Connecticut Department of Mental Health and Addiction Services
Recovery-Oriented Employment Services:
Vision Statement & System Interventions

Introduction:

The major, over-arching goal for the Department of Mental Health and Addiction Services is to foster the development of a recovery-oriented system of care for Connecticut citizens experiencing behavioral health conditions. One of the first significant steps to be taken in this direction is to ensure that all DMHAS clients have both the necessary opportunities and supports to become involved in meaningful activities of their choice. Participation in meaningful activity and having an opportunity to contribute to the broader community are both cornerstones of the recovery process. The forms of an individual's participation and contributions can vary considerably, depending on such factors as individual interests, talents, and disability. However, many individuals with behavioral health conditions identify employment, whether in competitive or non-competitive settings, as the single-most critical ingredient in their recovery and their sense of community belonging.

In recognition of the role of employment in the recovery process, the Connecticut Department of Mental Health and Addiction Services coordinated and hosted a large "Employment Services" consultation on April 3-4, 2003. This event brought together five national consultants who have an expertise in employment and educational strategies for individuals with serious behavioral health disorders. The consulting team included Joe Marrone from the Institute for Community Inclusion, Paul Barry from the Village Employment Services, Charlie Rapp from the University of Kansas, Wilma Townsend from the National Technical Assistance Center, and Karen Unger from Rehabilitation Through Education. During the consultation, the team met with a broad cross-section of Connecticut stakeholders including persons in recovery, family members and other allies, advocates and providers from the mental health community. These meetings were designed to give stakeholders the opportunity to share with the consultants their insights and recommendations regarding the role of employment and education in promoting recovery in Connecticut. The recommendations generated by this consultation should guide the Department in the process of designing a more flexible, comprehensive array of career development services, which will serve as a critical ingredient of its recovery-oriented system of care. This document captures those recommendations, and presents both a) an overarching vision for the role of employment services in the state of Connecticut and b) specific short-term, intermediate, and long-term action steps that will assist DMHAS in achieving that vision.

PART I: Vision – Where we are and where we need to go:

"The problem in Connecticut is NOT what is happening with the $10 million dollars of the budget that is going into employment services… It's the fact that employment doesn't seem to happen anywhere else in the system." ---- Employment Services Consulting Team

A. System-Wide Vision

This document offers a vision and recommendations for promoting employment/career development in the DMHAS system as a whole. It does not focus solely on the redesign of the "vocational rehabilitation" programs (to be referred to from this point forward as "employment services" programs) that are funded by DMHAS to offer employment services. Rather, this vision reflects the primary recommendation of the consulting team, which unequivocally noted that employment and education should be integral to the overarching recovery mission of the Department and they cannot be separated from the DMHAS treatment system in functions such as planning, systems design, funding, monitoring and staffing. To integrate employment within the larger system of care, the task of assisting people with psychiatric and/or addiction disorders to enter employment and education must be inherent in the responsibilities of the entire staff and provider network, including those not specifically charged with work service or supported education activities. In a recovery-oriented system of care, promoting employment and career development must be a part of everyone's job.

In order for all DMHAS stakeholders to work in partnership to achieve this objective, the following principles and practices must be fundamental to the vision of recovery-oriented employment services:

- Giving back to one's community, whether through employment or some other form of productive activity, is both a right and a responsibility of citizenship. All individuals, no matter what level of disability, are capable of such meaningful, productive activity. DMHAS providers at all levels must communicate the belief that people with serious behavioral health disorders can, and should, be productive members of society.
- The Department must recognize and publicly acknowledge that the ill-effects associated with long-term unemployment and under-employment almost always outweigh the potential stressors of pursuing work or enrolling in educational classes. In a recovery-oriented system of care, it is not acceptable for DMHAS clients to be discouraged from returning to work based on the erroneous assumption that doing so will lead to relapse and/or clinical instability.
- The current lack of supported education in Connecticut is a critical services gap that impedes individuals in the pursuit of their employment objectives. Serious behavioral health disorders often emerge in late adolescence or early adulthood and interrupt the attainment of educational milestones (e.g., a high-school diploma or completion of post-secondary academic or technical training programs). The absence of these milestones limits people to entry-level, low-pay, part-time positions that relegate people to a life of poverty and dependence upon state and federal entitlement programs. In a recovery-oriented system of care, "employment services" should be conceptualized broadly to include supported education as a critical element of meaningful career development. All principles and practices reviewed in this document are equally relevant to supported employment and supported education.
- Within a recovery-oriented system, employment should be seen as more than just as a valued, meaningful activity that can promote the development of a socially valued role. While this can be a critical element of the recovery process that should not be

understated, employment also has the capacity to offer much more to the individual, i.e., employment should be seen as viable pathway to greater financial independence. DMHAS must make a concerted effort, through provider and consumer education, to promote employment not just as a meaningful way to occupy one's time, but also as a potential vehicle through which to leave behind one's disabled role and the life of poverty that often accompanies it.

- DMHAS should actively encourage and support all people in exploring and pursuing the meaningful work and educational opportunities that lead to socially valued community roles. This process should begin with the individual's very first contact with the DMHAS system. Upon intake, all persons should a) receive information regarding the benefits of employment, b) be oriented to local supported employment and education resources, and c) be given the opportunity to consult with an employment/education specialist. All information that is routinely distributed by the Department should highlight employment and educational benefits and opportunities.
- Many individuals already enrolled in the DMHAS system have substantial fears and doubts regarding their ability to return to work or school. Provider agencies should use a person-centered planning process with such individuals to help them rediscover themselves as healthy persons with a history, a future, and with strengths and interests beyond their deficits or functional impairments.
- All DMHAS services in a recovery oriented system of care must respect the individual's right to self-determination. Consistent with this orientation, people should have the right to choose and change employment based on their self-defined interests and values.
- Career development should be the shared commitment of providers in all areas of the system, and not just providers funded by DMHAS to deliver "work services." [As stated by a member of the employment services consultation team: "it should be risky for any agency not to have clients employed."] The limited amount of resources allocated to "work services" providers should target, and be reserved for, only those individuals with the most severe functional impairments as such individuals have the greatest need for specialized, intense rehabilitation services that are both a) beyond the expected area of expertise of DMHAS clinical providers and b) less often available in non-behavioral health community agencies.
- Targeting work services for this population requires a substantial reorientation of current referral procedures, i.e., in many places, individuals are still screened for "work readiness" and are unable to access services unless they are deemed to be functioning at a high enough level to engage in employment services. An abundant body of research has shown that screening procedures based on work readiness criteria are arbitrary as such criteria have limited predictive validity regarding employment outcomes. In addition, such procedures suggest that individuals must attain, and maintain, clinical stability or abstinence before they can take up a life in the community – when, in fact, things such as employment are often the path through which people become clinically stable. Work readiness screening has no place in a recovery-oriented system of care, and DMHAS must adopt a "zero reject policy" that does not exclude people based on symptomatology, substance use, or unwillingness to participate in extracted "pre-vocational" activities.

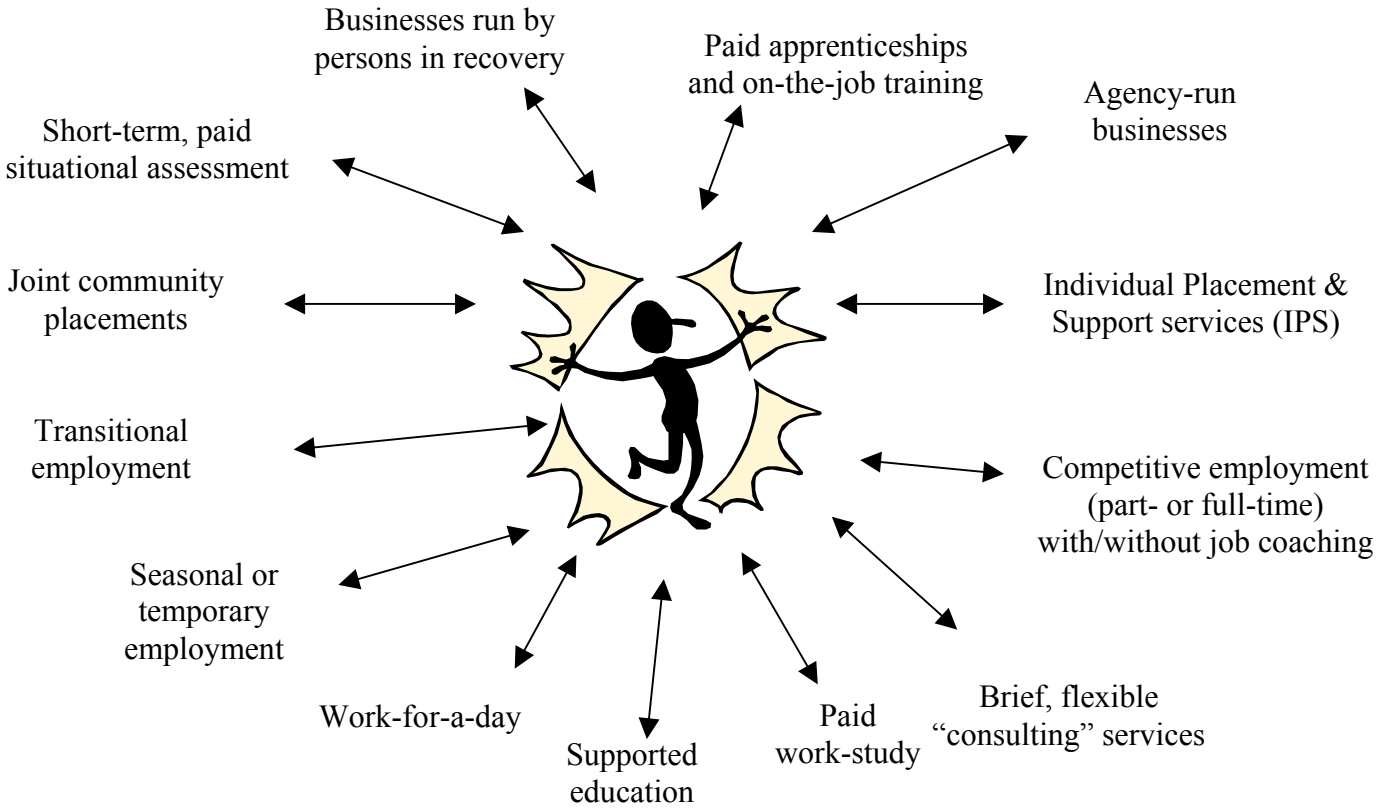
- Eliminating work readiness screening procedures will increase the accessibility of services for those individuals most in need of employment rehabilitation. However, it does not address the larger systems issue where access to any DMHAS specialized rehabilitation service is currently controlled by the primary clinical provider, i.e., the dominate service coordination structure within DMHAS requires that individuals be engaged in clinical services as a prerequisite to accessing specialized supports in the housing, social and employment areas. In many areas, referrals must be submitted by the primary clinical provider and the individual must remain engaged in clinical services in order to receive continued rehabilitation support. This structure is inconsistent with the premises of person-centered care as it places decision-making capacity with the clinical provider rather than the individual. Thus, the Department must rethink its position/policies regarding the relationship between clinical and rehabilitation services, and must eliminate the clinical "gate-keeper" function currently in operation within the system.
- If specialized work services supports are to be reserved for people with the most severe functional impairments, the employment, education, and community integration goals of all other individuals should become a core function of the primary clinical provider, more aptly termed the "recovery guide." Successfully functioning as a recovery-guide requires the providers to spend the large majority of their time in the community directly assisting their clients to take advantage of more naturally occurring supports. DMHAS providers should not recreate, in artificial settings and/or using artificial means, services or supports that already exist in naturally occurring ways in the local community, even if they are not yet accessible to DMHAS clients. As such, the recent employment services consultation to the Department suggested that the standard for community-based service delivery be as high as 75%. In the employment arena, the provider would spend his/her time working directly with the individual to pursue job leads and/or educational opportunities, including some on-site supports as necessary once the individual has enrolled in a job or classes, e.g., participating in an employee evaluation with the client and his/her supervisor, assisting with campus orientation, or connecting the individual to other community resources such as the Department of Labor, the Regional Workforce Investment Board, the Adult Education Department, or local community colleges.

B. Employment Services Vision

While many of the above recommendations reflect system-wide interventions that are <u>not</u> specific to employment services, recent consultation to the Department has clarified an array of opportunities and supports that are necessary for individuals to become involved in productive activity such as employment and/or education. Note: the diagram below reflects only those opportunities and supports which a) involve meaningful, paid work experiences or b) have been proven to lead to meaningful, paid work experiences (e.g., supported education). Other opportunities such as volunteerism and community recreational involvement are equally important dimensions of the recovery process, but are less relevant to the attainment of concrete employment outcomes. Therefore, beyond this employment services array, DMHAS must also offer a range of supports that allow individuals to make meaningful choices in pursuing their

own unique forms of involvement and giving back based on their particular interests, talents, and limitations.

Opportunities and Supports that Promote Career Development & Employment



Notes: In a recovery-oriented system-of-care, the individual should be able to choose from the above service options (see below for service definitions). That choice can be informed by, but should not be superseded by, the recommendation of the professional treatment team regarding the individual's "work readiness" status. In addition, the above diagram presents an array of supports that capitalizes upon what is currently known regarding "evidence-based" practice for employment services (e.g., IPS) while also reserving room for broader, innovative recovery-oriented practices to engage the greatest number of individuals possible.

Service Definitions:

- Work-for-a day: working in an agency-run or consumer-run business for one shift; meeting co-workers, accomplishing tasks, surviving failure, becoming needed, trying on a non-disabled role; individual is paid in cash at the end of the day.
- Seasonal or temporary employment: jobs that become available only at certain times of the year or are of short duration, which are often entry-level and time- or season-limited (e.g., holiday sales, placements through temporary agencies).

- Transitional employment: jobs in a community setting that are "owned" by agencies and offer work experience for a period of months.
- Joint community placements: Multiple jobs made available in one community location. Job site may be run by agency staff or peer-led. Comes with the security of working with people you know. On site job coaching may or may not be included.
- On-the-job training: a formal arrangement with an employer to pay individuals while simultaneously training them for the position.
- Apprenticeships: registered positions with the Department of Labor in which formal classroom study is coupled with paid on-the-job training.
- Businesses run by persons in recovery: paid work within peer-run businesses such as the Genesis We Can program or Catapult.
- Agency-run businesses: paid work at agency-run businesses such as snack bars, maintenance, driving or clerical support; often called "internships" within the DMHAS system.
- Work-study positions: paid work in community settings that is done during release-time from a college program.
- Individual Placement & Support: an evidence-based supported employment methodology developed by the Dartmouth Psychiatric Research Center that features rapid job placement, a zero reject policy, consumer choice and teamed clinical and employment staff.
- Competitive employment (full- or part-time): competitive jobs that best match the interests, skills and experience of each worker with job market options and offer job coaching at the level of intensity and duration that is needed.
- Career development: individualized assistance in negotiating job re-entry for those who lose jobs (maximizing the learning from prior positions), those who are offered promotional opportunities or raises, or those choosing to change (upgrade) their jobs; often includes enrollment in education/training courses for advanced skill development and periodic benefits advising.
- Supported education: individualized assistance in negotiating secondary and post-secondary courses including such elements as schedule advising, identifying needed accommodations, advocacy with instructors and assistance with financial aid.

Part II - Proposed System Interventions:

"All change is difficult, no matter how long you put it off."
-- Joe Marrone, Lead Consultant, Institute for Community Inclusion

Short Range Goals: Areas Ripe for Change at the Present Time (<1 year)

The below action steps, which require limited restructuring or additional resources, should result in immediate positive outcomes ("early, quick, wins") in reconceptualization of employment in

Connecticut's recovery-oriented system of care. They are necessary steps to lay groundwork for more complex systems change processes that follow in "intermediate" and "long-range" goals.

1. Education and training: The Recovery Institute is offering a number of training modules that promote awareness of the critical role of employment and education in recovery. The fall 2003 course on supported community living will teach the following knowledge/ skills: best-practice education and employment strategies; basic information/resources on the impact of earnings on disability benefits; employment discrimination strategies and the role of the ADA in community integration, etc. Coupled with the current training on person-centered planning, supported community living will emphasize the strength-based, *in vivo* approach, which is fundamental to effective employment services.
2. Internal stigma reduction campaign: To underscore the work of the Recovery Institute, the Commissioner should issue a policy statement regarding the role of work and education in recovery and the Department's commitment to making employment services available to all – either through clinical case management (via support from a "recovery guide") or through specialized rehabilitation services.
3. Eliminating the gatekeeper function: All individuals should be able to access education and employment services without clinical gatekeeper approval (e.g., screening based on symptomatology, substance use or participation in work-readiness activities) except "by exception." This also means that people who are not receiving clinical care should continue to have access to employment and educational services.
4. Providing information on employment services at intake: All persons who are new to the DMHAS system should receive information regarding the positive role of employment and education in recovery. They should be informed of available employment and education resources, both inside and outside the DMHAS system, and should be offered the opportunity to consult with an employment/education specialist regarding their interests. Other information that is routinely distributed at intake should highlight employment and educational opportunities and their positive effects on recovery as well as personal success stories that may inspire those who have given up.
5. Addictions consultation: By the Fall of 2003, DMHAS should coordinate a parallel consultation regarding best-practices in employment services for individuals with primary substance use disorders. DMHAS should draw upon the "model" programs currently in operation (e.g., Catapult) to learn from their successes and promote dissemination of effective strategies throughout the State.
6. Peer-run businesses: Wherever possible, DMHAS should look for opportunities to contract out services to peer-run businesses that can serve dual purposes of performing necessary functions while promoting the employment and recovery of people with psychiatric and/or substance use disorders. Obvious examples include transportation, food service, renovations, etc. While this action step can begin during the next year on a small scale as resources permit, it should be expanded during long-range planning as the Department begins to redirect funding from less effective programs and functions.
7. Conveying hope: DMHAS and provider staff must communicate their belief that all people should be employed with the rights and responsibilities that work entails. This requires that all staff be informed of the positive effects of employment on recovery (as

well as the negative impact of unemployment on one's health) and given feedback on positive outcomes through placement statistics and success stories. Such mechanisms as recovery newsletters and agency conferences must underscore the importance of employment as a locus for skills development, confidence building and community integration.

8. Distributing educational materials: Staff must also be given basic, "user-friendly" educational materials regarding the impact of employment earnings on disability benefits. These materials should include contact information for critical State resources that offer benefits planning and consultation, e.g., the Bureau of Rehabilitation Services Connect to Work Center.

9. Person-centered care: At the level of the individual provider or clinical treatment team, the widespread use of person-centered planning can move the focus of treatment beyond the maintenance of clinical stability/abstinence to include a greater emphasis on community integration. For example, a person-centered planning process would dictate that all treatment plans document areas such as physical health, social relationships, employment/education, spiritual life, housing satisfaction, community connections, etc., unless such areas are designated by the individual as not-of-interest. Substantial education is necessary across all levels of the DMHAS system regarding person-centered planning principles and practices. In addition, person-centered planning is based on the assumption that individuals are capable of self-determination in their treatment and life decisions and, based on this assumption, individuals are encouraged to take risks and explore new activities/roles in the community where they can best develop natural supports and an enhanced quality of life. Person-centered planning and care is already being disseminated via the DMHAS Recovery Institute and may be expanded via the Department's submission of a large NIMH grant (currently under review).

10. Conducting an educational needs assessment: DMHAS should conduct a brief needs assessment of people in recovery to determine their educational needs and desires. Such an assessment could inform an initiative in the supported education arena that might include convening a stakeholder task force to develop a comprehensive plan for expanding educational services in a community context.

11. Disseminating recovery-oriented practices: On-going discussions regarding recovery-oriented approaches and evidence-based employment practices should be facilitated throughout the field. Such organizations as the CT Community Providers Association, Advocacy Unlimited, Focus on Recovery-United, and the CT Community for Addiction Recovery should be engaged in the dialogue and encouraged to disseminate the message that rehabilitation services are a critical component of recovery.

12. Promoting interagency collaboration: DMHAS should pursue opportunities to coordinate education and employment services with such agencies as the Bureau of Rehabilitation Services, the One Stop Centers, community colleges, etc. It should showcase those regions with effective collaborative approaches to funding, staff teaming and shared programming. The Ticket to Work Program offers one funding stream that could be pursued by PNPs.

13. Exploring the Medicaid Rehab Option: DMHAS should explore strategies for using the Medicaid Rehab Option to provide supported employment services. The Department should consider the use of intensive case management under the Rehab Option to support

education and employment services. As the Department considers the Rehab Option as a potential source of revenue, it must take steps to ensure that selected provider reimbursement criteria are maximally consistent with its mission to promote recovery.

14. Integrated services where employment supports are provided by a brokered/external agency: Promote coordinated recovery services by establishing a "single fixed point of accountability" (likely with the "recovery guide"/ clinical case manager). This may help address the tendency of case managers/clinicians to refer consumers to employment programs with limited investment or accountability – the "it's not my job now" problem.
15. Increasing service integration where employment supports are available internally: Employment specialists are currently funded to provide services within several DMHAS treatment facilities. Despite their physical co-location, these specialists have limited contact with the primary clinical providers. Similar to the model that is used within the evidence-based IPS approach, these employment specialists should be dispersed to serve as members of clinical treatment teams. Restructuring their role in this way will enhance service integration AND increase the visibility of employment as a critical recovery resource.

Intermediate Range Goals: (1-2 years)

These goals include specific and concrete activities that can be more clearly defined and mobilized within the next two years.

1. Requiring employment and educational outcomes in treatment plans: Employment and educational outcomes should be addressed on all treatment plans for those unemployed for over three months. DMHAS should actively engage all people in considering and pursuing viable work and educational activities. It is imperative that young adults be encouraged to enroll in education and pursue employment before they become entrenched in the treatment system. The integration of rehabilitation goals will facilitate the conceptual shift from "treatment plans" to "recovery plans."
2. Enhancing accessibility: As more individuals are encouraged to enter employment and education, clinical administrators will need to review their services for accessibility. Such adjustments as making services available after hours or on weekends may be necessary to accommodate those who are working or attending school.
3. Linking with Connect to Work benefits counselors: Clinical and employment staff should develop formal linkages with the benefits counselors from the Bureau of Rehabilitation Services to facilitate access to accurate and comprehensive information regarding the impact of earnings on benefits. Individuals should be encouraged to review their benefits situation throughout their careers, particularly when they are considering an increase in work hours or wages, to encourage informed decision making and thoughtful career planning. Benefits counseling can guide the choice that some will ultimately make to move off benefits entirely and become self-sufficient.
4. Disseminating preferred practices: Preferred employment and education practices would be widely disseminated and reinforced through the Recovery Institute's Centers of

Excellence. Within the Centers of Excellence, *in vivo* technical assistance is available to increase the transfer of skills and knowledge to day-to-day practice. Centers of Excellence are expected to maintain high-fidelity to a best-practice model and to serve as laboratories for immersion training of other DMHAS providers.

5. Establishing key outcome indicators: The DMHAS reporting system must be realigned to reflect meaningful employment and educational outcomes. This will require progressive changes to the information system and data collection procedures over time to enable the collection of recovery-oriented employment and education measures (e.g., numbers entering competitive employment and enrolling in education).
6. Revising contract criteria: Employment contracts should mandate consistent standards of best practices by articulating the evidence-based services that will be purchased (e.g., rapid job search, a menu of competitive employment services, integrating employment services with treatment, attention to consumer preference and choice, time unlimited support, etc.).
7. Targeting employment contracts: A designated percentage of DMHAS employment funds should be reallocated for underserved populations (e.g., cultural/ethnic minorities, ex-offenders) and special services (e.g., consumer-operated employment projects, transportation).
8. Incentivizing performance: Financial incentives should be introduced into contracts to reward high-performing providers. Given the current fiscal climate, this may not be possible unless the Department is simultaneously willing to redirect funding from less effective programs.
9. Tracking employment outcomes over time: While an array of services has been identified in the diagram of supports detailed above, the ultimate goal for all individuals should be competitive employment that is consistent with their preferences and talents as this is a normalized, adult expectation that can provide a valued social role and promote recovery. (However, DMHAS can simultaneously acknowledge that some individuals may find alternative means of engaging in productive, meaningful activity such as full-time parenting, volunteerism, etc). While individuals should be free to choose from the DMHAS service array, if their self-identified goal is to progress toward competitive employment, the Department must develop ways to track their progress over time across service types. Tracking consumer movement in this way time is critical when offering a "continuum" of services as research has shown that the continuum model can inadvertently lead to "stalling" where the consumer is unable to progress toward his/her ultimate objective. DMHAS might want to consider a pilot implementation (with a funded work services provider) of an outcomes monitoring system that has been used with substantial success by the Kansas Department of Mental Health. This system allows programs to report data on the number of consumers moving from one type of service to another – toward the objective of competitive employment. The system is completely computerized and it generates one simple "movement" score that reflects the ratio of individuals who have progressed to those who have "stalled" or taken a step backward. Charlie Rapp, a member of the employment services consulting team, has been heavily involved in the development of this system in Kansas and is available for additional consultation in this area.

Long Range Goals: (2-4 years)

These goals represent a full paradigm shift to a model in which a recovery philosophy is embedded in all aspects of its practices.

1. Making employment everyone's business: As the employment indicators are refined and the outcomes monitoring system becomes fully operational, these quality assurance mechanisms should be extended to the DMHAS treatment system as a whole. In the long range vision, employment should be seen as a key outcome indicator for the total service delivery system (vs. the employment providers only) and a critical measure of the success of its recovery-oriented services.
2. Integrating employment services with treatment: Employment services must be provided and available internally on all treatment teams. This can be facilitated by the disbursement of existing facility employment staff (see short-term goals) or through the placement of PNP employment specialists on clinical teams (which would be a longer-range goal requiring significant restructuring). The placement of employment specialists on clinical treatment teams is not to suggest that they are the only individuals responsible for employment services. While they may provide intensive services to individuals most in need of such supports due to their level of functional impairment, all other individuals should be supported in their employment goals by their primary clinical case manager ("recovery-guide"). However, as necessary, the employment specialists could provide consultation and/or training to the team as a whole (or individual clinical case managers) regarding effective employment strategies.
3. Introducing flexible funding options: DMHAS should consider the use of such flexible funding options as fee-for-service purchasing mechanisms, client vouchers, on-the-job training and/or funding pools that address transportation needs. Incentives would continue to be used to reward those providers that achieve the highest outcomes or most positive consumer feedback, incorporate mechanisms that increase choice, and promote recovery services.
4. Introducing system- and agency-level report cards: Performance outcomes in key areas, including educational and employment indicators, should be aggregated into recovery report cards that guide consumer choice and on-going performance improvement throughout the state. Report cards would be widely distributed to promote awareness and the integration of preferred practices. They should reflect such elements as the percentage of people who are working, hours worked in competitive environments, employment tenure, completion of educational/skills training programs and consumer satisfaction as gathered through consumer surveys. This is again an area where DMHAS might benefit from the work that has been done by the Quality Assurance Division of the Kansas DMH.
5. External stigma reduction campaign: An on-going anti-stigma campaign would focus on community-based institutions including employers as part of the DMHAS effort to build integrated community systems that support recovery.

6. Facilitating interagency collaboration and community partnerships: All DMHAS providers must enhance their knowledge of the broad array of naturally occurring community supports that are available beyond the formal treatment system. This knowledge might be facilitated by the establishment of "local community collaboratives." Collaboratives would bring together, on a regular basis, leadership from agencies within the treatment system as well as from the community at large. They would focus on developing a shared vision to guide their work as well as on the capacity-building of services and resources that promote long-term recovery, community integration, and career advancement. Collaboratives may be led by leadership from LMHAs or coordinating substance abuse treatment agencies, but should include representation from the following: the Bureau of Rehabilitation Services, Adult Education, community colleges, Departments of Recreation, Transportation Boards, Regional Workforce Investment Boards, Legal Organizations, faith/religious communities, State College Offices for Disability Services, local business leaders and Chamber of Commerce members, providers of primary medical services, and other local stakeholders where appropriate. Expanded partnerships with community organizations will result in greater utilization of their services and activities by people in recovery – an objective that is consistent with the recovery process AND fiscally necessary given the current resource demands on the formal treatment system funded by the Department.
7. Community resource mapping: The collaboratives described above should be assembled following, or in the process of, a comprehensive "mapping" of the resources of each community. The purpose of mapping is to identify existing, but untapped, resources and other potentially hospitable places and organizations where the contributions of people in recovery will be welcomed and valued. Note: such "places" should NOT be limited to clinical and/or social service agencies but should include natural, community-based resources, e.g., faith communities, local businesses, social groups, volunteer organizations, etc. Resource maps can be used to assess, and recommend changes in, the treatment system and its interface with the broader community on local and state levels.
8. Creating Community Resource Coordinators: Greater knowledge of, and collaboration with, community supports should be the shared responsibility of ALL DMHAS providers. However, the "macro" community development that is necessary to achieve successful community collaborations would be greatly facilitated if DMHAS creates positions or designates staff in each facility whose focus of responsibility is to build community and to establish partnerships that will promote recovery beyond the DMHAS system. These "community resource coordinators" can be responsible for the cultivation of local community collaboratives, the development of resource maps, and the provision of consultation to individual teams and clinical providers. While this recommendation might at first appear to be both time and resource intensive, it should not require additional resources, but rather a reallocation of resources. A percentage of the staff time and resources that go into the planning and delivery of facility-based clinical and rehabilitation services should be reallocated to community development efforts. While carving out time for such efforts might translate into a slight reduction of traditional "clinical" services, it will ultimately open doors and enhance access to the normalized community and social roles that most DMHAS clients desire as a part of their recovery process.

9. Developing State-level collaboratives: The development of local community collaboratives should be mirrored by parallel initiatives, at the highest state level, that aim to enhance DMHAS' relationship with, and use of, the broader Connecticut community. For example, an ongoing dialogue (modeled after successful collaborative efforts between DMHAS and HUD) is necessary at the State level between DMHAS and the publicly funded Connecticut educational institutions to promote greater access of DMHAS consumers to both Adult Education and post-secondary training opportunities. This might include the formation of a statewide "Supported Education" task force with representation from all geographic regions of the State. This task force might convene several times a year to discuss access issues, successful collaboration strategies, and training needs. There are certain model programs in the State and in the country (e.g., Texas Tech and the CT Merge program) that have, in various ways, created welcoming and supportive environments for people in recovery. The experiences of these programs could be shared with the CT Taskforce as a means of replicating and expanding supported education strategies that support people in their recovery. This same "State Task Force" model should be replicated with other State organizational bodies in the areas of business, recreation/leisure, faith communities, volunteer/civic activity, etc. For example, in the employment arena, the task force should include the Departments of Education and Higher Education, the Community College System, the Bureau of Rehabilitation Services, the Department of Labor and the Regional Workforce Investment Boards. Within these partnerships, MOUs would be developed to guide collaborative approaches to service planning and delivery.