

**Testimony before Task Force to Study the Provision of Behavioral Health Services for Young Adults  
January 14, 2014**

David Woodworth

Age: 31

Past and Current Affiliations: Advocacy Unlimited, JoinRiseBe, Prime Time Club House

To the members of the Task Force to Study the Provisions of Behavioral Health Service for Young Adults - my name is David Woodworth and I am from Winsted, Connecticut.

I am here today because I would like to share my perspective as a young person in long-term recovery from a primary diagnosis of Bipolar Disorder, Generalized Anxiety, and marijuana addiction. Recovery for me means that I am seeking mental freedom and emotional triumph over these disorders.

I would like to specifically address the recommendation area related to improving the delivery system for Behavioral Health Services and Involuntary Outpatient Commitment. It has been my experience that embracing the peer support model should be used to enhance the delivery system, while this model should be implemented systemically across systems prior to adopting a policy on Involuntary Outpatient Commitment.

Briefly, I would like to share what my experience has been. In 2008 I experienced a psychiatric break, which was the direct result of substance abuse and mental health issues that led to social isolation and paralyzing fear. I spent days by myself in my room and in my bed with little motivation or hope. I was finally admitted to Waterbury Hospital's Psychiatric Unit where I spent three weeks receiving inpatient treatment.

Upon discharged I was instructed to follow up if any symptoms requiring treatment occurred. I didn't really understand what all of this meant, because there was no information provided to me about community resources or recovery supports so when symptoms did return I started to withdraw and began self-medicating with marijuana again.

Eventually, my parents encouraged me to begin counseling at Charlotte Hungerford Hospital's Behavioral Health Unit, as I was eligible for Husky Part D state insurance at that point. I also connected with the Social Rehabilitation agency called Prime Time House through DHMAS, and finally, in 2011, to a Dual Diagnosis Intensive Outpatient Program at McCall Foundation in Torrington.

I believe there is an opportunity to provide peer outreach to individuals immediately upon discharge and at regular intervals following inpatient or outpatient care. In my personal experience, this is when we are vulnerable to the reoccurrence of symptoms, decompensate, and consider substance abuse or suicide.

In the end, I really just needed someone that related to me and offered me guidance on how to connect with community resources that would help me to not withdrawal and isolate upon discharge. A person that is willing to reach out, listen, and will talk to me like a fellow human being. We need advocates that know how to navigate the system because they've been in our shoes and know how we feel.

This is happening to a degree as individuals with lived recovery experience receive training through organizations such as Advocacy Unlimited or CCAR, but there are not enough jobs for them. Why doesn't Medicaid reimburse for peer-support, why aren't private insurance companies paying for recovery supports like peer services?

Those who do find jobs as recovery support specialists, or recovery coaches provide a critical component of care because they offer guidance and mentorship to individuals who have, in many cases, have just received a life long chronic diagnosis that is marked by a 20 year loss of life expectancy. That is scary.

What we can do is we can increase the peer supports available in our state and enhance them by offering peer outreach to any young person who is discharged from inpatient care, or who is receiving outpatient services. If this can be achieved within Connecticut, then individuals will be offered the opportunity to make informed choices about our personal pathway into and through recovery.

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In conclusion, it is important for us to build healthy relationships with peers we trust as they teach and share with us about the resources and supports that have allowed them to grow toward emotional triumph and mental freedom. Enforcing involuntary outpatient commitment eliminates our freedom to choose our own pathways to recovery and will continue to perpetuate the stigma that we are not capable of making informed choices. The point is - we need to be given the information, and that is just not happening consistently enough to say that it isn't working.

Thank you, members of the Task Force, for giving us the opportunity to offer our perspective on this important issue. I hope our testimony helps in your decision making process.