things
16 that we wanted to avoid was going out and saying to
17 people, "Tell us what you need in the system", in some
18 ways because we feel like we've been doing that since the
19 Blue Ribbon Commission was established. We've had lots of
20 bodies of individuals who have said to us, "Here's the
21 gap. Here's what the needs are", not only at the
22 Department of Mental Health and Addiction Services but at
23 the Department of Children and Families, in the Department
24 of Corrections, in all the departments involved in this.

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1 So we worked with Yale, who contracted
2 with us, to evaluate all the written reports since the
3 year 2000. There were over 150 reports that they
4 evaluated and looked for like scenes and areas that were
5 identified where we needed to address different issues.

6 In addition, we conducted a phone survey
7 of over 550 households, random survey, to ask what their
8 experience had been with the mental health system in the
9 state.

10 We also did a resource inventory, went to
11 all the state agencies and asked them to identify what the
12 expenditures were. What was the dollars that they were
13 spending on mental health care in that agency? How many
14 individuals were they serving? And to share with us the
15 policies that they had that addressed individuals who had
16 mental health needs. All of that was put together and a
17 state plan was drafted.

18 An additional area that we decided to
19 focus on was addressing the rights of persons with mental
20 illness. That was because as we submitted the needs
21 inventory and resource inventory in draft form to the
22 federal agency that had oversight, they did not see enough
23 evidence in that report that we were paying attention to
24 that. We're not sure if that's because we didn't do

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1 enough of a detailed evaluation of policies, if we didn't
2 include enough of that in the report, or, in fact, if it's
3 an area that we really need to pay more attention to. So
4 we've got some work to do in that area.

5 So what were the recommendations?

6 Oops. Sorry.

7 What were the recommendations that came
8 out of the work groups and the Oversight Committee's final
9 rating of those recommendations? By the way, the total
10 number of recommendations out of the work groups were 48.
11 And so we are starting with these seven and that doesn't
12 mean the others go away. It just means we need to figure
13 out what the process is to bring them in over time.

14 And, again, let me say as I -- before I
15 show you each of these, keep in mind that the mandate of
16 this process is that we take a life span approach. So if
17 one of these goals looks like it's very specific to a
18 population, it may look that way but we will be looking at
19 it across the life span.

20 So, for example, the first recommendation
21 was to prevent suicide and increase mental health
22 awareness throughout health education in schools. In
23 addition, we are looking at suicide and anti-stigma
24 education in schools, at the university level and for

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1 different populations.

2 The next recommendation was to give
3 individuals and families a voice regarding mental health
4 services through universal feedback tools. How can we get
5 real-time, real information from families and individuals
6 using the system in a way that we can take back to the
7 system and create change?

8 The third recommendation was to identify
9 and eliminate mental health disparities through
10 standardized data collection. Again, this gets back to
11 the issue of across state agencies. The data collection
12 and the bits of data that we collect all look very, very
13 different. So we can't compare information across state
14 agencies. We don't really know where the largest amount
15 of disparities are. We certainly have some hypotheses
16 about those. But we need to be able to collect the data
17 in a uniform way so that we can begin to try and eliminate
18 disparities.

19 Expand access to prevention, screening,
20 early intervention and treatment by maximizing state and
21 federal dollars. This is happening in a variety of
22 settings already and we need to continue to build on that.
23 The Behavioral Health Partnership for Children and Their
24 Families has a strong emphasis on screening and

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1 collaboration with primary care. We know that that's
2 completely consistent with one of the New Freedom goals.

3 Rehab option funding for traditional
4 services. We've begun that process at the Department of
5 Mental Health and Addiction Services and are beginning to
6 recoup federal dollars. We need to continue to grow that.

7 Home and community-based waiver, a waiver
8 that we are working on to assist us with bringing
9 individuals out of nursing homes and assist them in living
10 in the community.

11 These are all areas that we need to
12 continue to work on and think about as we move forward.

13 Prevent youth from becoming involved in or
14 having repeated involvement in the juvenile justice system
15 through the use of evidence-based practices. This
16 recommendation is consistent with the recommendations
17 outlined in the Juvenile Justice Strategic Plan which was
18 just published in August of 2006.

19 The use of evidence-based practices is
20 also recommended in the Jail and Prison Overcrowding
21 Report for adults.

22 Provide Connecticut citizens with a first-
23 of-its-kind, comprehensive mental health website to
24 improve access to mental health information and resources.

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1 We think about this as a website for one-stop shopping.
2 You can go to this website and get information that is the
3 latest available, perhaps on a diagnosis. You can look at
4 pertinent legislation to mental health issues. You can
5 create a personal folder.

6 We believe that this will help people who
7 are living in Connecticut to easily go on the web and
8 access services and information as they need it.

9 Expand and enhance mental health training
10 throughout Connecticut's workforce. This is an area that
11 all the commissioners of the state agencies really
12 heartily reinforced with us as we met with them.

13 Again, I can't overstate enough we have a
14 workforce in Connecticut that is aging. We are hearing
15 from the local universities and colleges that as we -- as
16 they talk to students who are coming into the programs,
17 they're not terribly interested in behavioral health.
18 That could create a real problem for us.

19 We need to find out what it is that is
20 making people less interested. We need to know what our
21 current workforce needs in terms of training, education,
22 clinical supervision. We need to further develop our peer
23 workforce. Individuals in recovery who may want to work
24 with other individuals who are struggling may be another

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1 part of the workforce that we really need to focus on.

2 And, again, the eighth area that we added
3 was the protection and enhancement of the rights for
4 persons with mental illness. And this was based again on
5 feedback that we got from SAMHSA and our need to go back
6 and look at what we're currently doing and ensure that
7 we're doing enough and, if we're not doing enough, look at
8 where the gaps or holes are.

9 Our tools may be different, our vision may
10 be different and our approach may be different to change.
11 What really matters as we go through this process is that
12 we're all open to change and really open to working
13 together to make that change happen.

14 Now, here's the questions we have for you.
15 How will we know that people consider mental health as
16 essential to overall health? How will we know that our
17 efforts to reduce suicide and stigma related to mental
18 illness are working? How will we know that our mental
19 health system is directed by individuals in recovery and
20 their families, that every person receives equal and
21 appropriate mental health services regardless of their
22 age, race, ethnicity, gender, et cetera?

23 How will we know when prevention,
24 screening, early intervention and treatment are

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1 commonplace amongst all health care providers, that
2 current research is used in all mental health practices,
3 that technology is used to improve knowledge,
4 understanding and access to mental health information and
5 services?

6 How will we know that Connecticut's
7 workforce is well prepared to address the mental health
8 needs of all citizens? And how will we know that the
9 rights of persons with mental illness are being protected
10 and enhanced?

11 I'll put this back up later in the
12 evening. But I just wanted to say that if you're
13 interested in either participating more in work groups or
14 talking more with us, there's multiple different ways you
15 can get in touch with us. But this is one of the ways.

16 Let me put the questions back up. This is
17 what we're interested in having a dialogue with you about
18 this evening. We want to know how you think the system
19 should move along.

20 Let me just also say -- I neglected to say
21 it in the very beginning. We're going to need the
22 microphones for questions because this is being recorded
23 and that's the best way to make sure that everybody's
24 voice is heard on the recording. So we'll be running

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1 around the room with the microphones.

2 A VOICE: That's a very global question.
3 And certainly everything you've talked about are goals
4 that we would all agree with. I'm both a parent and a
5 provider. And I guess the two things that really struck
6 me in looking over the material and listening to you was
7 the goal of the cross-networking, orientation and sharing
8 information between the departments, which I think is
9 missing. And the other, of course, is getting feedback.

10 And when I looked at your brochure as to
11 the agencies that were involved, I was very surprised not
12 to see the Psychiatric Security Review Board down here or
13 the Office of Advocacy and Protection, both of which deal
14 with mental health consumers who are really caught in
15 loops of almost too many services, and the other, Policy
16 and Advocacy at least would give you some of the
17 complaints that are being made and some of the grievances.

18 CHAIRPERSON REHMER: That's very helpful
19 feedback. I think that's the kind of thing that we're
20 looking for. And, again, I'm not sure because there were
21 over 150 people involved. I know that we invited
22 Protection and Advocacy to sit on the work groups. I
23 don't know whether they did or not. But we need to
24 continue to reach out to different agencies, even if

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1 they're not on the Oversight Committee, to ensure that
2 they're in the work groups and feeling like their voices
3 are heard.

4 Thank you.

5 (QUESTION FROM AUDIENCE): John Kennedy
6 here. I'd like to address the first question, how will we
7 know that people consider mental health as an essential to
8 overall health. The more -- well, if -- the more mentally
9 healthy you are, the more independent you are. The less
10 of a burden you are on society.

11 CHAIRPERSON REHMER: Okay. Thank you.

12 A VOICE: Thank you. It's hard to address
13 all of the questions. So I'm just going to give you a
14 couple of things off the top of my head. And I was a
15 member of Work Group 2, which was the Consumer and Family
16 Work Group.

17 But I think it's a really important
18 question, "How will we know people's rights are being
19 protected?" We can't say things like "Well, fewer
20 grievances" because that doesn't measure it. People's
21 rights might be, in fact, more protected as more
22 grievances. But I think we can look at policies in
23 existence, things like the number of times people are
24 restrained, the department moving toward a restraint-free

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1 policy or individuals within the department moving --
2 individual hospitals moving toward a restraint-free
3 policy, policies like that and seeing how well it's being
4 complied with.

5 I know that other facilities in New
6 England have adopted restraint-free policies and say, you
7 know, "We had zero restraints this month" or "It's a goal
8 that restraints will be zero this month. Okay. We had a
9 couple last month." But working towards that goal. And
10 it's something that hospitals celebrate and advertise and
11 put on their websites as a point of pride. So that's one
12 thing that will indicate that.

13 The other thing is you talked about people
14 being treated equally regardless of race, gender,
15 ethnicity, et cetera. I'm hoping that in the et cetera is
16 disability. And I know that was mentioned in our work
17 group because you need to realize that people with
18 psychiatric disabilities also can have other disabilities,
19 other physical disabilities. And one of the things that I
20 think is really important is Americans with Disabilities
21 Act compliance. And we can't know we have compliance, but
22 we can know we have things like an Americans with
23 Disabilities Act self-evaluation, which was due in 1992
24 and many state agencies have not yet done that. So it

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1 doesn't mean we're bad because we haven't done it. But it
2 hasn't happened yet.

3 The self-evaluation which analyzes the
4 compliance in employment, in general operations, equally
5 effective communications to individuals with speech,
6 visual and hearing disabilities, and also look at
7 programs, facilities, accessibility. So that's something
8 that could be looked at.

9 Also, the transition time which looked at
10 architecture. And, beyond that, the ADA compliance plan,
11 the self-evaluation could be monitored periodically. How
12 are we doing with these things? What do we have? So if
13 we at least had documents to start with, that doesn't
14 promise your compliance, but it's a big step towards it
15 and to meeting the federal obligation.

16 Those are a couple of things. I'll
17 probably have more. And, also, I thought it was a very
18 good point that the Psychiatric Security Review Board, to
19 the best of my knowledge, didn't participate in the work
20 groups that I was aware of. And that's -- there's a chief
21 issue with people in the net of Department of Corrections,
22 DMHAS and all of those things. And there's lots of
23 questions around those. So it would be nice to hear their
24 voice at the meetings. They may have been invited and

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1 they may have participated. But they didn't participate
2 in my work group.

3 CHAIRPERSON REHMER: Thank you.

4 A VOICE: Thank you.

5 CHAIRPERSON REHMER: Barbara?

6 Barbara's going to get her exercise
7 tonight.

8 (QUESTION FROM AUDIENCE): Dr. Leonard
9 Spaulding in his book, "How to Live Longer and Feel
10 Better" described the first double-blind experiments of
11 schizophrenia at the University of Hartford, Saskatoon in
12 Canada concerning placebos which is niacin and they found
13 that the niacin was successful. I'm wondering why it
14 isn't used more often instead of the neurologic drugs
15 which cause a lot of brain damage.

16 CHAIRPERSON REHMER: I'm not really sure
17 that I can answer that question. That's a pretty
18 difficult question to answer off the top of my head. I
19 mean I think that's something that I could -- I'd be glad
20 to talk with you about or try and find out more
21 information about. But I don't know the answer to that.

22 (QUESTION FROM AUDIENCE): Are they doing
23 research on orthomolecular psychiatry?

24 CHAIRPERSON REHMER: Not that I'm aware

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1 of.

2 In the back there.

3 (QUESTION FROM AUDIENCE): Hello. I'd
4 like to address the first question. And I believe if
5 we're going to consider mental health as part of overall
6 health, we need to draw in pediatricians, general care,
7 primary care physicians. Pediatricians can pick up early
8 signs of mental illness. They need to have some mental
9 illness training in their medical school education. And
10 education of doctors is essential for recognizing when a
11 person has a mental health problem. Doctors could be our
12 first line of defense against it, prevention.

13 CHAIRPERSON REHMER: I think that's an
14 excellent point. It's one of the areas that one of the
15 work groups -- and now I'm not going to remember which one
16 -- spent a lot of time talking about; that the education
17 and training needs of primary care physicians and
18 pediatricians is really critical and that that is often
19 the first line that people go to. And if they are trained
20 and able to help us identify, we would really be improving
21 care.

22 One of the interesting findings that we
23 saw when we did the telephone survey was, you know, you
24 sort of always think that your world is the world that

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1 everybody comes to. But the fact of the matter is that a
2 very small percentage of individuals reach out to the
3 public health mental -- the public mental health system
4 when they first begin having difficulties. They go to
5 their family and friends and they go to their primary care
6 physician.

7 So you're absolutely right. And it's an
8 area that we really have to spend some time on.

9 Thank you.

10 (QUESTION FROM AUDIENCE): Yes. I'd like
11 to address the doctor that just spoke. I've read there's
12 five different categories, at least five different
13 categories, of schizophrenia. I'd like to know what --
14 what category does the molecular stuff address? There's
15 audio. There's visual. There's, you know, being --
16 there's fear. There's -- there's another two that escape
17 me.

18 Could you follow that, sir?

19 A VOICE: It seems -- it seems as though
20 our research is being neglected. For example, the book by
21 Dr. Peter Brady on Toxic Psychiatry, which he describes
22 the brain-damaging effects of neurologic drugs and, yet,
23 that's been largely ignored.

24 (QUESTION FROM AUDIENCE): (Indiscernible,

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1 too far from mic.)

2 A VOICE: Well, it seems that the research
3 needs to be broadened to include some of the newer
4 findings. And, for example, after patients recover, it
5 seems their discharges are long delayed, costing taxpayers
6 a great deal of money. And that's another matter that
7 needs attention.

8 (QUESTION FROM AUDIENCE): Okay. Thank
9 you, sir.

10 CHAIRPERSON REHMER: I think, again, if we
11 look back at the goals and the questions, one of the goals
12 that the New Freedom Commission focuses on and one that we
13 are really trying to spend some energy on is ensuring that
14 current research, evidence-based practices, guide the way
15 we develop the mental health system and ensure that that
16 research is embedded in the transformation process. So I
17 think it is critical.

18 (QUESTION FROM AUDIENCE): Yes. I agree.
19 Thank you.

20 (QUESTION FROM AUDIENCE): I'm Dale
21 (indiscernible) next ten to twenty years software problem
22 where individuals can go get the care that they need,
23 whether it be mental health, food, clothing, shelter,
24 whatever they need. I want to know what is the population

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1 of Connecticut. Because each person, if they chose to,
2 could set up their part of the system and have their needs
3 try and met by the state, if they choose to. The people
4 that feel the states may bother, they can do other things.
5 But in order to provide cost-effective care to the million
6 people in the state, a computer system to try and make
7 sure each individual receives care might be a good way to
8 go.

9 CHAIRPERSON REHMER: Thank you.

10 (QUESTION FROM AUDIENCE): Hi. I just
11 want to say Number 4 about every person receives equal --
12 equal -- what? -- and appropriate mental health services.
13 I think that African-American people do not get
14 appropriate services. I think that we -- just because
15 we're black and Latino, there's all these -- I don't want
16 to say this but -- there's all these white doctors and all
17 that. There's hardly no African-American or Latino. And
18 we need more of Latino and African-American people to
19 serve us.

20 CHAIRPERSON REHMER: I think that that
21 county has to be part of the workforce development issue
22 as well. That part of what we need to do is ensure that
23 we're including people of different colors, different
24 ethnic origins in the workforce to ensure that people feel

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1 like they're getting their needs met.

2 (QUESTION FROM AUDIENCE): I'm -- Number
3 5. It says every person receives equal and appropriate
4 mental health services regardless of their age, race,
5 ethnicity. That's not true. There's a lot of disparity
6 due to culture, race, ethnicity, depending on where you
7 live. There is still a lot of red-lining involved in
8 agencies, banks and organizations. So that's not true.
9 You don't get the same service.

10 CHAIRPERSON REHMER: I think that that's a
11 part of what we're talking about. How would we develop a
12 system where that would be true? We know that that's not
13 true now. Our goal is to have a system where that is
14 true.

15 (QUESTION FROM AUDIENCE): Okay. My name
16 is Charles. I wanted to address the issue about rights
17 being protected. And I think one of the things that can
18 be immediately done is to have observers, you know,
19 advocates or people that are concerned with patient's
20 rights in emergency rooms and acute care units 24/7,
21 around the clock observers, so that when a person's rights
22 is violated, they don't have to make a phone call. The
23 person is there that they can talk to. And that -- being
24 an infrastructure kind of thing dealing with the workforce

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1 I think is something that can be addressed by the grant.

2 CHAIRPERSON REHMER: Thank you.

3 (QUESTION FROM AUDIENCE): Hi. I may be
4 off topic. But I'm an advocate of services. I work at a
5 community services organization. And we have people from
6 all walks of life, all needs, who their biggest complaint
7 is that there's no funding for housing.

8 A barrier that I see is that there's no
9 living skills programs that are being developed for
10 adults. They are being developed in the high schools for
11 kids at this time.

12 Homelessness is a huge issue. Shelter is
13 a huge issue. Teaching a person how to budget, you know,
14 the cost of energy, cost of housing. That is what is
15 causing triggers in mental health. So that's an issue --
16 this 13.7 million would be great if it went towards
17 something like that.

18 CHAIRPERSON REHMER: I think that what our
19 hope is -- and we've had lots of conversations with lots
20 of individuals about that issue; that, you know, I think
21 there was some disappointment about this not going into
22 the service system for services.

23 I think that our hope, though, is that we
24 -- if we can build the infrastructure, if we can sort of

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1 use this to build the base around which to build services
2 and to share services, for example, more adequately across
3 state agencies, we may end up leveraging more dollars for
4 services and programs.

5 I don't disagree with you at all. We have
6 a huge homeless problem in this state. We have a very
7 difficult time finding adequate, safe housing. We have a
8 difficult time getting our many individuals employment.
9 And we know those are the things that people want.

10 These dollars can't be specifically put to
11 that issue. But we think that there's a way to utilize
12 these dollars to still help the system.

13 So I do understand what you're saying.
14 But we hope that we can use these dollars to leverage the
15 service system.

16 (QUESTION FROM AUDIENCE): Hi. My name is
17 Sue Turry and I'm a social work intern at the UConn School
18 of Social Work in West Hartford. I'd like to slightly
19 address two points to people who spoke to perhaps give
20 them a little bit of information that gives them hope.

21 Among my co-students, fellow students at
22 UConn, are many Latino and Latina and African-American
23 people learning to become clinical social workers. I mean
24 there's much more happening than that. But I can tell you

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1 that.

2 In terms of housing, it may only be a
3 small thing. I'm not well informed about it. But I will
4 be participating in a major housing conference about
5 homelessness and housing that's occurring in Mystic,
6 Connecticut on Monday, October 30, to discuss and address
7 issues of housing.

8 I also want to kind of underscore the
9 issue of primary-care providers. They mean well, but
10 unless they are particularly wise -- and some are -- wise
11 enough to know they don't know, and therefore refer to
12 psychiatrists and therapists. Sometimes mental --
13 primary-care providers will give out psychotropic
14 medications without clear explanations about side effects.
15 And sometimes side effects can be bad from even one pill.

16 So not only do they need to be trained
17 while they're in school, I think it would be helpful for
18 them to have continuing education requirements around
19 screening and dealing with people who come in who might
20 have -- not be presenting with mental health problems but
21 they may be there.

22 Thank you.

23 CHAIRPERSON REHMER: Barbara, I'm just --
24 I'm standing up here a little in the dark. Are we unable

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1 to communicate with the other sites? Is that the issue?

2 BARBARA: They're coming back on line. We
3 did have some --

4 CHAIRPERSON REHMER: Oh.

5 BARBARA: -- difficulty. We lost a couple
6 of the questions. We're getting those back.

7 CHAIRPERSON REHMER: Okay.

8 BARBARA: But I do have one that came in
9 over the web. And the question is "Will transcripts of
10 this meeting be available to the public and, if so, how
11 can I get a copy?" And perhaps I can answer that.

12 We will be making transcripts available
13 and posting them on the DMHAS website. So that will be
14 available for folks.

15 The presentation will be archived on the
16 web. So the whole presentation can also be viewed. And
17 we will be receiving a DVD. So that if people are
18 interested in viewing the presentation through that medium
19 as well, then you can do that.

20 CHAIRPERSON REHMER: I just didn't want to
21 spend all our time here and have people off-site feeling
22 like we weren't paying any attention.

23 BARBARA: They'll be back.

24 CHAIRPERSON REHMER: Okay.

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1 CHERYL: Pat, we do have a comment from
2 the web.

3 CHAIRPERSON REHMER: The beauty of using
4 the new technology.

5 Yes. Actually, Cheryl, if you have
6 comments or questions from the web, why don't you go ahead
7 with one now?

8 CHERYL: Okay. One writer writes "I
9 suggest in the opening summary that you do not use the
10 language 'state services' as this may have an
11 unintentional effect of sending a message of exclusivity
12 and could work as a barrier. There are tens of thousands
13 of people with permanent residency who are not federal
14 citizens and those who do not have status. The term
15 'citizen' is sensitive to those of us who are not. Use of
16 the term 'people of Connecticut' is more inclusive."

17 CHAIRPERSON REHMER: Interesting feedback.

18 CHERYL: One --

19 CHAIRPERSON REHMER: Yeah. Just so people
20 know, we have one of our staff members in a booth in the
21 back picking up questions from the web that she'll be
22 reading overhead.

23 Sorry. I should have said that earlier,
24 too.

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1 CHERYL: One question that came in as well
2 is "How do you plan to address the needs for training of
3 DMHAS and DSS workers for working with people with mental
4 health issues?"

5 CHAIRPERSON REHMER: There is a workforce
6 development work group, which is one of our most active
7 work groups, that has a plan that is looking specifically
8 at training and education not only for employees of the
9 Department of Mental Health and Addiction Services or the
10 Department of Social Services but for all the human
11 service agencies, as well as the other agencies involved
12 in this.

13 And one of the things that we are
14 beginning to look at is how is training done currently
15 across those agencies. And many of those agencies, by the
16 way, also provide training for the private, non-profit
17 providers that they contract with. How is that training
18 conducted? And what do we need to do to make sure that
19 that training is uniform across agencies and that we're
20 using evidence-based practices, that people have
21 opportunities to attend training. Should we be using more
22 web-based training where we can? How do we embed clinical
23 supervision back into the system?

24 So I think that we are looking at multiple

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1 recommendations from that work group and working closely
2 with Michael Hoge, who led that work group, who, if you
3 don't know, is a Yale staff member who is also heading up
4 something called the Annapolis Coalition on Workforce
5 Development at the federal level and is guiding us in our
6 work in Connecticut in terms of looking very specifically
7 at this issue.

8 (QUESTION FROM AUDIENCE): Okay. That
9 question was kind of tied to what I wanted to ask, also.
10 But the other part of it is if you're going to have
11 patient rights, I think somehow -- I mean I'm sure that
12 there are consequences tied to it. But I think if that --
13 that should be stepped up a bit in terms of people --
14 people need to be made accountable for violating other
15 people's rights.

16 And a lot of times on a unit, people will
17 get their heads together and protect each other. And --
18 but somehow there should be some accounting when -- when
19 somebody's rights are violated and the people responsible
20 for that. And I don't necessarily mean, you know, taking
21 somebody's job. But some type of consequences need to be
22 brought to bear so that it will be -- they will think
23 about it before that's done.

24 And the other part that I wanted to ask

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1 about is is there a way to track the spending on this
2 grant? If you're interested in how the money's being
3 spent, is there a way to track it?

4 CHAIRPERSON REHMER: We will certainly be
5 reviewing with the Oversight Committee and tracking the
6 dollars through the system. Are you asking are we going
7 to --

8 (QUESTION FROM AUDIENCE): Is there a way
9 for, say, like an agency that I work for to be able to
10 pull it up on line and see how the money's being spent in
11 this grant?

12 CHAIRPERSON REHMER: When we develop
13 budgets specific to recommendations, those would be public
14 documents so that you will be able to see what the
15 recommendation is. And let me just emphasize again that
16 the expenditures of dollars for this grant come under the
17 auspices of the Oversight Committee. This is not the
18 Department of Mental Health and Addiction Services making
19 decisions about how to spend money. This is a group of
20 consumers, family members, state commissioners, key
21 stakeholders, advocacy organizations, trade organizations
22 -- the glad-- and, in fact, is the Oversight Committee
23 list on our website currently?

24 If it's not there, we'll list it there so

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1 you can see who the members of the Oversight Committee
2 area because you could also have dialogue with them about
3 these issues. I think that's important.

4 One of the things that we emphasized when
5 we went to the Oversight Committee with recommendations
6 was that we wanted them to go out to their constituency,
7 however they define that, who are the people that they
8 interact with, the voices that they thought needed to be
9 heard, and talk to them about all of the recommendations
10 and then work with them to decide which ones should sort
11 of be rated how.

12 So the Oversight Committee is -- is
13 charged with talking with people in their communities, in
14 their workplaces, in the system to get the feedback about
15 the recommendations and the dollars associated with them.

16 (QUESTION FROM AUDIENCE): If you don't
17 mind? Can I make a few comments as well. One of the
18 things that strikes me -- and I want to just say it for
19 the record -- is that this grant is -- is not to be used
20 for programs and services. But with that said -- because
21 I think that there's some room for new programs. But with
22 that said, I want to say that I am struck in the
23 conversations that I have been a part of that a lot of
24 talk is -- has not been made with regards to the link

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1 between adult and continuing education programs and -- and
2 the rest of the agencies that are listed.

3 I understand that the Department of Ed is
4 listed and the Department of Higher Ed is listed. But
5 there -- there seems to be still room for interagency
6 collaboration, which you said would be a focus, between
7 adult and continuing education programs or high school
8 completion programs and the mental health agencies that
9 are listed. So I think that that's an area that
10 Connecticut needs to explore.

11 And, also, having said that, Central, in
12 terms of its supportive education programs, offers a
13 fairly good supportive education program. But it needs to
14 be duplicated, I think, across, the board because I think
15 that people who have mental health issues and still want
16 to get back to work can benefit from supportive education
17 programs. And we shouldn't have to only choose Central
18 Connecticut University to receive those services. So
19 that's an area we can look at as well in terms of how will
20 we know that it's effective.

21 And understand, also, that Connecticut
22 added a seventh goal, which is the workforce development
23 piece. So supportive education has to be a focus.
24 Technology programs, I look because I'm an advocate at AU.

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1 And I was doing some research for one of our other
2 advocates on a free technology program. Students who need
3 to learn Microsoft Office, for instance. And I was struck
4 by the fact that the community colleges offer those
5 programs but it's not affordable for most people who are
6 living on FSDI or SSI.

7 And so in terms of their motivation, they
8 have the motivation to learn more skills and to develop
9 skills. But they don't have the opportunity to do so at
10 an affordable rate. So we -- we continue to need to focus
11 on that.

12 And the final comment I'd like to make is
13 to the woman who spoke about what's happening at UConn
14 School of Social Work. We understand that there are many
15 different types of moves to the end and that the end is
16 wellness and recovery.

17 In terms of evidence-based practice,
18 there's a lot of evidence that expressive art therapy
19 works. And I mean I'm -- that's an oversimplification to
20 say that it works. But it is an effective form of
21 treatment. And Connecticut, none of the schools in
22 Connecticut offer it as a field of study for people who
23 are interested in doing work with our population of
24 people. So I want to point that out, that expressive art

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1 therapy programs might be an area we look at when we link
2 with the higher education division so that we create it.

3 CHAIRPERSON REHMER: Thank you.

4 CHERYL: We have another comment from the
5 web.

6 (Interruption in taping - changing from
7 Tape 1-A to Tape 1-B.)

8 (QUESTION FROM AUDIENCE): -- addressing
9 the question of training the workforce. And I was
10 commending Connecticut DMHAS for partnering with the
11 National Alliance of the Mentally Ill. They have some
12 excellent programs for training people working with people
13 with mental health needs. And this is a good, positive
14 step to continue.

15 And as far as the Department of Higher
16 Education, I think there are such -- there are such a
17 thing in Connecticut as the Board of Higher Education.
18 They must be part of the Department of Education. But I
19 believe those are the people that make the decisions that
20 filter down into the community colleges across the state.

21 And I agree. Community colleges need to
22 get on board and partner with these human service agencies
23 so they're listed in this plan here. And we need to work
24 more closely with community colleges because they have the

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1 ability to reach the general public at affordable prices.

2 And I'm very much in favor of expressive
3 arts because there's nothing like the theater to bring
4 reality into a person's life and it's a reflection of
5 ourselves when we go to the theater. So expressive arts
6 are very important to recovery. I speak as a person in
7 recovery myself.

8 CHAIRPERSON REHMER: Thank you.

9 (QUESTION FROM AUDIENCE): That's all I
10 wanted to say.

11 CHAIRPERSON REHMER: Okay.

12 Cheryl? Cheryl, did you have a question
13 from the web?

14 CHERYL: Yes. We have several, actually.

15 CHAIRPERSON REHMER: Okay.

16 CHERYL: The first is someone has written
17 in that they -- that they think there should be more
18 leniency and respect towards the patients, that they are
19 suffering enough and that staff should be a service to the
20 patients.

21 And a question is where did the funds come
22 from to put the telecast on?

23 CHAIRPERSON REHMER: Let me just repeat
24 both of those. There was a comment that came in that

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1 there needed to be more leniency and respect -- and I'm
2 paraphrasing a little -- for clients who are on in-patient
3 units. That was the comment.

4 And the question was where did the funds
5 for this town hall meeting come from. And they came from
6 the transformation grant.

7 But I also wanted to comment that the
8 community colleges, in the instance of this town hall
9 meeting, did step up to the plate and offered up all these
10 locations. So I think we have the basis for the beginning
11 of furthering our relationships with them as they're
12 hosting these town hall meetings and working with us on
13 this process.

14 Cheryl, did you have another question from
15 the web?

16 CHERYL: Yes. "If we are transforming to
17 a consumer and family-driven system, at what point in
18 one's life does having the care family-driven cease to
19 become just consumer-driven and how is it determined that
20 family is best to drive the recovery when there are
21 numerous circumstances when family has caused trauma or
22 can be a barrier to one's recovery?"

23 CHAIRPERSON REHMER: I think -- I think I
24 understand the question. Let me repeat it again. The

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1 question is at what point in an adult's life does family
2 no longer -- if I -- again paraphrasing -- have the right
3 to drive that treatment and especially when -- in
4 circumstances where family may have been involved in a
5 negative way in that individual's life.

6 I think when we talk about family
7 involvement in the system, there's a number of different
8 ways to think about it. Clearly, we need family
9 involvement in the system with our youth, with our
10 children. And they are the drivers for that population
11 and should be and should be telling us what the needs are
12 of those children and adolescents that are in need of
13 care.

14 This is in many ways a rights question
15 because when somebody turns 18, the family no longer has
16 the right to any information about their medical
17 treatment. So if somebody's in the system receiving care,
18 obviously there's a requirement in terms of the services
19 from having any interaction with the family that that
20 individual would have the right to make a determination
21 about.

22 I don't think that that means the family
23 has to be excluded from the system. But they can be kept
24 separate from the individual adult member's care. If that

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1 makes sense.

2 (QUESTION FROM AUDIENCE): Yeah. My name
3 is Karen. And -- is it on?

4 CHAIRPERSON REHMER: No, I don't think it
5 is on.

6 (QUESTION FROM AUDIENCE): Yeah. My name
7 is Karen. And I like that last question, you know,
8 especially around trauma because sometimes families don't
9 have people's best interest at heart, especially in early
10 childhood. And there is a whole continuum of juvenile
11 delinquency and the acting-out behaviors that can also
12 lead up into adulthood where, you know, women and men are
13 incarcerated.

14 So I think that there needs to be a
15 continued focus on the trauma, which I applaud DMHAS for
16 doing, because -- I, myself, come from that background and
17 I'm not supposed to be alive today. I'm not supposed to
18 be out in the community today. You know. I'm supposed to
19 be locked up in an institution. But I'm not. I'm
20 working.

21 And when it comes to working is I do work
22 for a private, non-profit but I work in a state agency.
23 And there's a disparity. I am sometimes seen and made to
24 feel less than because I'm not a state employee. And

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1 there's other people that fall into that category, too.
2 So there needs to be a really coming together and
3 accepting of each other and being really willing to work
4 together instead of just word of mouth.

5 CHAIRPERSON REHMER: Mm-hmm.

6 (QUESTION FROM AUDIENCE): That's what I
7 wanted to say.

8 CHAIRPERSON REHMER: Thank you. I mean I
9 --

10 (QUESTION FROM AUDIENCE): Thank you.

11 CHAIRPERSON REHMER: The trauma work that
12 you're talking about is critical. And I would say again
13 our state agency partners, DCF, CSSC, the Department of
14 Corrections, everybody has taken a great interest. And I
15 think one of the things that we are looking at is ways to
16 ensure that we are educating staff about the impacts of
17 trauma on individuals who are seeking services and
18 approaching it in many ways as much as we can from the
19 same framework. Not always easy to do, depending on where
20 you were.

21 In terms of the work environment that
22 you're talking about, again I think that we need to
23 continue to work on individuals in recovery and where they
24 work in the system and ensure that they are being treated

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1 with respect and that they feel like they have the support
2 that they need in the agency that they're working in.
3 We've been having lots of dialogue with individuals in
4 recovery about that issue.

5 You have another question from the web?

6 I'm trying to balance both. So --

7 Go ahead, Cheryl.

8 CHERYL: First I'd like to let people know
9 that for a moment during your presentation, Pat, the
10 server went down. So there are many people that were on
11 the web that lost the presentation for a few minutes. So
12 we have many people who are now sending questions in. I
13 wanted to make sure that people who are sending the
14 questions in or who experienced problems for a moment know
15 that we are now back up and receiving the questions.

16 And to that end, I have one question here.
17 "Can federal and state dollars be used to update the
18 toxicity panel of the Medical Examiner's Office to test
19 suicide victims to see if psychotropic medications were in
20 their bloodstream when they passed away?"

21 CHAIRPERSON REHMER: I don't know the
22 answer to that question. I would -- we will have to get
23 back to whoever that person is because I -- I don't know
24 the answer to that.

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1 Next question?

2 I'm going to try and take a couple of
3 questions off the web, given that we weren't able to do
4 that. And the questions, I believe, from the off-site are
5 coming in via the web, too.

6 So, Cheryl, why don't you run a couple of
7 questions by us?

8 CHERYL: Okay. Another was, given the
9 trouble that you had on the web stream, can we tell them
10 when the recorded version will be available on the
11 website?

12 And we do know that it is going to be web-
13 - archived immediately after this. So anyone that wants
14 to watch it or tries to log on again, they can do that as
15 soon as this is over.

16 CHAIRPERSON REHMER: So it will be
17 available immediately following the conclusion of the
18 meeting.

19 CHERYL: That's correct.

20 CHAIRPERSON REHMER: Okay.

21 CHERYL: Can I ask one more question while
22 I've got it?

23 CHAIRPERSON REHMER: Sure.

24 CHERYL: "Could we not use a portion of

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1 this funding to develop and implement a plan to fully fund
2 staff? They are a powerful base for regaining and
3 improving the child's mental health functioning, family
4 coping, advocacy and family voices to create systems
5 change."

6 This writer speaks of a specific community
7 collaborative that cannot continue to remain staffed only
8 by volunteers. "The time it takes to coordinate the scope
9 of work requires dedicated staff. There should be a
10 collaborative coordinator and a family member employed by
11 the system."

12 "The legislative mandating the creation of
13 collaboratives is truly an example of an unfunded mandate.
14 Funding of all of the existing collaboratives will take
15 legislative change and targeted systems advocacy. By
16 fully funding all collaboratives temporarily until a
17 permanent funding stream can be secured, they will be able
18 to educate the legislature about the critical gaps that
19 unfunded mandates represent."

20 "I feel strongly that the ripple effect of
21 funding collaboratives will bring about, and most
22 importantly, healthy children who are better prepared to
23 enter adulthood with minimum to no assistance from the
24 adult serving systems, which are all overburdened

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1 presently."

2 CHAIRPERSON REHMER: I think I'm hesitant
3 to say to any idea that comes out, you know, uniformly or
4 unequivocally no, because that would just be a little too
5 quick to pull a trigger on an idea. But I would say that
6 in general funding staff positions would be seen as
7 funding a program.

8 That being said, again, I would encourage
9 individuals who have these kinds of ideas to participate
10 in the work group process and get the ideas out on the
11 table because really, again, these ideas have to get to
12 the Oversight Committee for funding. So it's going to be
13 really critical that -- and -- and there may be ways to
14 embed parts of that in another recommendation. I don't
15 know off the top of my head. But I think that I would
16 encourage that person, if they can, to think about
17 participating either in the workforce development sub-
18 group or to look at the work groups and think about which
19 one might be right for them. And if they're not sure, to
20 contact Barbara Bugella, who is the assistant chairperson
21 for the grant, or Cheryl Stockford, the manager for the
22 grant. And we'll put information to contact us again.

23 We're always looking for more people to
24 work with us on these work groups so that people feel like

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1 they've had a voice in this.

2 Cheryl, is there one more question from
3 the web that we could take?

4 CHERYL: Sure. Okay. "A website should
5 bring consumers directly to objective information about
6 medication not websites that are funded by pharmaceutical
7 companies" was one comment.

8 One question is "How can we ensure that
9 any new requirements that come out of this are not
10 unfunded mandates, especially in education?"

11 CHAIRPERSON REHMER: Well, again, I would
12 say that that is going to be things that -- the idea that
13 there will be unfunded mandates that come out of this is,
14 I think, always a concern for certainly all the state
15 agencies and the private, non-profit providers as well.

16 I think that as the work is moving along,
17 if people feel like it's starting to move in the direction
18 of an unfunded mandate, then we need to hear that feedback
19 and work to think about whether there's a way to fund it
20 through the grant or whether we need to rethink what it is
21 that we're talking about implementing.

22 There is a possibility that policies or
23 legislature that changes things could result in people
24 feeling like there are unfunded mandates. And it's going

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1 to be critical that we get that feedback if that's what
2 people feel like they're experiencing.

3 Oh. Go ahead.

4 (QUESTION FROM AUDIENCE): Hi. I
5 understand that this grant can't be used for new services
6 or programs. However, I'd like to hear what other
7 creative options or partnerships DMHAS might implement for
8 the population that Australia called young parents or
9 young people who live with a parent or parents who have a
10 mental illness. Those children often go unrecognized,
11 especially if they don't qualify for services in the
12 current system. They're often in single-parent households
13 taking on adult roles with children's coping skills.

14 In addition, there has been a lack of
15 parenting services for parents despite statistics that
16 show us that over 50 percent of men and I think it's over
17 65 percent of women who are living with mental illness are
18 parents.

19 And I just hope these concerns will be
20 looked at when implementing grant funds to educate the
21 workforce, the educators and when assessing whether every
22 person and their family or support system of choice
23 receives equal and appropriate mental health services.

24 CHAIRPERSON REHMER: I think that the

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1 youth question you ask is a good one. I'm not familiar
2 with the Australian program. I'd love to hear about that,
3 actually.

4 But I do think that the young adult area
5 from 16 through 24 is an area that we are increasingly
6 seeing as problematic in many of the state agencies and
7 that there is an increased focus on certainly recognizing
8 and understanding that early intervention, again, results
9 in better outcomes.

10 And so I think that increasing our focus
11 on prevention and early intervention through these grant
12 dollars will help us address some of that. It won't
13 replace the service dollars. But, again, if we can use
14 those dollars that we put into those things to leverage
15 service dollars, that would be a very good thing to do.

16 The parenting issue clearly is a key one
17 that we have to pay attention to. It's, again, the
18 importance of including family as a concept that we think
19 more about in the system, that individuals don't often
20 exist in and of themselves but they have some family,
21 however they define it, around them and that we need to
22 take that into consideration.

23 (QUESTION FROM AUDIENCE): What you're
24 saying about early intervention makes me think about --

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1 the first question there, people consider mental health as
2 essential to overall health. And it seems to me that if
3 mental health is going to be equal to health, then we have
4 to think of what's needed for mental health as equal to
5 what is needed for health.

6 And so the early intervention is something
7 we'd like to see in the health care system. I mean it's
8 unthinkable that we wouldn't be screened for breast cancer
9 and having early intervention to prevent later, more
10 serious difficulty. And so that same standard should be
11 applied to mental health.

12 And mental health being part of the
13 training for the whole health care system. Also, we
14 should look at what are the best practices and make sure
15 they're implemented. Again, it would be unthinkable in
16 the medical profession to have some practices that are --
17 that have been proven to work and, yet, not to be funded,
18 not to be supported and not to be implemented. And we
19 need to demand outcome and that we are assessing what
20 works and when something isn't working, we're not funding
21 it. But we are funding what works because mental health
22 would be equal to what we demand of the health care
23 system.

24 CHAIRPERSON REHMER: Thank you.

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1 BARBARA: Pat, we -- Pat? We have a
2 question from both Gateway and Norwich. I'm wondering if
3 we could take those --

4 CHAIRPERSON REHMER: Sure.

5 BARBARA: -- at this point.

6 CHAIRPERSON REHMER: Yeah. Cheryl, go
7 ahead.

8 CHERYL: Coming from Gateway. "Home
9 health aides play an important role in the continuum of
10 services, yet are knocking at the door to be included --
11 yet are knocking at the door to be included in the mental
12 health system. How can we be included in processes such
13 as the transformation grant planning?"

14 CHAIRPERSON REHMER: I'm going to start to
15 feel a little bit like a broken record. But, again, we
16 are more than interested in having people at the table.
17 And the best way to be involved with the planning process
18 for these grant dollars is to begin to work with us on one
19 of the work groups. There are seven work groups. We may
20 develop an eighth at this point. They're large at times
21 because we have been all-inclusive. We don't want to
22 exclude anybody that wants to work with us.

23 But we're starting another process now in
24 terms of we've got what the recommendations are. Now we

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1 really need to think about how to operationalize them and
2 implement them and come up with plans for how we're
3 actually going to do this.

4 So we do believe that some people who were
5 involved in coming up with the recommendations may fall
6 away from the table and we need other people to take those
7 places.

8 So, again, if you're interested in
9 becoming involved, you simply need to let us know and we
10 will make sure that there's a way to get you involved.

11 BARBARA: Coming from Norwich. "What role
12 do peer support specialists play in this initiative?"

13 CHAIRPERSON REHMER: Peer support
14 specialists are key, I think, in this initiative. We have
15 heard repeatedly from individuals in recovery that they
16 are interested in working more with us on developing our
17 peer support program. I think that as I speak about this
18 I'm realizing one of the cautions that I have to
19 constantly give myself through this process is that it's
20 easier for me -- it's easy for me to slip into what the
21 Department of Mental Health and Addiction Services is
22 doing and we really need to think about this across other
23 state agencies.

24 But let me just say, that being said, that

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1 we have been meeting with individuals in recovery to try
2 and come up with concrete ways to increase peer support
3 job opportunities in the system. We've just completed
4 several -- two episodes of training for individuals who
5 are interested in getting into peer support roles with
6 consultants from the state of Georgia. And we are
7 constantly looking at what are the competencies that
8 people need and where can we fit individuals into the
9 system because we think there are a variety of different
10 roles for people in recovery to serve.

11 That being said, I think, again, one of
12 the leaps that we have to make through this transformation
13 grant is looking at in some -- at some times the different
14 missions of the department and how we think about things
15 like people in recovery, peers, recovery, recovery versus
16 resiliency for children and adolescents. We have to
17 really think about who the people are that we're talking
18 about, what is the population we're serving and how do we
19 best meet -- reach the mental health needs of that
20 population. And it may be different for different
21 populations.

22 (QUESTION FROM AUDIENCE): Hi. I've got
23 two questions here. One is the fact of the matter is my
24 friend, her son has become schizophrenic. And it was --

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1 it happened before he turned 18. And so before 18, he was
2 in one system with the mental health services. And then
3 after he got -- became 18, he had fallen off -- you know,
4 fallen into a place where he didn't have insurance because
5 he'd never really worked. And that is a big problem where
6 the kids between 18 and whatever -- they're having a
7 problem getting services because they don't have insurance
8 or, you know, the -- it's very hard to do.

9 Another thing, too, is that -- I'm going
10 to put a little twist on this. It's possible that people
11 could be misdiagnosed mentally disabled when actually it's
12 a physical ailment.

13 I might have been misdiagnosed with
14 bipolar. I was diagnosed with Cushing's Syndrome and that
15 could cause mood disabilities, mood swings, psychosis,
16 depression and hormonal changes. Since then, I've been
17 operated on. I no longer have the Cushing's. Maybe I
18 don't have the bipolar, either. I'm looking into that.

19 But things that have to be considered is
20 that you shouldn't just label somebody that has -- that
21 might have a mental disability when there could be a
22 physical problem behind the situation, whether it's, you
23 know, thyroid or endocrine or diabetes, you know, or maybe
24 an environmental situation that causes depression.

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1 CHAIRPERSON REHMER: I think that's a very
2 good point. We know through some of the research that
3 sometimes when women in particular arrive at emergency
4 departments, they can be misdiagnosed because people are
5 responding to them as if they're anxious rather than
6 potentially having some sort of serious heart condition.

7 So I think that it gets back again to the
8 training and education of primary care physicians, of
9 emergency room physicians and other health care workers to
10 ensure that they're looking at every individual from a
11 holistic standpoint, everything that's going on in terms
12 of physical and mental health. The two are not separate.
13 They are very, very intertwined and we need to promote
14 that message.

15 (QUESTION FROM AUDIENCE): I wanted to
16 pick up on some of the comments people had made on youth
17 and address the question of how will we know that people's
18 rights are being protected and enhanced.

19 One of the ways we'll know that the rights
20 of youth are being protected and enhanced is when we do
21 forums like this and we have meetings. We'll have youth
22 and young adults here. By youth I mean teens and children
23 younger than that. And by young adults I mean 18 to 25.

24 So it's important that the families

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1 represent them. But it's also important that we see those
2 actual people here at meetings like this through DCF,
3 through DMHAS, as they go across the life span.

4 (QUESTION FROM AUDIENCE): In terms of
5 training and education of the workforce, we have one very
6 entrenched belief that we need to change. And that is
7 that the mentally ill can actually recover, get better, go
8 out into the community and become just like ordinary
9 people.

10 It's -- especially in long-term care
11 facilities, our staff tend to believe that if you've been
12 there, you know, five, ten years or so, that it's going to
13 be -- they tend to lose the initiative to try to help you
14 to become better and to leave. And I think that's a very
15 serious belief that has to be changed.

16 CHAIRPERSON REHMER: I think it gets back
17 to part of the vision statement for transformation, which
18 is ensuring that we all believe that everybody is able to
19 have a life in the community. And you're right. We have
20 to change the culture and the way people think. And
21 that's not going to be an easy task. And we're going to
22 need a lot of help to do that.

23 (QUESTION FROM AUDIENCE): Peer support
24 specialists may be very helpful in that respect.

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1 CHAIRPERSON REHMER: I agree. I agree.

2 (QUESTION FROM AUDIENCE): I'm addressing
3 the question current research is used in all mental health
4 practices. Yufar (phonetic) and the other four drugs they
5 came out within the last four years, also other -- those
6 that don't take medication at all, those in group and
7 those that see a therapist privately.

8 I'd like to know of the categories of the
9 medications, what is the newest drug that they're working
10 on? I know -- well, the newer drugs don't have as many
11 side effects. The only -- the only side effects I see is
12 an occasional -- I'm on one myself, Yufar, and I see an
13 occasional -- I take a nap in the afternoon.

14 But on those -- for those that don't take
15 drugs at all, I'd like to know what are their advances.
16 What is the research coming up with for them? And, also,
17 the -- those are seeing therapists one on one, what's
18 their -- what advances are coming up for them that they
19 are speaking of.

20 CHAIRPERSON REHMER: So you're asking what
21 the research is in terms --

22 (QUESTION FROM AUDIENCE): Yeah. In terms
23 of these in all mental health attitudes. Yes.

24 CHAIRPERSON REHMER: Okay. So it's going

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1 to be important for us to be able to answer that question
2 to know whether research is being utilized throughout the
3 system.

4 (QUESTION FROM AUDIENCE): Well, I know
5 research is -- you said it -- I'd like to know maybe if
6 someone knows like what is the next thing upcoming.

7 CHAIRPERSON REHMER: And that may be one
8 of the areas that a website that is available to all
9 individuals who live in Connecticut could access. The
10 latest research and articles about the latest research
11 could be made available so that you will be able to have
12 the answer to those questions. Because I'm sure there are
13 a lot of people that share those questions. And nobody's
14 going to have all those answers. I know I don't.

15 But, again, if we had a website that was
16 developed to look at all of those issues, there would be a
17 place that people could go and easily look for
18 information. And I want to emphasize what the person that
19 called in said. The websites that are funded through
20 pharmaceutical companies, I don't know what -- how many
21 people go to those. I do hear that people have concerns
22 about going to those because obviously there may be some
23 interest on the part of the pharmaceutical company to
24 promote their own medications.

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1 If we have a website that's not linked to
2 that kind of funding, then we are in a better position of
3 knowing that this is clean and accurate information.

4 BARBARA: Pat, we have several questions
5 from the web.

6 CHAIRPERSON REHMER: Okay.

7 BARBARA: So --

8 CHAIRPERSON REHMER: All right.

9 BARBARA: Cheryl?

10 CHAIRPERSON REHMER: Cheryl?

11 CHERYL: I have a couple of comments. One
12 is "You asked if there's -- you asked if there is a need
13 to consider the rights of the mentally ill. We believe
14 there definitely is a need. There should be more respect
15 of the clients. We do not need to be treated like
16 children. Some of the programs need more training on
17 patient rights. Some are not following the rules. How
18 can we improve this?"

19 CHAIRPERSON REHMER: I think that -- let
20 me just be clear that when I asked about or said we had to
21 look more into the rights of individuals and whether they
22 were being protected and enhanced, I don't think that I
23 was asking -- well, maybe I was. I guess I was saying
24 that we needed to do more research to understand where

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1 that question came from.

2 So I think that what I'm hearing is that
3 there are issues out there and we need to address those
4 issues. From a staff point of view, again, for me it gets
5 back again and again to training and education. People
6 need to understand at the very basic level what people's
7 rights are to ensure that we're not violating them without
8 even knowing that we're violating them. And once they do
9 have an understanding of that and they know how they
10 should be interacting with people, then I think, as
11 somebody said earlier, we need them -- we need to hold
12 them accountable for their behavior.

13 CHERYL: A question from Gateway. "One of
14 the biggest concerns heard from parents and support groups
15 is regarding children on the autism spectrum, early
16 screening, access to services. How will this plan address
17 their needs?"

18 CHAIRPERSON REHMER: Cheryl, can you just
19 repeat that for me?

20 CHERYL: Sure. "One of the biggest
21 concerns heard from parents and support groups is
22 regarding children on the autism spectrum, early screening
23 and access to services. How will this plan address their
24 needs?"

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1 CHAIRPERSON REHMER: I think that children
2 on that spectrum would be included with the population
3 that this grant is intended to address, which is anybody
4 who lives in the state of Connecticut who has a behavioral
5 health issue. It doesn't specify what your diagnosis
6 needs to be. In fact, you don't need to have a diagnosis.
7 Remember that we're looking at early intervention and
8 prevention as well.

9 So I would suggest that a child who is on
10 the autism spectrum -- again, there needs to be some
11 ability through the infrastructure to address some of that
12 issue. But let me emphasize again that that doesn't
13 necessarily mean that through this grant we could bring up
14 a particular program or service for children with autism.

15 But I think increasing awareness about the
16 needs for those things -- again, the media campaigns, the
17 anti-stigma issues, as well as training and education of
18 staff that are dealing with those young children.

19 Go ahead. Cheryl?

20 A VOICE: We're currently taking a
21 question from the telephone. So we have none at this
22 point.

23 CHAIRPERSON REHMER: Okay.

24 A VOICE: Maybe one from the audience?

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1 CHAIRPERSON REHMER: Yep. We have one in
2 the audience. Thank you.

3 (QUESTION FROM AUDIENCE): Okay. I've
4 been sitting here thinking. I'm just a little bit
5 confused because you say that programs and services aren't
6 covered and -- but best practices is. I mean sometimes it
7 would seem to me like to implement best practices, some
8 programs would have to be changed. So I'm just wondering
9 how, even with the -- even with the increase in workforce
10 and training of workforce -- I mean training them with
11 what and into what? I mean unless you have something --
12 if transformation is about change and programs that you
13 have set up aren't working, I'm just confused.

14 CHAIRPERSON REHMER: I think if I'm
15 understanding your question correctly, you're saying could
16 some of the grant dollars be used to embed evidence-based
17 practices into programs and, well, but isn't that then
18 funding programs.

19 And I think there are some very fine lines
20 in this grant. But I do think that that is something that
21 would be allowable. But it's not about bringing up a new
22 program or a new service. It's about perhaps retooling
23 what we have there to ensure that it's reflecting the best
24 care that can be given.

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1 So I can't tell you exactly how we would
2 think about doing that. But I don't think trying to embed
3 evidence-based practices into the service system is in any
4 way excluded in terms of this infrastructure grant. And
5 it may be through things other than training and
6 education.

7 BARBARA: Pat, I wonder if we could turn
8 for a moment to Quinnebaug and see if there are any
9 questions from the group there.

10 (QUESTION FROM AUDIENCE): Yes. There are
11 several questions.

12 CHAIRPERSON REHMER: Yes. We can.

13 (QUESTION FROM AUDIENCE): -- there is
14 questions and comments here how can we increase the
15 services, when the services are not appearing. The
16 current ones are being cut off at times, benefits staff
17 has been drastically sliced, truly the forgotten part of.

18 The comment is these assessment folks
19 should base their planning data on more than just
20 population. We have to hear some dialogue within our group
21 that population is the determinacy of what services aren't
22 provided. Just because we have less density doesn't mean
23 we have less need. This area of the state has not --
24 (indiscernible) state physically access transportation

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1 out.

2 CHAIRPERSON REHMER: Okay. Well, I guess
3 in terms of what you're saying, it's important for us to
4 remember that this is a statewide grant and that it's part
5 of the reason that we did this meeting tonight the way
6 that we did. We need to be able to hear from all parts of
7 the state and to think about how to reach other parts of
8 the state.

9 You know, we were one of six -- seven
10 states that got awarded this grant. And what I have been
11 struck by when we talk to other states is that -- some of
12 the states involved are Washington, Texas, Oklahoma, New
13 Mexico. These are states with huge, huge rural areas.
14 And so part of what we need to do, I think, is have
15 dialogue with them about these sorts of issues. It's not
16 that we have that much -- you know, we're a relatively
17 small state. So how are they addressing the issues of
18 getting to the areas of the state where the services are
19 not readily available? And is there anything that we can
20 learn from them?

21 I think one of the exciting pieces of this
22 grant is having an opportunity to interact with a small
23 number of other states who are going through a similar
24 process who can give us feedback about what's working and

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1 what's not working for them. And so I think all of the
2 states are looking forward to that.

3 I don't know if that will answer this
4 question in its entirety. But I think it's one of the
5 areas that we can look to.

6 Jim, do you have another question?

7 A VOICE: No. Thank you.

8 CHAIRPERSON REHMER: Okay.

9 A VOICE: Thank you.

10 BARBARA: Maybe we can go to Norwalk?

11 CHAIRPERSON REHMER: Okay. Can they hear
12 me?

13 CHERYL: A question came in from Norwalk.

14 CHAIRPERSON REHMER: Okay.

15 CHERYL: "In terms of infrastructure, what
16 provisions are there that can ease the transition of youth
17 under the age of 18 to the adult mental health system? If
18 there are none, what can be implemented?"

19 CHAIRPERSON REHMER: I think that having
20 responsibility for the youth transition program, again,
21 through the Department of Mental Health, we work closely
22 with DCF on this; that part of what we need to look at and
23 part of what this grant can assist us with is
24 communication and data sharing between state agencies.

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1 We work very hard to start that transition
2 when that individual is 15, 16, 17 at the absolute latest
3 so that we can assist with a smooth transition. But I can
4 tell you that that doesn't always work for a variety of
5 reasons. And we need to try and figure out what those
6 reasons are and address them.

7 And, again, in the same way, our inability
8 sometimes to share data or to share information even
9 across the two systems can create roadblocks that are
10 really unintended but that get in the way of a smooth
11 transition.

12 So I think one of the earliest outcomes
13 that I have seen of this grant is that we have 14 state
14 agencies and the judicial branch sitting at a table
15 together on a regular basis, beginning to talk about what
16 the issues are that we share and what are the lessons that
17 we have learned and how we can do things differently.

18 And there's agreement among the agencies
19 about many of the issues that we need to address. And,
20 again, I think the recommendations reflect some of the
21 earliest things that we've agreed on.

22 But I can tell you that there is an
23 amazing coherency and amazing cooperation that I think we
24 were frankly surprised by. You know, it's not unusual to

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1 have partners in grant applications and for people to say
2 that they're going to work with you, but then we all go
3 back to work and get very, very busy and we have a hard
4 time getting together to talk about what we're actually
5 going to do.

6 That has not been the case with this
7 grant. We've had really amazing cooperation from other
8 state agencies in terms of sharing information, sharing
9 data and talking with us about the direction they would
10 like the transformation to go in. So I think that's the -
11 - that's one of the most positive notes that I've seen.

12 BARBARA: We're just about out of time,
13 coming upon 6:15. I know that there are many, many
14 questions that have come in over the web. I wonder if we
15 can take one more from the web.

16 CHAIRPERSON REHMER: Sure.

17 BARBARA: And perhaps once we lose the
18 connectivity with the other sites, take the questions from
19 the audience here for the remaining time.

20 Also, any questions we don't get to we'll
21 certainly respond to by E-mail, those that have come in
22 that way.

23 CHAIRPERSON REHMER: All right. Let me
24 just repeat that to make sure people heard. Any questions

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1 from the web that we do not get to we will respond to via
2 E-mail. So if we don't get to you in the next few
3 minutes, we will get back to you.

4 Go ahead, Cheryl.

5 CHERYL: A couple of important ones that
6 might be worth jumping to are "How can we sign up to work
7 on the work group?"

8 CHAIRPERSON REHMER: The -- I'm actually
9 now going to put up the website so that people can quickly
10 get it. And this is the best way to get in touch with us.

11 Whoops. Let me make -- there it is.
12 There's an E-mail address that you can reach us at and our
13 website. We have a website that's devoted to
14 transformation. You can get all the work group reports.
15 Every report that we write will end up on this website.
16 So you will have an opportunity to review them.

17 Cheryl, go ahead.

18 CHERYL: "Beyond showing up for meetings,
19 which I'm sure you realize is very hard to do, how can
20 families with children with mental health challenges
21 become agents of transformation?"

22 CHAIRPERSON REHMER: I think that there is
23 a number -- if you can't come to meetings -- and we do
24 understand that that's very difficult for -- especially

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1 people with small people but even some individuals in
2 terms of transportation.

3 We would be glad to hear from you what
4 your thoughts are about the directions we're going in.
5 Again, we published the work group -- we don't publish
6 Minutes on the website but overviews of what we're doing.
7 You could certainly give us feedback or give a work group
8 chair feedback in terms of the work that you're doing.

9 We are going to look to all of you tonight
10 for feedback about this kind of meeting and whether it's
11 useful. And, again, let me remind you. Please fill out
12 the evaluation forms because that's the best way for us to
13 know whether we should venture into doing one of these
14 again.

15 And I know that we are going to lose
16 connectivity with some of the sites at this point. So let
17 me just thank people again for joining us. Please fill
18 out the evaluation form. This will be archived. So you
19 should share it with people that were not able to
20 participate. And here's the best way to contact us right
21 up on your web screen now.

22 Thank you.

23 A VOICE: And just to let you know, we
24 probably have about another 15 minutes before we lose

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1 connectivity.

2 CHAIRPERSON REHMER: Okay.

3 Okay. Right. Right. I think that what
4 we know is that some of the sites, because of the room
5 capacity, needed to change at 6:15. That's why we're
6 ending.

7 Do you want to do a couple of questions?

8 (QUESTION FROM AUDIENCE): Hi. I just
9 wanted to say when I was young, I was in -- my mother put
10 me in the hospital. And when I got out -- because her
11 insurance ranned out, so they kicked me out of the
12 hospital. So I started getting services when I was 18.
13 And I got my first apartment when I was 18. And let me
14 tell you. Giving an 18-year-old an apartment who don't --
15 haven't worked or anything and have everything taken care
16 of and all that, you was very happy.

17 So I think that people, young adults, need
18 to work, get a job. I think that's very important for
19 them to stay out of trouble. And -- that's it.

20 CHAIRPERSON REHMER: Thank you.

21 CHERYL: We have a question from Norwalk.

22 CHAIRPERSON REHMER: Go ahead.

23 CHERYL: "You're discussing much about
24 training and providing information on mental health. My

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1 concern is is the community ready to provide the support
2 needed to people who have mental health issues. Is it the
3 system that needs transforming or is it the community?"

4 CHAIRPERSON REHMER: Very good question.
5 I think that it's probably both. And it's one of the
6 reasons that we need to look to media campaigns. We need
7 to look to education of community members. We need to be
8 talking to legislators. We need to be talking to our
9 neighbors. We need to be talking to anybody that will
10 listen about not only the mental health system but what it
11 means to try to have a life in the community when you are
12 struggling with a mental health issue because I think that
13 there are many areas of the state where we need to do a
14 better job with having the communities and the natural
15 supports in the communities support individuals in their
16 recovery. We know that that works very well when it
17 works. We know that when it doesn't work it can be
18 relatively damaging.

19 So I think it's a combination of community
20 education, public awareness and systems transformation.

21 CHERYL: Another comment from the web?

22 CHAIRPERSON REHMER: Okay.

23 CHERYL: From families at Clifford Beers
24 Clinic. "With the focus on consumers and strength-based

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1 services, what changes have been proposed to heal some of
2 the hurt families have experienced utilizing services run
3 by the state? Families with children feel distrustful,
4 guarded and reluctant to utilize the potential positive
5 services because of their negative experiences."

6 CHAIRPERSON REHMER: I think that part of
7 what we are going to have to do as we work on transforming
8 the system is rebuild relationships in many arenas. We
9 need to rebuild relationships with individuals who have
10 experienced the system that feel the same distrust as
11 those families feel. We're going to need to rebuild
12 relationships with those families. And that's going to
13 take time.

14 We understand that people have experienced
15 things in the system that have not been pleasant for them
16 and that have made them distrustful. And we're going to
17 have to work together to change that. We can't change the
18 experiences, but we change the experiences going forward.

19 (QUESTION FROM AUDIENCE): Hi. It -- I'm
20 a consumer who's in recovery. It took me 33 years to get
21 my GED with my mental illness. And I only got it last --
22 last year, my GED.

23 CHAIRPERSON REHMER: Congratulations.

24 (QUESTION FROM AUDIENCE): And I'm working

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1 on trying to focus on going to college with my mental
2 illness. I know it's going to be hard for me. But with
3 the education, I know I could go through it because like I
4 tell myself, I tell other people; if people don't know who
5 you are, don't tell them who you are. If they don't like
6 you, don't pay them no attention. Just let it go in one
7 ear and out the other ear.

8 And I think education is very important
9 for mental illness people to get so they could be more in
10 the recovery process. Like I'm helping -- I'm helping out
11 my husband. He's trying to get services and he's getting
12 denied every time from people he went to get services.
13 And he doesn't know how to go about doing it. And I don't
14 know how to go about doing it for him, either. So I'm
15 just hoping that this -- the state fundings will help him
16 because he wants to go back to school and get his GED.

17 CHAIRPERSON REHMER: Maybe one of us can
18 touch base with you after this to see if there's something
19 that we can do to help.

20 (QUESTION FROM AUDIENCE): I have a
21 comment on Question No. 9. "Connecticut workforce is well
22 prepared to address the mental health needs of all
23 citizens." That also is not true. Disclosure is not
24 recommended because of high discrimination rates. And

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1 that needs to be addressed.

2 CHAIRPERSON REHMER: So you're suggesting
3 that when people go to get jobs, that your experience has
4 been that when they disclose that they have a mental
5 illness, they get a negative response.

6 BARBARA: Cheryl, do we have more from the
7 web?

8 CHERYL: Yes.

9 BARBARA: Okay.

10 CHERYL: A question from Gateway. "Are
11 there plans to look at the very special needs of the
12 elderly mentally ill, both mentally ill people as they
13 become elderly and elderly people who develop mental
14 illness? Often, the care of this population gets lost or
15 goes unrecognized in the current system of care."

16 CHAIRPERSON REHMER: Again, let me
17 emphasize that this is a grant that looks across the life
18 span. And so our -- our commitment is to children,
19 adolescents, youth and older adults. If you remember, the
20 Commission on Aging actually participates with us on the
21 Oversight Committee and in several of the work groups.
22 We've also had a couple of conferences, conference calls -
23 - excuse me -- with national organizations who are very
24 interested in helping us look at that population in

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1 particular and what would be the best way to reach them
2 and to serve them through these transformation dollars.

3 We hear, at least preliminarily, that
4 probably that's one of the populations where stigma is the
5 biggest issue. People are unwilling to disclose that they
6 are suffering from depression or having difficulty. And
7 that, again, it's an area where primary care physicians
8 could be extremely helpful in doing screenings and working
9 with us on that issue.

10 So our intention is to address the needs
11 of older adults.

12 One more question from the web, Cheryl?

13 CHERYL: Yes. Well, first we have a
14 comment.

15 CHAIRPERSON REHMER: Okay.

16 CHERYL: "We appreciate your having a sign
17 language interpreter. This will ensure people with
18 hearing -- hearing disabilities can partake in this
19 webcast."

20 Another one is "How can we use this grant
21 to train people who come into contact with people with
22 mental illness in the workplace and our schools, in the
23 law enforcement community?"

24 CHAIRPERSON REHMER: The intention in

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1 terms of training and education is to go across many, many
2 departments. Certainly the Department of Education is at
3 the table. The Department of Higher Education is at the
4 table. The Department of Corrections. So I think that we
5 have opportunities to begin to work with workforces that
6 we have not worked with before in this area.

7 CHERYL: A question from the web. "Is
8 DMHAS the gatekeeper for the grant dollars that involve
9 all of the agencies that participate in the mental health
10 transformation process? Is DMHAS the only agency that
11 will spend grant dollars for this effort?"

12 CHAIRPERSON REHMER: No. Let me clarify
13 again that the Department of Mental Health and Addiction
14 is the lead agency on this grant. For any grant you have
15 to designate a lead agency. This is a grant that came to
16 the Governor's Office for the state of Connecticut. The
17 14 agencies and the judicial branch signed a Memorandum of
18 Understanding saying they would work on this process with
19 the Department of Mental Health and Addiction Services in
20 terms of transforming the mental health system. They are
21 involved at the oversight level. They are involved at the
22 work group level. They are involved on the sub-committee
23 level of the Oversight Committee. And, again, the
24 Oversight Committee really has the responsibility and the

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1 authority for the oversight of this grant.

2 So, while we are taking the lead on this
3 and the staff is deployed through DMHAS, we are working on
4 a daily basis with other state agencies on this.

5 One more from the web?

6 CHERYL: "Can you continue to work with
7 Yale-New Haven on mental health issues? Also, how can we
8 help teachers recognize if a student is suicidal?"

9 CHAIRPERSON REHMER: Yes, we can continue
10 to work with Yale on this. They are actually a partner in
11 this as well. And I think that that's -- our first
12 recommendation is specifically about suicide prevention in
13 school-aged children. And so I think that that's a
14 question we have to take to the work groups. Now that we
15 have this recommendation, how are we actually going to do
16 it? What are the means to operationalize this?

17 And so this is really the -- it will be
18 the first work group that will work on that.

19 One more question, Cheryl?

20 CHERYL: Yes. This is from a group. "We
21 are the partners of Hartford/West Hartford Community
22 Collaborative watching this presentation at the Village
23 for Families and Children. We have the following
24 question. How can systems of care, community

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1 collaboratives become involved in the work of this grant?

2 CHAIRPERSON REHMER: I think there's a
3 number of different ways that the community collaboratives
4 and the systems of care can become a part of this grant.
5 Again, becoming a member of the work group, if time
6 permits, is always a good way to do that. I would say
7 that DCF is at every table of every work group and talking
8 with individuals at DCF specifically. Bert Plant and
9 Susan Smith, who are in our audience tonight, are the DCF
10 designees for this grant. Commissioner Dunbar is sitting
11 on the Oversight Committee and participating in the
12 planning and the recommendations from that group. So I
13 think there's a number of different avenues that you have
14 to become involved.

15 Okay. Oh.

16 (QUESTION FROM AUDIENCE): I just had a
17 final comment. It's quite obvious that there is a great
18 deal of work to be done. But I, who have been briefly a
19 provider and in the mental health system a volunteer,
20 worked briefly -- I'm very proud to work briefly with
21 Larry Davidson at the Programs for Recovery and Community
22 Health.

23 I think that we can be proud of some of
24 the things that have been done, the efforts to put peer

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1 specialists in emergency rooms, to have the people from
2 PERCH out going around the country affiliating with other
3 universities, learning and teaching, and many more things
4 that I won't even try to get out.

5 So I'm very proud to be a citizen of
6 Connecticut. And I plan very much to become a part of
7 your work group. And I wish us well as a state.

8 CHAIRPERSON REHMER: I think I'll take the
9 opportunity on that positive note to end. Thank you very
10 much for coming this evening. And, again, don't forget to
11 fill out the evaluation forms.

12 Thank you.

13 (Whereupon, the meeting was concluded at
14 6:30 P.M.)

15