

Testimony Submitted to the Appropriations Committee:

H.B. No. 6824:

An Act Concerning the State Budget for the Biennium Ending June Thirtieth 2017,
and Making Appropriations Therefor and Other Provisions Related to Revenue

Submitted by: Linda Buchanan, Hartford, CT

Mother of Nicholas Harrity, November 20, 1981 - August 7, 2013, big brother, and
John Harrity, November 14, 1990 - November 7, 2012, little brother

March 6th, 2015

Senator Bye, Representative Walker and distinguished members of the Appropriations Committee, my name is Linda Buchanan. Let me state upfront that I do not know if I will make it through my testimony, I ask that you bear with me. (If I cannot, I have submitted it in writing, and I humbly request that you review it.)

I am a parent of and advocate for people living with mental illness and the agencies that serve them. For me, both are heroes. I am also a consumer of mental health services and an 18-year legislative employee. I have trained as a NAMI Family-to-Family teacher, and in 2004, I served as a Parent Representative on Lieutenant Governor Kevin Sullivan's Mental Health Cabinet, producing the report that I submitted as an attachment to my written testimony. That is where I first met the extraordinary Pat Rehmner, then Deputy Commissioner of the Department of Mental Health and Addiction Services (DMHAS). I suspect that many of you are not aware of and have never read that report; I humbly urge you to do so.

Two years ago, I first testified before this committee in support of essential funding for, and for the Nonprofit Behavioral Health Agencies that provide a continuum of direct behavioral healthcare services to those in our communities, and their families, living with mental illness.

I shared, what was at that time, our recent loss of our youngest son, Johnny, who died a week before his 22nd birthday in November, 2012. I pleaded with this Committee to increase the Governor's 2013-2015 proposed budget for DMHAS, to ensure that nonprofit agencies would be able to meet the immediate and critical need for services for their clients, to enable them to live with dignity, with security, in our communities.

My very personal plea was directly connected to my fear that our oldest son, Nick, would not be able to receive the services, the support, that he so desperately needed due to the staffing shortages directly caused by devastating budget flat-funding and rescissions over many years. Nick was a client of Gilead Community Services' Assertive Community Treatment (ACT) Program from approximately January, 2011 until August, 2012. As a family, as a mother, we could not bear to lose another son.

As a parent, advocate, consumer and legislative employee, I am better informed than many - forgive me, but I suspect perhaps than some members of this committee - on the shell game that has been the funding stream for mental health services in our state over the last decade. Nonprofit Behavioral Health Agencies have been not just flat-funded through biennial budget cycles and gubernatorial rescissions for more than ten years, they have sustained severe reductions due to rising costs.

Since 2012 alone, DMHAS has sustained \$32 million in budget reductions -- \$25 million was moved out of the budget on the assumption that behavioral health agencies would realize an increase due to more clients being covered by Medicaid under the Affordable Care Act. Forgive me, but I going to say this very slowly - it does not take a rocket scientist to realize that almost all clients receiving and DMHAS services ***were already covered by Medicaid***. So that "anticipated fee increase"? Not only did it never happen, we knew it would never happen.

Pat Rehmer, by then Commissioner of DMHAS following in the footsteps of the equally extraordinary Tom Kirk, was able to ameliorate a portion of that \$25 million budget cut with a one-time transfer of \$10 million from the state's Tobacco Settlement fund. That rainy day fund no longer exists as a resource to fill the deep holes that we continue to create. On top of that \$25 million reduction in DMHAS's budget, the Governor's rescissions added another \$4.5 million in cuts. That \$4.5 million reduction is carried forward in the Governor's budget before you today. \$32 million in cuts just since 2012, following 7 years of flat-funding - meaning real-world cuts, deep cuts, as we know that medical, utility, facility maintenance, benefit and a myriad of other costs continued to rise over the last ten years.

(By the way, the last budget - the one that I spoke on before you two years ago - included a .5% COLA increase for Nonprofit Behavioral Health Agencies, in the last 6 months of that budget. You guessed it, swept away by rescissions, never happened.)

These are a lot of numbers to throw around, numbers on a piece of paper. But now let me put this in human terms - these are not numbers, they are *people*. They are some of the most vulnerable people in our communities, and their struggling, stressed families that love them, and the dedicated workers that do their very best to support and serve them.

These are all numbers on a page... easy to see as abstractly, who cares? Here is what these numbers meant to Nick, meant to me and to my family -

When Nick was first accepted for services by River Valley Community Services, the Middletown division of DMHAS, and referred to Gilead Community Services for Case Management Services, after, as I so often had to, I shifted into warrior mode, it was a happy day.

Nick was - as is so often the case for people who later emerge with major psychotic disorders, Bipolar Disorder, Schizoaffective Disorder, Schizophrenia - was stunningly brilliant, deeply creative, precocious from an early age, a gifted writer and photographer, equally facile with physics or aperture setting. A social worker at the Institute of Living, Nick's case manager in one of his many, many psychiatric hospitalizations after his 15th birthday, once told me that Nick's neurons fired at ten times the speed of ours, that if he thought the way that most of us do, he would feel as though he was mentally slogging through mud. Neurons that crackled and fired so fast, his brain broke.

We do not have the time for me to tell you all that I wish that I could of Nick's life. The short-as-I-can-make-it version is that this beautiful young man, full of promise, full of life, first exhibited symptoms of serious mental illness during his sophomore year of high school at 15, what is referred to as "early onset." Panic attacks evolved into Bipolar 1 Disorder, with Nick's first full psychotic break occurring in the fall of his senior year of high school. Many failed trials of antipsychotics followed, many, many hospitalizations, Bipolar Disorder evolved into Schizoaffective Disorder - a thought disorder to accompany the showed up by 21. Eventually the thought disorder, Schizophrenia, was, as we say, "driving the train."

At 22, in a residential treatment program that would be laughably impossible today, Nick was finally, after exhausting all other available antipsychotics, given a trial of the gold-standard antipsychotic for Schizophrenia, clozapine. *Within two weeks*, his psychosis was lifting, his personality returning, after more than five years of acute illness. "There you are!! We knew you were still there!" Treatment Works. Nick was able to have 6 or 7 stable years - he was still never able to work, or go to college, but he had friends, he had a life, he was Nick.

Anyone familiar with the course of severe mental illness knows that it does not stay in one place, it moves along a continuum, sometimes a little better, sometimes more acute, and medications need to be adjusted accordingly, especially as one ages. The majority of people living with severe psychotic disorders will, at some point in their lives, go off of their meds. It is as inevitable as an alcoholic who relapses before they are able to sustain sobriety. If a clinician does not recognize the small window of opportunity, as someone ramps up toward mania and active psychosis, in which medications need to be changed or dosages increased, psychosis will return and the ability for the client to partner in their treatment may well vanish. This is what happened to Nick.

This is when he was no longer safe living with the family, this is when Gilead entered our lives, this is when he Gilead provided at DMHAS housing voucher, case management, and, for the first time at the age of 31, he was able to live in his own apartment in Middletown, he was able to live independently. Nick was so very, very proud of that apartment, of his independence. We began to feel hope.

Forgive the length of my story, but we have finally reached the climax. This is what happened:

- In the first year, Nick was assigned a case manager, scheduled to see him once each week for 30 minutes. The social worker, Nick's case manager, was a great guy, met Nick in a coffee shop where he was more comfortable, slowly got to know him, and - so critical - began to build trust.
- Nick's case manager left for another non-profit (in Hartford, as it happens) that could afford to pay more. Gilead did not have the funding to immediately fill the vacancy.
- The ACT Program clinical psychologist, a long-time vacancy that had only recently been filled, and whom Nick had just begun to see for counseling every other week, begun to trust ("She listens to me!") was drafted to fill in as case manager. Now, instead of being his therapist, she had to assess how well he was functioning with day-to-pay personal care - Was he eating? Was he bathing? Was he taking his meds? No more therapy. **Case management visits were reduced from 30 minutes every week to 15 minutes every other week.** The ACT Program stopped accepting new clients - no available staff.

- Not long after Nick's placement with the ACT Program, the program manager was transferred to supervise another program - acting manager named. After months, a new manager was finally hired. **Severe funding constraints make it extremely difficult for Behavioral Health Nonprofits to both recruit and retain staff, whether front-line workers, program managers or administrative.** A few months later, that manager was gone. Another "acting manager" (which means a regular case manager adding administrative responsibilities). Another program manager, also gone after a short period. As of today, the ACT Program is once again functioning under an acting manager.
- In the summer of 2012, Nick began to (another technical term) decompensate - his delusions became worse, darker, more relentless, escalating. I called, I emailed (a program manager that was no longer there..), I rang all of the alarm bells that I could. Gilead staff agreed, they were worried about Nick, too. We scheduled a meeting to discuss next steps for Tuesday, August 13th.
- The week before we were to meet, to assess whether Nick was a danger to himself and needed a higher level of care, Nick's clock ran out. When we found him, on August 7, 2012, Nick had likely been dead for several days. My sweet, kind, funny, brilliant son was gone at the age of 31, 9 months after his little brother.

I need to take a moment here to personally acknowledge and thank, from the bottom of my heart, a member of this committee, State Representative Matt Lesser, who got a call on that terrible, hot Wednesday afternoon in August, and came to the 90+ degree small vestibule of my Nick's apartment building, and stayed with me, while I waited for three hours, before the Middletown police would allow me to go up to my son's apartment, to kiss him goodbye before his body was removed. Words fail to express my profound gratitude for that act of generosity and kindness for someone that he barely knew. I will never, ever forget it.

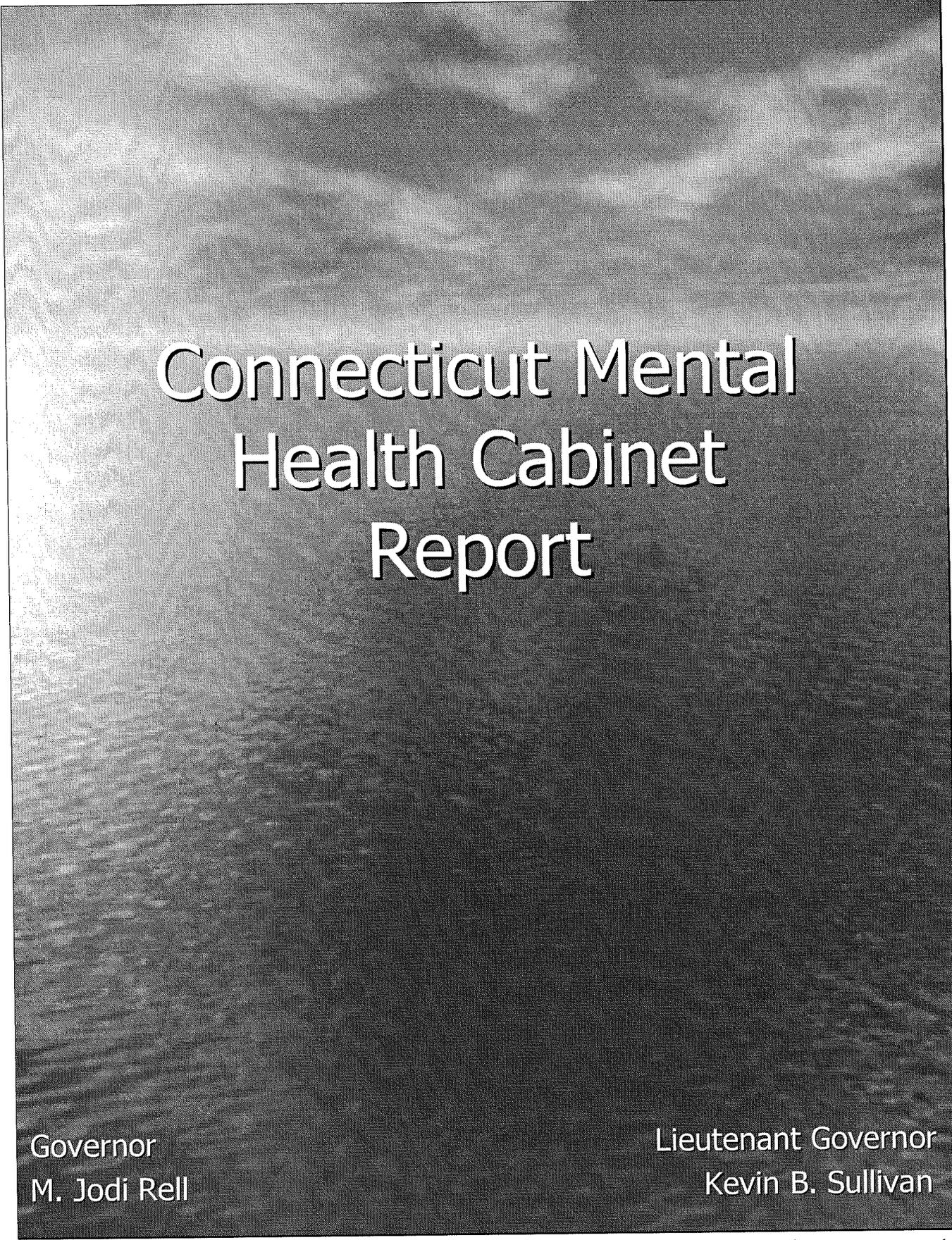
Please know this - there is a bright, sharp, absolutely direct line between the funding cuts to the DMHAS budget over the last 10 years and, through that, to the Community Behavioral Health Nonprofits, and my son's death. Nick needed the greater trust that came with more frequent contact, the ability of a case manager who knew and saw him over time to recognize the danger he was in. He got less time, a stand-in case manager who did not know him, a program that no longer had the funds to support experienced, consistent program management.

Two years ago I begged you to make sure that I did not lose my surviving son. Six months later, that son was dead. We are all culpable in this room, each of us bears some piece of responsibility for not only my son's death, but for other deaths that treatment may have, could have, prevented.

When I say that if we do not find **the political will**, to - at bare minimum - restore the \$32 million in funding that DMHAS has lost in the **last three years alone**, there will be blood on the floor, it is not a figure of speech. It is real people, and actual blood - *people will die* - and their innocent blood, like my sweet son's, will be on our hands.

Thank you for your patience, thank you for listening to Nick's story, to my story. I know that task before you is hard; I give you my trust, and my gratitude.

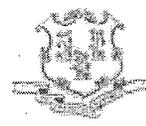
Linda Buchanan



Connecticut Mental Health Cabinet Report

Governor
M. Jodi Rell

Lieutenant Governor
Kevin B. Sullivan



Achieving the Promise:

Recommendations of the Lieutenant Governor's Mental Health Cabinet

Introduction

Mental illness is not the face of a stranger. It's about our families, friends, neighbors, co-workers and sometimes ourselves. One in 5 adults, slightly more for children and adolescents, are dealing with or not dealing with mental health challenges every day. Biology, behavior and stress combine to make mental illness a condition of disease that by any standard is epidemic.

Treatment works when it is appropriate, accessible and sustained. Early identification makes all the difference. Failure to provide effective treatment costs us all every day in paying for the consequences. Yet, Connecticut continues to fail. In the words of one of the many who spoke with us during our work, "If the problem persists than there must be a more powerful reason to it ignore it and that's fear."

We do not need more studies; we need action that makes a difference. We can no longer let stigma, fear and lack of investment stand in the way. Connecticut must build a comprehensive, accessible, affordable, community-based, family-oriented, culturally competent and recovery focused system of care. If community-based services are not available, children and adults with mental illness will continue to fill expensive, inappropriate, and non-therapeutic settings such as hospital emergency rooms, the criminal justice system, and nursing homes or simply go untreated.

I thank Governor Rell for the opportunity to lead this non-partisan initiative and am grateful to all those who will continue to work together in this effort. Most of all, I deeply appreciate the real heroes who came to speak in public of their private struggles and personal victories.

Kevin B. Sullivan
Lieutenant Governor

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Executive Summary

The recommendations of the Lieutenant Governor's Mental Health Cabinet build on the Governor's Blue Ribbon Commission Report on Mental Health, Delivering and Financing Children's Behavioral Health Services Report, and the planning and initiatives of the Community Mental Health Strategy Board and its first initiatives.

These recommendations directly address the reality that so many who face mental health challenges in our state remain inappropriately institutionalized, underserved or unserved as well as all those who can better be helped before they experience greater disability. When implemented as a whole, these recommendations would turn less effective institutional spending into more effective community support, treatment, and recovery. Consequently, Connecticut's mental health spending would shift away from fragmented, ineffective approaches that disrupt families, promote unnecessary institutionalization, fuel homelessness and do not sustain recovery. Instead, private insurance and the state would invest in cost-effective, long-term and proven solutions based on greater awareness, easier access, more adequate funding and insurance coverage, and true systems of care with strong family-centered best practices in a community infrastructure of treatment, support, and sustained recovery for children, adolescents and adults.

It is symptomatic of what needs to be done that Connecticut is the *only* state in the nation that not fully implementing the federal Medicaid Rehabilitation Option for adults, and uses the Children's Rehabilitation Option *only* to maximize revenue for clinical services in residential treatment rather than community services. In effect, Connecticut continues to transfer millions of dollars from our state to every other state while our mental health care needs remain unmet. Maximizing federal revenue, as all other states do, can pay for about half the cost of the mental health initiatives recommended in this report and even more if state government more effectively seeks federal matching funds for existing programs and services.

Overall, Connecticut faces a dual challenge today. We must build our capacity to provide age appropriate prevention, diagnosis, treatment and supportive services as well as help individuals and families access mental health care in more coherent, compassionate and timely ways.

Connecticut cannot afford to wait any longer. Achieving the promise must begin now.

Summary Recommendations

At Governor Rell's request, Lieutenant Governor Sullivan organized a broadbased Connecticut Mental Health Cabinet. Working groups were formed to develop recommendations with the Lieutenant Governor's charge to "focus on specific actions that could be taken within the next four years and would substantively improve the availability and effectiveness of mental health care in Connecticut. Between August 12 and December 16, the Lieutenant Governor's Mental Health Cabinet met regularly to review the existing efforts of key state agencies – especially the Department of Mental Health and Addiction Services, Department of Children and Families, and Office of Policy and Management. Draft recommendations were developed, extensive comment received at five public forums (one in each of the state's congressional districts), and revised into the following recommendations for action:

Outreach

- Provide a statewide, on-line inventory of resources and services for children and adults.
- Expand specialized telephone information, referral and follow up for children and adults.
- Support education and training by the Governor's Prevention Partnership to improve awareness for early childhood, schools, higher education, senior centers, public safety, and pediatric, geriatric and other general health care providers.

Best Practices

- Continue funding "Second Initiatives" begun by the Mental Health Strategies Board.
- Enhance Assertive Community Treatment teams and include co-occurring services.
- Pilot intensive home and community services, with housing options, for serious mental illness under the Medicaid Home and Community Based Services waiver and appropriate reinvestment from incarceration to community services.
- Expand Young Adult Services early intervention, treatment and transition in catchment not now served.

Children's Mental Health

- Extend Connecticut Community KidCare to add care coordinators, family advocacy services, community collaborative coordinators and flexible emergency funding for children *not* in state custody.
- Expand evening and weekend availability of emergency mobile teams that include home, early childhood and school liaison.
- Increase payment rates and available hours to enhance family respite care

Supportive Housing

- Create and maintain 1,000 additional units: 350 for families and 650 for single adults (including 100 for young adults transitioning from state custody or otherwise at risk) with adequate, ongoing rental support.
- Provide effective individual adult, family and young adult transition services that include case management, training in independent living and employment support.

Real Parity

- Create an ongoing working group of payer, provider, advocate, patient and agency representatives at the Office of the Managed Care Ombudsman to ensure private insurance coverage consistent with best practices.
- Pilot a private employer group mental health care coverage productivity and savings initiative. Require that state licensure assures mental health coverage at least meets National Council on Quality Assurance standards
- Complete an independent evaluation of mental health parity in Connecticut through the Legislative Program Review and Investigations Committee.

Provider Rates

- Provide effective outpatient rates (85% of Medicare for adults, 100% of Medicare for children and adolescents) for providers, including hospital outpatient that meet the criteria for "enhanced care clinics."
- Fully implement the Medicaid Adult and Children's Rehabilitation options in order to maximize federal funding for state reinvestment.
- Provide reimbursement for general hospital child and adult inpatient care on a per diem basis similar to Connecticut Community KidCare.
- Fully fund the indexing of private provider rates toward parity.
- No longer reduce state benefits when federal Social Security benefits are increased to keep pace with the cost of living.

Mental Health Care in Connecticut

Funding Fails

In the mid-1990's, Connecticut downsized and closed state mental hospitals that tended to warehouse patients rather than focus on recovery. Savings derived from closures were not reinvested to create an effective community-based mental health safety net. State funds, rather than Medicaid revenue, were used to finance limited mental health services. State funding for core mental health services remained essentially flat, adjusted for inflation. Eventually, the state's Medicaid program and most private health insurers moved to managed care that tended to very narrowly define "medical necessity" for purposes of mental health care and made extended psychiatric care unavailable for all but self-payers.

Demand Expands

Meanwhile, the demand for adult mental health services rose 20% and community services were stretched to a breaking point. Mental health resources, from general hospital emergency rooms to state facilities to community placements, experienced gridlock. At the same time, prisons, nursing homes and shelters saw more and more adults with behavioral health issues. This pattern was paralleled for children and adolescents by greater reliance on residential treatment and increasing numbers of youngsters in the juvenile justice system, the latter composed disproportionately of poorer children and youth of color.

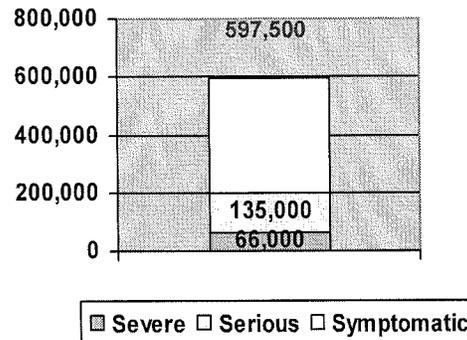
Limited private mental health care coverage, lack of available community facilities and increased demand soon caused a major cost shift back to the public sector. One response was the start of KidCare, an initiative to develop systems of care with strong family-centered practices and a community infrastructure for treatment, support, and restorative care. Available federal funding was not fully accessed while state funding lagged and is once more at risk given the cost of compliance for DCF-involved children in response to the *Juan F* federal settlement. Similarly, while DMHAS has gained national recognition for leadership in focusing on outcome-driven strategies of care and support, available federal resources for adults are minimally tapped and state investment lags. In the absence of a statewide system of community-based mental health care, children and adults have effectively been reinstitutionalized in more expensive and less therapeutic out placements, juvenile detention, hospitals, jails and nursing homes.

Prevalence of Mental Illness

Out of nearly 600,000 Connecticut adults who evidence symptoms of mental illness, 135,000 have serious mental illness while another 66,000 suffer from severe and persistent mental illnesses. Addictive disorders with or without additional mental illness account for a

significant proportion of homeless and prison populations.

Mental Illness in Connecticut Adult Prevalence & Severity



Estimates of children and youth with a mental health condition vary from 87,500 to 125,000. For children admitted to pre-trial detention centers:

- 55% show signs of a mental health disorder.
- 20% require prompt psychiatric intervention.
- 22% of children were in the mental health system when referred to court supervision.

Black and Hispanic youth and adults disproportionately make up Connecticut's juvenile detention and prison populations. As associated with poverty, Black and Hispanic youth have a higher proportion of mental health issues, including addiction and suicide attempts. There is also an alarming trend, especially among very young children, in increased suspensions and expulsions from schools or early care and education that are often the result of underlying mental health disorders.

Costs of Inadequate Mental Health Care

Several years ago, the U.S. Surgeon General documented the billions of dollars lost nationally every year in productivity costs and expensive treatment of secondary symptoms due to inadequate mental health coverage and care. Public mental health care traditionally focuses on children and adults in poverty who rely SAGA, Medicaid or Medicare. Public payments provide the bulk of funding for community mental health care but usually well below the actual cost of providing care. Similarly, payments to private non-profit providers lag behind expenditures for comparable state-operated programs, services and facilities. Chronic underfunding is a major reason for the contraction of available mental health care, especially outpatient care. Underfunding leads to expensive consequences. People with unmet mental health needs become unemployed and often homeless. Families become dysfunctional. People unnecessarily end up in the juvenile justice and adult criminal justice systems, juvenile detention and prisons, and nursing homes and homeless shelters, or rely on

extended emergency hospital admissions and inpatient units because there is no appropriate place to go. Rather than effective treatment and recovery, Connecticut pays more for less.

Criminal System

The most recent data obtained from the Department of Corrections documents an alarming increase to 3,072 prisoners with mental illnesses -- 16% of the prison population and a 40% increase in four years. People with serious mental illness, especially with co-occurring substance abuse, are more likely to be incarcerated for minor offenses and serve longer sentences, all related to the lack of community alternatives. The annual cost of incarceration is about \$44,000, compared to \$13,000 for supportive housing.

Nursing Homes

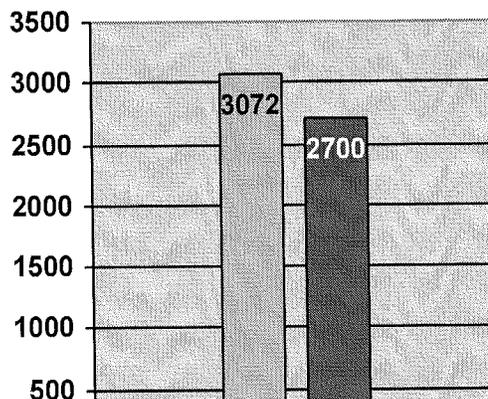
Without intensive community supports and affordable housing, many mentally ill people end up living in nursing homes at great public expense. Admissions to nursing homes of adults with serious mental illnesses are growing at a rate between 5 to 10% per year. Only 47% of those admitted are over the age of 65, indicating a huge long-term public cost for inappropriate care. More than 2,700 adults with serious mental illness are in nursing homes at an annual cost to the state's Medicaid program of \$60,000 to \$70,000 per person.

Homelessness

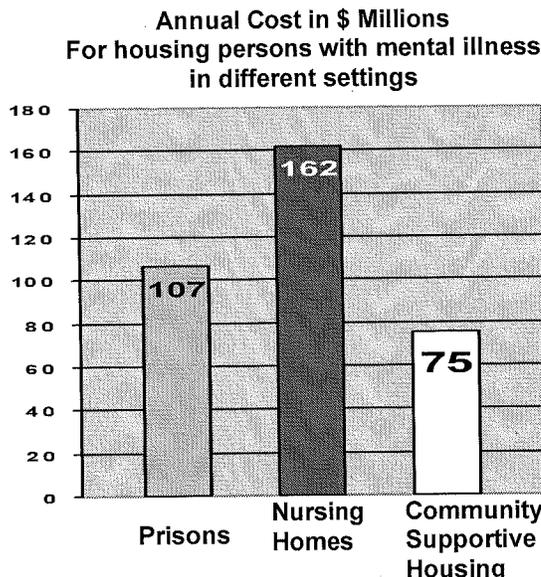
More than 33,000 people, including 16,000 children, experienced homelessness during the past year. Another 37,500 were turned away from full shelters, a 38% increase over the previous year. A substantial proportion of those homeless or living in shelters have a serious mental illness.

Potential Sources of New Funding

Connecticut has not effectively leveraged mental health expenditures. Opportunities available under the federal Medicaid Home and Community Based Services waiver process could release funds now spent on nursing home care to provide wrap around services to help more people with mental health challenges live in the community. If only 20% of those currently in nursing homes could be discharged under this waiver, \$32 to \$37 million in service funds would become available to reinvest in community-based care and services.



People with Mental Illness Housed in Prisons and Nursing Homes
 ■ Criminal justice settings ■ Nursing homes



Connecticut's Response

In July, 2000, the Governor's Blue Ribbon Commission issued its report identifying a mental health "crisis" in Connecticut. The State Legislature followed up by creating a broadbased Community Mental Health Strategy Board and funded significant new initiatives for the first time in years. Despite these new beginnings, the 2004 inter-agency Mental Health Policy Council's report tracking progress was far from encouraging.

Budget Shortfalls

Significant financial strains on the mental health system have been driven by:

- Budget cuts eliminating 15% of DMHAS employees.
- Medicaid rates for private non-profit programs remaining effectively unchanged for years.
- Cost of living adjustments for community-based agencies not keeping pace with inflation.

Lagging Provider Funding

Connecticut Medicaid reimbursement rates for clinic-based psychiatric outpatient care remain far below the actual cost of providing services. The state still needed to:

- Follow through on Blue Ribbon Commission recommendations to increase reimbursement rates for inpatient and community-based services.
- Pay for increases by capturing federal revenue under the Medicaid Rehabilitation Option.
- Maximize the use of optional Medicaid State Plan services, including the Rehabilitation Option and Targeted Case Management services.
- Utilize Medicaid waivers (e.g., home and community based services) to expand services to adults and children.

Federal Revenue Not Maximized

Connecticut remains the only state in the nation to not implement the federal Medicaid Rehabilitation Option for adults. The Child Rehabilitation Option is used only to maximize revenue for clinical services in residential treatment, with no community services covered. In fact, state implementation of the Adult Rehabilitation Option has been limited to securing federal Medicaid reimbursement for services in adult group homes, producing the least revenue of any potential covered service.

Programmatic and Financial Needs

The Department of Children and Families, Department of Mental Health and Addiction Services, Judicial Branch, Department of Social Services, Office of Policy and Management and other key state agencies had yet to develop multi-year plans containing specific programmatic and fiscal proposals to support and enhance mental care health systematically.

Continuing Gridlock

Adults with serious mental illnesses continued to fill hospital emergency rooms and inpatient settings. To address this gridlock, the state still needed to:

- Develop and support a continuum of housing and employment opportunities that sustain people in community-based mental health care.
- Fully implement the Medicaid Rehabilitation Option and reinvest additional federal revenue in the targeted initiatives of the Community Mental Health Strategy Board.
- Adequately fund KidCare to stem the still growing flow of children into inappropriate custodial and residential placements
- Fund less intensive community-based mental health services for children to strengthen early identification and intervention rather than crisis.

Only such increased access to outpatient, wrap around, and rehabilitative services would decrease gridlock.

Absence of Community-Based Systems of Care

While mental health authorities oversee services locally and regionally, there are still not enough community-based services to meet current and projected needs. Attrition, driven mostly inadequate compensation, is placing additional pressure on institutional services and reaching a point where people are at risk.

Too Much Out-Of-State Residential Placement

In January, 2004, 500 of the almost 1,500 Connecticut children were receiving services in residential facilities in out-of-state facilities. In addition to stressing families and lessening longterm recovery, annual costs are approximately \$65,000 for in-state compared to \$95,000 for out-of-state facilities. There is still no system to determine how children enter residential services, take steps to avert residential placement and reduce barriers for families trying to access care for a child with mental health needs.

Falling Through the Cracks

Lead responsibility for children's behavioral health and adult mental health remain separated in two state agencies with much of the funding managed by a third. DCF Voluntary Services is a hopeful but still very limited development. At the same time, referral of age-outs from DCF to DMHAS increased from only 1 in fiscal 1997 to 59 in just the first quarter of fiscal 2004, along with increases from schools, jails, hospitals and families. By 2003, DMHAS served 4,244 young adults. Many have intensive service needs, severe and disabling psychiatric illnesses and years of institutionalization with 25% requiring higher level of care than exist through DMHAS. Still others, especially those aging out of foster care, just fall through the cracks.

OUTREACH WORK GROUP: CONNECTING TO CARE Recommendations

"...how fragmented the system is and how hard it is for families to maneuver the system."

Few of us or our families are prepared to deal with mental health challenges. Too often, fear and isolation are compounded by frustration. Those in need of help are left with confusion and despair. Just as there is no real system of mental health care, there is also no comprehensive and accessible way to find assistance. In addition, many who could be first responders simply lack the necessary information and training. From child care to senior centers, schools to higher education, and in general medical practices of all kinds, opportunities for prevention and early intervention are regularly missed.

Connecticut should build on existing efforts and develop a statewide "Connecting to Care" initiative. This initiative would provide timely and accessible information and referral, as well as outreach that informs and trains those who can best be supportive first responders.

- **Interactive, web-based inventory**

Self-directed technology can be especially helpful to individuals who are dealing with socially limiting illness. One model for mental health is the user-friendly, web-based on-line "Network of Care" available from Trilogy Integrated Resources. The National Association of County Behavioral Health Directors has already partnered with Trilogy to develop websites and would likely provide a discount for Connecticut to affiliate. This system could be implemented in three months and would be much more extensive than what is currently provided by *Infoline* as well as interactive. There may be other, similar systems available to contract with. Costs would include one-time set up and monthly maintenance, including updates based on user feedback.

- **Specialized telephone information and follow-up**

The child development "Help Me Grow" model already implemented as a component of *Infoline's* 211 system provides telephone outreach for families with children from birth through age 5. Trained and culturally competent telephone care coordinators provide information and screening. With permission, the profile of individual need is referred to community liaisons who researches services and then link families back through care coordinators to available resources. This service includes follow up to assure that contact has been made with providers and to assess user satisfaction. The service is available regardless of income level or insurance coverage. With added emphasis on mental health, this service should be expanded to include adolescents up to age 18 and to add a unit for adults. Costs include planning, 5-6 additional care coordinators and 3 more liaisons in the unit for children and adolescents plus 2 supervisors, 10-12 care coordinators and 6-8 liaisons for the new adult unit.

- **First responder outreach & training**

Those most likely to see the first signs of mental illness are often least prepared to notice or know what to do. The Governor's Prevention Partnership should be funded to work with appropriate state agencies and professional associations in order to develop and implement pre-service and in-service training for parents, early childhood providers, school and higher education professionals, police, senior center staff, and general health care practitioners from pediatric and family medicine to geriatrics.

BEST PRACTICES WORK GROUP: RECOVERY IS REAL Recommendations

"We are past the point of happy inexperience."

Recovery is real when mental health care is based in sustained best practices and best practices are adequately funded. Therefore, Connecticut needs to build on the work begun and the further priorities set by the Community Mental Health Strategy Board in its 2002 Strategic and Financial Assistance Plan. Best practices are also pre-condition for greater federal Medicaid reimbursement that requires effective provider staff training and evaluation rooted in evidence-based practice.

• "Second Initiatives"

The State Legislature has already funded certain initiatives launched by the Community Mental Health Strategy Board with the support of DHMAS, DCF and OPM. Since it probably does not go without saying so, these recommendations assume sustained funding of those "Second Initiatives" underway and planned.

• ACT Teams

The Assertive Community Treatment (ACT) model of community treatment is a proven, evidence-based practice implemented in many states as a Medicaid reimbursable service. The ACT model focuses on people who have fallen out of the treatment system, are homeless, involved or at risk of involvement with the criminal justice system, and are usually facing both severe mental illness and an addictive disorder.

ACT programs provide team-based integrated service delivery system to support individuals with severe mental illnesses in the community. This process provides care using a team that together understands the needs of each client, integrates medication management and provides supervision. The team is the primary point of accountability. Intensive care management is provided in the community by case managers, nurses and physicians. The team also includes a vocational specialist, peer specialist and a substance abuse specialist who is the lead clinician for assessment, planning and treatment of substance abuse disorders.

In Connecticut, ACT teams are currently attempting to adhere to the basic model but not all teams have substance abuse counselors, vocational counselors or peer engagement specialists. The nature of those served is also changing to include more people with co-occurring substance abuse who have a history of jail involvement and pose higher risks to themselves and the community. This means that ACT teams need to provide intensive residential wrap-around and services that target young men. Those with co-occurring substance abuse often are turned away from abstinence-based

programs or deemed inappropriate for treatment because they lack insight.

Implementation of this recommendation anticipates significant positive outcomes that include:

- Decreased emergency room usage, psychiatric bed days and average hospital length of stay.
- Decreased use of crisis services.
- More stable housing, less homeless and use of shelters.
- Less involvement in the criminal justice system.
- Longer average time-in-community.
- Improved perceived quality of life.
- Better links to vocational, social club and employment opportunities.

The federal Medicaid option allows the state to recover the cost of bringing ACT teams up to model standards, with state funding required only for the relatively small proportion of the target population not qualifying for Medicaid.

Since ACT teams already provide care and services in Connecticut, the state should give priority to federal Medicaid plan amendment with a target date for approval by end of 2005. Training and documentation, however, can begin immediately with up front funding of an estimated \$250,000 so DMHAS can utilize experienced consultants to audit provider practices and make necessary changes in anticipation of plan amendment approval. Some federal Medicaid billing can occur prior to plan amendment with the goal of 30% of projected income in fiscal 2006, and the full amount in fiscal 2007.

• Intensive Supportive Community Services

As part the continuum of care essential in any true mental health system, intensive community supportive services reduce the need for hospitalization or other institutional care and provide housing stability for those who are considered at high risk for prison recidivism or return to inpatient facilities simply if discharged to the community. The target population is those who meet DMHAS eligibility standards and reside in inpatient facilities, nursing homes, prisons or homeless shelters. For every intensive supportive housing slot created, an individual can be supported in the community and a hospital or other institutional bed can be re-utilized or eliminated.

Intensive supportive community services rely on staffing ratios that can range from 1:2 to 1:8, "wrapped around" the individual as needed and including:

- Intensive support, assessment, and skills training to ensure independence and stability in the community.

- Individualized comprehensive service plans, regularly reviewed and revised, that offer learning life-skills (shopping, nutrition, housekeeping and money management), medication education and compliance, and appropriate supervision.
- Capacity to provide 24 hour supervision as needed.

Services must be recovery and rehabilitation oriented, with emphasis on housing stability, employment, avoiding hospitalization or reincarceration, and achieving independent living. Staff must be well trained in evidence-based models effective with co-occurring disorders, trauma, and psychosocial rehabilitation. Staff also need to be culturally and linguistically competent and preferably reflect the ethnic and cultural make-up of the individuals served. Referral to traditional case management programs occurs once sufficient stability is achieved.

For those in the forensic system who are eligible for early release or for individuals who can be safely diverted from prison, a day reporting center would provide an additional link. Coordination between the DMHAS and the Department of Corrections can maximize resources in each system and, for residential alternative incarceration centers currently being planned, allow "hand-off" to a permanent community program.

Intensive supportive community services staff assist in locating safe, affordable and stable housing. This assumes that permanent housing assistance will be leveraged through various federal and state sources (Section 8 or RAP subsidies), private owners and housing development. In the meantime, DMHAS providers would work with other agencies such as public housing authorities, YMCAs and YWCAs, and private owners to secure rental and development support while more permanent housing subsidies are secured. Application would be made for federal HUD "Shelter Plus Care" rental subsidies, project or tenant based. Ten percent (10%) of non-federal project funds should be designated for security deposits and emergency rent, given the severe limitation of decent, affordable housing in the state.

Providers will be expected to develop plans that detail securing housing for the target population. They may choose housing best suited to the level of supervision required (congregate sites or a clustered apartment in combination with scattered site units as an individual's need for supervision diminishes). As income increases through employment or as permanent rental subsidies become available, rental supports can be reallocated.

Here again, significant positive outcomes are anticipated as follows:

- Less use of medically unnecessary emergency room and acute care beds.
- Decreased substance abuse and critical incidents in the community.

- Reduced reliance on nursing home care.
- Safe and appropriate early prison release.
- Improved function, increased employment and greater independence.

Implementation would proceed with two pilot initiatives:

▪ **Prison Bed Reduction**

Closure of prison beds will be targeted for those with serious mental illnesses who can live in the community with support. Conservatively, only half of the amount expended by the state for incarceration is anticipated to be available in order to offset this pilot initiative at \$35,000 per person served. Over time, this approach, combined with the ACT model, will reduce arrests, rearrests and incarceration attributable to mental illness.

▪ **Nursing Home Placement Reduction**

Using the federal Medicaid Home and Community Based Services waiver for people with serious mental illnesses can sustain a second pilot aimed at reducing expensive and inappropriate reliance on nursing homes. This would transfer funds now paying for nursing home beds to community care with at least \$60,000 per person. State or other non-Medicaid funding will be required for housing costs. Since the waiver will take at least one year to be developed and approved, implementation is targeted for fiscal 2007.

• **Early Intervention, Age Appropriate Treatment & Transition for Young Adults**

Early and effective intervention can lessen the severity of mental illness, prevent disability and improve recovery. Yet less than 20% with mental health issues actually receive care. Young adults need help when they first experience serious medical and behavioral changes. Most of the major changes in the brain associated with schizophrenia, for example, occur within the first two years of the illness. Unfortunately, that is also how long it commonly takes to get treatment. Delay and failure to get treatment for children and young adults leads to greater homelessness, school dropout rates, unemployment, substance abuse and juvenile crime.

Innovative mental health services for this age group have had profound effects on young people's lives and their ability to live as independent, productive adults, especially:

- Earlier intervention that reduce delay in treatment from the typical two years to two months.
- Age appropriate treatment, including providers and other professionals who are trained to work with children and young adults.
- Transition services targeted for young adults in employment, education, independent living and social skill development.

DMHAS has developed effective Young Adult Services but referrals from DCF and others have already outpaced availability. There are Young Adult Services in 10 mental health catchment areas, but 2 are limited and 13 catchment areas of the state still do not have these services. Connecticut needs to identify gaps in Young Adult services that related to the need for more intensive wrap around services and housing and use funding already approved by the State Mental Health Planning Council to disseminate best practices in serving young adults.

Outcomes expected from implementation of these recommendations include:

- o More effective access to community mental health services earlier upon onset.
- o Decreased emergency room use, hospitalization and length of hospital stays.¹
- o Increased adherence and trust in mental health services.
- o More sustained progress in transitional education, employment, independent living and social skills development.
- o Decreased substance abuse and dependency, homelessness, social isolation, delinquency and crime.
- o Improved family relationships and support.

The Governor's Blue Ribbon Commission Report, the Mental Health Policy Council in its 2004 updated recommendations, the State Mental Health Planning Council in its 2004 Transition Services Workgroup Report, and the Community Mental Health Strategy Board's 2002 Strategic and Financial Assistance Plan all endorsed additional funding for young adults as a priority. Some \$2 million needs to be invested annually to strengthen Young Adult Services. Costs can be offset through Rehabilitation Option and Targeted Case Management under Medicaid plus savings from hospitalization, juvenile custody and incarceration. The state will be able to serve approximately 400 more children in the first year and up to 1,000–1,200 families over the course of the second year and beyond.

¹ While outside the scope of this report, issues of medical compliance need to be considered more carefully in all therapeutic settings. It is especially challenging when transition from emergency stabilization to hospitalization occurs but medication cannot be administered absent informed consent or appointed authority except when patient again become dangers to themselves or others.

CHILDREN'S MENTAL HEALTH WORK GROUP: FAMILIES & COMMUNITIES

Recommendations

"We only get the kids at the end of the line."

- **Connecticut Community KidCare**

Connecticut's Community KidCare initiative relies on locally-based systems of care. This requires effective care coordination that connects families to services and support so that children and youth can remain at home and in the community. Currently, 60 care coordinators are available to serve some 600 families of children who are not in DCF custody. Connecticut must increase the number of care coordinators by 30 in each of the next 2 years along with ongoing quality training and supervision. This can meet the needs of approximately 400 more children in the first year and up to 1,000–1,200 families over the course of the second year and beyond.

Family advocates help assure care coordination through the Community Collaboratives, with 243 families served in fiscal 2003. The need, however, is far greater. Connecticut should add 12 additional family advocates and 2 supervisors under the auspices of FAVOR.

More flexible emergency funding for care coordination services to non-DCF children can make a big difference. A \$1 million investment by the Community Mental Health Strategy Board proved highly successful in keeping families from entering voluntary services and out-of-home placements. Increasing funding to \$2 million can meet the needs of 200 children and their families each year.

Many Connecticut cities and towns now have a Community Collaborative made up of local service providers, parents, school staff, community organizations, business representatives and others. This collaboration works to identify and address service needs and advocate for supports. Care coordinators and family advocates assist in developing and implementing individualized service plans. This important grassroots work is done, to the extent that it is done at all, for the most part without paid staff. Connecticut should assure that every Community Collaborative has the services of at least half-time care coordinators.

- **Emergency Mobile Crisis Teams.**

Emergency mobile crisis teams offer more effective and more efficient response than inappropriate hospital emergency room admissions. At present, 16 teams provide services statewide from 10:00 a.m. to 7:00 p.m. Monday through Friday, and 1:00 p.m. to 7:00 p.m. on Saturdays. The teams have responded to over 12,000

calls in the past 2 years but major gaps remain in the evenings and on weekends. Major improvement in response and outcomes would result if the hours of availability were extended 3 hours per day including evenings, from 7:00 p.m. to 10:00 p.m. on weekdays and 10:00 a.m. to 1:00 p.m. on Saturdays. This would require one more licensed staff person per team. In addition, a school liaison is needed for each team to provide onsite consultation in emergency situations and follow-up, provide training and coordinate services.

- **Respite services**

Experiencing mental health challenges in children, especially persistent acting out, can be devastating for families. Respite services help families keep children at home and families intact but there is just not enough of it widely available in Connecticut. First, respite care-giver rates should be raised from \$25 to \$30 per hour. Then, twice the amount of service should be available, from the current 16,000 to 32,000 hours, in order to serve 150-200 more families in need of respite.

- **Behavioral Health and Primary Health Care**

Pediatric primary care practices need consultation and support from mental health providers. This can include onsite and remote assistance for screening, brief intervention, training, and medication consultation. The consultation services are reimbursable under Medicaid but additional funding is necessary to design and implement training curriculum for medical and nursing students, residents, and practicing providers.

- **Sustained & Coordinate Initiatives**

These recommendations build on sustaining initiatives already supported by the Mental Health Strategic Investment fund in budget options for intensive home services, early childhood mental health consultation and juvenile justice intermediate evaluation services. The recommendations are also predicated on significantly enhanced outpatient treatment services through rate-setting or other means to address waiting lists and gridlock. Funding from Medicaid for some of these recommendations should be explored, such as targeted case management under a fee for service arrangement the Rehabilitation Option for school liaisons.

- **Evaluation**

Ongoing, comprehensive evaluation is needed to document how enhancing a community based systems of care for children and adolescents, as well as family supports, improves outcomes, effectiveness and efficiency.

SUPPORTIVE HOUSING WORKING GROUP: HOME IN THE COMMUNITY

Recommendations

“Housing is the Holy Grail.”

Housing in hospitals, nursing homes, juvenile detention facilities, prisons and shelters for people with mental illness is neither humane nor recovery-oriented. This is especially true for adults transitioning from institutional settings and young adults transitioning from foster care. Yet these are the only options for many.

Fortunately, Connecticut has begun to develop a successful approach to providing decent and more cost efficient shelter as well as living skills. Since 1993, some 2,300 units of supportive housing have been created in the state. Through public-private partnerships, renovation and new construction creates decent and manageable housing units that are linked to supportive services. These services include intensive case management, training in medical compliance and independent living, employment assistance and peer monitoring.

Connecticut is now implementing a Supportive Housing Pilots initiative to create 700 apartment units in 20 communities. Financing is provided through a combination of charitable, federal, state and quasi-public agency sources. This collaborative model is ready to be expanded to help meet the mental health crisis in our state.

• New Supportive Housing Units

Connecticut's Supportive Housing Pilots initiative should be expanded by financing the creation of 1,000 additional units statewide, 700 new units and leasing 300 existing units. Of these supportive housing units, 350 would be for families and 650 for single adults,

including 100 young adults ages 18 to 23 who are aging out of the DCF system and at risk of homelessness. The housing will integrate people with special needs and people who do not have special needs in order to avoid stigma and encourage independent living.

Capital financing would be through the Connecticut Housing Finance Authority with the state paying for debt service. Philanthropic support would be available for pre-development and technical assistance. Rental assistance would come from federal and state Shelter Plus Care, project-based Section 8 and tenant-based RAP or local housing authorities. From plan to development to occupied units will likely take 1 to 4 years.

• Supportive Services

Private non-profit providers will provide essential supportive services under contract. Estimated costs per year range from \$14,000 for families, \$10,000 for individuals and \$4,000 for aftercare. State funding will be provided for these services through DSS and DCF for families, DMHAS for adults with mental health needs, and DCF for young adults.

Positive outcomes will include:

- Stabilized families and individuals.
- Improved health and employment.
- Greater self-reliance
- Cost savings from diminished use of inpatient medical care, emergency care, prisons and shelters.
- New and rehabilitated housing stock.

REAL PARITY WORK GROUP: PRIVATE COVERAGE THAT WORKS

“Mental illness should not be a terminal disease.”

Passage of Connecticut's landmark full mental health parity law marked significant progress toward ensuring that mental illness and addiction disorders are treated in the same manner as other illnesses. For coverage regulated by the state, insurers are not supposed to differentiate between the benefit structure for traditional health insurance coverage and mental health coverage. Previously, various benefit limitations applied to mental health care. Similarly, state health care programs and private insurance regulated by the state cannot interfere with prescribed psychotropics.

In practice, however, the promise of parity appears to be unfulfilled. For patients and mental health practitioners, managed care often seems like mismanaged care that fails to maximize therapeutic results and sustaining recovery. There may be in fact be differences between the way that diseases, especially long-term diseases, are managed on the traditional medical side compared to mental health best practices. There is no regular mechanism for communication between mental health providers and payers. Pharmacy benefit management, including formularies, may more significantly disadvantage mental health treatment.

Payments to mental health providers may be significantly discounted when compared to other types of providers, and may this may constitute a de facto barrier to access. Above all, medical necessity determinations prerequisite to coverage appear to be much narrower for coverage decisions in mental health.

• Coordination & Communication:

The state Office of Managed Care Ombudsman should establish a process to provide active, regular, ongoing communications among mental health providers, patients and payers. Such a mechanism would foster discussion and resolution of issues such as the perceived lack of real parity, best practices, sufficiency of networks and possible “phantom networks”; prompt payment and provider rates. The process should be organized and launched early in 2005.

• Employer Outreach & Best Practices

A pilot outreach project should be initiated with employers of various sizes to evaluate costs and benefits (including productivity savings) of providing effective mental health care coverage to employees and their families. In addition, state insurance regulation

should incorporate National Council on Quality Assurance standards in order to ensure an adequate number of appropriate providers in mental health care networks and sufficient geographical distribution.

• Evaluation

The State Legislature's Program Review and Investigations Committee should undertake and thorough evaluation of the implementation of Connecticut's parity law to date and report its findings and recommendations in time for the beginning of the 2006 legislative session.

PROVIDER RATES WORK GROUP: FAIR FUNDING Recommendations

“Where is the mental health Mianus Bridge?”

This November, the people of California voted to raise the state income tax on millionaires and dedicate all of the new funding to expand community-based mental health care. Despite growing advocacy, awareness of the benefits and evidence of crisis, Connecticut has yet to invest significantly and effectively in mental health. In fact, state agency staffing and initiatives have been cut back in recent years while funding for practitioners and private providers who offer the bulk of care lags behind even the cost of living. Initiatives of the Mental Health Strategy Board are at risk, especially if further funds to be derived and dedicated from the sale of the former Norwich Hospital property are not realized by the state.

Connecticut can improve mental health prevention, care and recovery in ways that maximize federal funding and result in real efficiencies – *but not without a long overdue additional investment now.*

• **Outpatient Rates.**

Outpatient rates for clinics, including hospital-based clinics, should be comparable to Medicare rates for similar services. This will also help leverage increased federal financial participation in the funding mental health care. More specifically:

- Provider eligibility for increased rates would be based on meeting DSS criteria for “enhanced care clinics” in order to ensure improved access to outpatient care. The criteria will apply to a sufficient number of providers to cover at least 80% of Medicaid beneficiaries using services.
- Target rates should be indexed to 85% of Medicare for adult services and 100% of Medicare for services to children and adolescents, given the higher costs for serving children and adolescents. Current HUSKY rates are only about 80% of Medicare on average.

The increased outpatient rates will increase access to care, estimated at 15% growth in utilization for children (1,000 more) and 10% for adults (1,500 more). This recommendation is consistent with both the Blue Ribbon Commission and the Community Mental Health Strategy Board’s Strategic Investment Plan.

• **Medicaid Adult Rehabilitation Option**

There is no good reason for Connecticut to continue to pay for but be the only state to forgo the benefits of fully implementing the Medicaid Rehabilitation Option for adults. As provided in Public Act No. 01-08, covered service would include Assertive Community Treatment as well as Supported and Supervised Housing personal assistance and targeted case management. All net

revenue related to reimbursement for existing expenditures must be reinvested to increase mental health capacity and care. Notably, there is a significant danger that

• **Hospital Inpatient Rates**

As indicated in the 2004 report of the interagency Mental Health Policy Council report, reimbursing general hospital inpatient care on a per discharge basis acts as a significant barrier to access. With the implementation of the Connecticut Community KidCare initiative, paying for all HUSKY children on a per diem basis will ensure that children, retroactively eligible for Medicaid during hospital stays, be paid for on a per diem basis. The same approach should be implemented for Medicaid eligible adult inpatient care services, along with a similar use of ASO management.

• **Private Provider Rates**

One of the most important bipartisan achievements of the 2004 legislative session is the requirement that the next proposed biennial state budget include private provider rate increases indexed to contractual increases in compensation for comparable work by state employees. Private providers continue to be the principal mental health lifeline in Connecticut and this step toward parity should be funded.

• **Social Security COLA**

Many low income people facing mental health challenges rely on federal Social Security payments to continue independent living. Yet Connecticut has made a practice of reducing its benefits when federal payments are adjusted for the cost of living. This unnecessarily jeopardizes financial security and often forces greater reliance on more expensive federal and state funded care and services. This is hardly a best practice therapeutically or fiscally, and should end.

All of these initiatives should be tracked to evaluate and document improved outcomes and less reliance on more costly emergency admissions and inpatient stays.

APPENDIX A: GOVERNOR'S LETTER



M. JODI RELL
GOVERNOR

STATE OF CONNECTICUT
EXECUTIVE CHAMBERS
HARTFORD, CONNECTICUT
06106

August 16, 2004

The Honorable Kevin B. Sullivan
Lieutenant Governor
State Capitol
Hartford, CT 06106

Dear Lieutenant Governor Sullivan:

As Governor, it is my sincere intention to continue to focus on the unmet mental health needs in Connecticut. I know that the public and private costs of not providing effective treatment and support continue to burden the lives of our citizens and the budgets of so many of our agencies, as well as place great strain on the capacity of the non-profit providers and health care facilities.

These challenges, of course, are not unique to our state and Connecticut has recently made greater efforts to focus on these needs. However, as the May 2004 report to the then Governor Rowland by the Mental Health Policy Council makes clear, "gridlock" continues to block progress: "Gridlock is not a single problem, but rather a constellation of problems that make it difficult for people to obtain the type of care they need, when they need it, for the right durations of time."

Over the years that we have worked together, I know we share these concerns and that you were one of the State Legislature's foremost advocates for mental health care. Over the next few months, I am asking you to bring additional focus to our efforts to strengthen mental health care in Connecticut. As such, I particularly ask that you work cooperatively with Commissioner Tom Kirk and the Community Mental Health Strategy Board as their work relates to adult services.

Further, I know you are cognizant of the work of Commissioner Darlene Dunbar and the DCF Transition Task Force and that they are currently implementing a number of Exit Plan outcome measures as well as the Kid Care initiative. I ask that you also work with them with regard to other aspects of children's services, especially with regard to those not served by state child protection services. I think it is also important that you work with key legislative leaders interested in these initiatives.

Page Two
The Honorable Kevin B. Sullivan

There have been numerous findings and recommendations made over the years by a myriad of groups. It is my hope that your effort will quickly inventory the current condition of mental health care. This inventory should then be matched with proposed action steps based on a sense of priority for phased action over a reasonable period of years. An evaluation of cost and benefit should be offered keeping an appropriate balance with the fiscal capacity of the state and our obvious fiscal constraints moving forward.

In asking you to take on this responsibility, I am not expecting yet another voluminous report. Rather, we should see this as an initiative to provide direction to me and the General Assembly in order to make continued progress in mental health care, particularly as I prepare my budget recommendations for the next legislative session. To that end, I would appreciate receiving a set of clearly defined objectives and action steps by December 1, 2004.

Thank you for your willingness to take this on. I look forward to our work together.

Sincerely,


M. JODI RELL
Governor

cc: Tom Kirk, Commissioner-Department of Mental Health and Addiction Services
Darlene Dunbar-Commissioner Department of Children and Families
Marc S. Ryan, Secretary, Office of Policy and Management

APPENDIX B: PARTICIPANTS

- Lieutenant Governor Kevin Sullivan
- State Senator Christopher Murphy
- State Senator Toni Harp
- State Senator Andrew Roraback
- State Senator William Aniskovich
- State Representative Art Feltman
- State Representative Christel Truglia
- State Representative Patricia Dillon
- State Representative Jack Malone
- State Representative Mary Ann Carson
- Commissioner Thomas Kirk, Department of Mental Health & Addiction Services
- Commissioner Darlene Dunbar, Department of Children & Families
- Commissioner Patricia Wilson-Coker, Department of Social Services
- Commissioner Betty Sternberg, State Department of Education
- Commissioner Theresa Lantz, Department of Corrections
- Secretary Marc Ryan, Office of Policy & Management
- Deputy Commissioner Pat Rehmer, Department of Mental Health & Addiction Services
- Mark Schefer, Department of Social Services
- Karen Snyder, Department of Children & Families
- Charlene Russell-Tucker, State Department of Education
- Daniel Bannish, Department of Corrections
- Anne Foley, Office of Policy & Management
- Judith Dowd, Office of Policy & Management
- David Abrams, Connecticut Psychological Association, St. Raphael's Hospital
- Daniel Abrahamson, Ph.D., Connecticut Psychological Association
- Diane Randall, Director, Partnership for Strong Communities
- Ezra Griffith, Yale University School of Medicine
- Heather Gates, Community Health Resources
- Jacqueline Coleman, Connecticut Psychiatric Association
- Alfred Herzog, Hartford Hospital
- Ann Steele, Mental Health Association of Connecticut
- Jan VanTassel, Connecticut Legal Rights Project
- Jeff Walter, Rushford Center
- John DeFigueiredo, Connecticut Psychiatric Society
- Judith Meyers, Children's Fund of Connecticut, Child Health and Development Institute of Connecticut
- Keith Stover, Connecticut HMO Association
- Leslie Woods, Advocacy Unlimited
- Linda Buchanan, Parent
- Molly Cole, Families Advocacy Organization for Children's Mental Health
- Patricia Droney, North Central Regional Mental Health Board
- Patrick Monahan, Connecticut Hospital Association
- Phillippa Coughlan, Wesleyan University, State Board of Mental Health and Addiction Services
- Randolph M. Lee, Trinity College
- Raymond J. Gorman, The Village for Children
- Robert Hurvitz, Psychiatric Nurse
- Ron Cretaro, Connecticut Association of Non-Profits
- Sharon Castelli, Chrysalis Center
- Sheila Amdur, National Alliance for the Mentally Ill - Connecticut
- Shelley Geballe, Connecticut Voices for Children
- Sheryl Breetz, North Central Regional Mental Health Board
- Steve W. Larcen, Natchaug Hospital
- Terry Edelstein, Connecticut Community Providers Association

APPENDIX C: PUBLIC FORUMS

- | | |
|----------------|---|
| October 19 | Housatonic Community College,
Bridgeport |
| October 25 | University of Hartford,
Hartford |
| October 27 | University of Connecticut,
Torrington Campus |
| November 8 | Three Rivers Community College
Norwich |
| November
16 | University of Connecticut,
Stamford Campus |

APPENDIX D: INVESTMENT IMPACT

	Startup	FY 2006	FY 2007	FY 2008	FY 2009
OUTREACH					
Web-Based Resource Center ¹	1-Jan-06	\$217,500	\$135,000	\$135,000	\$135,000
Telephone Information System (Children & Adolescents)	1-Oct-05	\$600,000	\$600,000	\$600,000	\$600,000
Telephone Information System (Adults)	1-Jan-06	\$700,000	\$1,400,000	\$1,400,000	\$14,000
Governor's Prevention Partnership Education & Training	1-Jan-06	\$250,000	\$500,000	\$500,000	\$500,000
CHILDREN'S MENTAL HEALTH					
Connecticut Community Kid Care	1-Oct-05	\$1,350,000	3,600,000	\$3,600,000	\$3,600,000
Care Coordination	1-Oct-05	2,000,000	2,000,000	2,000,000	2,000,000
Flexible Emergency Funds	1-Jan-06	\$335,000	\$670,000	\$670,000	\$670,000
Family Advocates	1-Oct-05	\$628,125	\$877,500	\$877,500	\$675,000
Community Collaboratives	1-Oct-05	\$350,000	\$350,000	\$350,000	\$350,000
Program Evaluation	1-Oct-05	\$2,040,000	\$2,720,000	\$2,720,000	\$2,720,000
Emergency Mobile Crisis Teams	1-Oct-05	\$440,000	\$560,000	\$560,000	\$560,000
Family Respite Care					
SUPPORTIVE HOUSING					
1,000 Units ²	Various				
DMHAS Service Contracts		\$937,500	\$3,000,000	\$4,500,000	\$4,500,000
DSS Rental Assistance		\$649,500	\$2,395,500	\$4,350,000	\$5,130,000
DSS Service Contracts		\$175,000	\$700,000	\$2,100,000	\$2,100,000
DCF Aftercare		\$140,000	\$250,000	\$350,000	\$500,000
Debt Service (700 Units)		\$4,100,000	\$8,200,000	\$9,600,000	\$9,600,000
PROVIDER RATES					
Outpatient Provider Rates ³	1-Oct-05	\$5,850,000	\$8,700,000	\$8,700,000	\$8,700,000
Hospital Reimbursement ⁴	1-Oct-05	\$750,000	\$3,000,000	\$4,000,000	\$4,000,000
Private Provider Indexing	1-Oct-05	\$7,500,000	\$10,000,000	\$10,000,000	\$10,000,000
Social Security COLA	1-Jan-06	\$750,000	1,500,000	\$1,500,000	\$1,500,000
BEST PRACTICES					
ACT Teams ⁵	1-Oct-05	\$1,600,000	\$1,800,000	\$1,800,000	\$1,800,000

Home & Community Services Option								
Prison Pilot (20 people)	1-Jan-06	\$404,000	\$808,000	\$808,000	\$808,000	\$808,000	\$808,000	\$808,000
Nursing Home Pilot (20 people)	1-Jan-06	\$684,000	\$1,368,000	\$1,368,000	\$1,368,000	\$1,368,000	\$1,368,000	\$1,368,000
Young Adult Services	1-Oct-05	\$2,062,500	\$2,750,000	\$2,750,000	\$2,750,000	\$2,750,000	\$2,750,000	\$2,750,000
TOTAL INVESTMENT		\$34,513,125	\$56,384,000	\$65,238,500	\$64,580,000			
CORRECTIONS COST OFFSET								
FEDERAL REVENUE								
TANF (flexible funding, respite care, family advocates)	1-Jan-06	\$202,000	\$404,000	\$404,000	\$404,000	\$404,000	\$404,000	\$404,000
Medicaid FFP (care coordination, emergency mobile services)	1-Oct-05	\$1,153,750	\$1,445,500	\$1,445,500	\$1,445,500	\$1,445,500	\$1,445,500	\$1,445,500
Medicaid FFP (outpatient rates)	1-Oct-05	\$1,271,250	\$2,370,000	\$2,370,000	\$2,370,000	\$2,370,000	\$2,370,000	\$2,370,000
Medicaid FFP (hospital rates)	1-Oct-05	\$2,925,000	\$4,350,000	\$4,350,000	\$4,350,000	\$4,350,000	\$4,350,000	\$4,350,000
Medicaid Rehabilitation Option (ACT) 6	1-Oct-05	\$375,000	\$1,500,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
Medicaid Rehabilitation (supervised & supported housing) 7	1-Jan-06	\$4,200,000	\$10,500,000	\$10,500,000	\$10,500,000	\$10,500,000	\$10,500,000	\$10,500,000
Medicaid Home & Community Based Waiver	1-Jul-06	\$600,000	\$9,698,414	\$11,216,452	\$11,216,452	\$11,216,452	\$11,216,452	\$11,216,452
	1-Jan-06	\$600,000	\$1,200,000	\$1,200,000	\$1,200,000	\$1,200,000	\$1,200,000	\$1,200,000
TOTAL REVENUE & OFFSET		\$10,727,000	\$31,467,914	\$33,485,952	\$33,485,952			
NET INVESTMENT		\$23,786,125	\$24,916,086	\$31,752,548	\$31,094,048			

NOTES:

1. First year costs include one-time start-up fees of \$150,000.
2. Three year phased development but annual costs may be lower if more time required.
3. Full impact on access and utilization not realized until FY 2007.
4. Assumes hospital reimbursement for child inpatient converted to per diem 10/1/05, adult inpatient converted 10/1/06.
5. ACT teams enhanced to meet federal rehab standards 01/05, requiring \$250,000 FY2005 and FY 2006.
6. Based on Mercer Report estimate of \$10.5 million annually as implemented 1/1/06 with 5 months of revenue in FY 2006.
7. Based on Mercer Report estimate for Supervised and Supported Housing of \$18.2 million, reduced by current revenue.

NOTE: RECOMMENDED THAT NEW FEDERAL REVENUE-BASED INVESTMENTS BE OFF STATE BUDGET CAP