PRIORITIES AND RECOMMENDATIONS FOR MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES AND SUPPORTS

SUBMITTED BY:
THE EASTERN REGIONAL MENTAL HEALTH BOARD (ERMHB)

NORTHEAST COMMUNITIES AGAINST SUBSTANCE ABUSE (NECASA)

SOUTHEASTERN REGIONAL ACTION COUNCIL (SERAC)

DMHAS REGION 3

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INTRODUCTION

Every two years, the Department of Mental Health and Addiction Services (DMHAS) Planning Division is required to carry out a statewide needs assessment and priority planning process in order to capture needs and trends on the local, regional, and statewide basis. Regional Mental Health Boards (RMHBs) and Regional Substance Abuse Action Councils (RACs) assist in this process by gathering local and regional data and perspectives. Information gleaned from this process is used to inform the DMHAS Mental Health Block Grant and DMHAS biennial budgeting process as well as the planning and priority setting process for each RMHB and RAC.

This report summarizes the findings of the 2016 DMHAS Region 3 biennial needs assessment and presents recommendations for improvement in mental health and addictions services for Eastern Connecticut. Region 3 includes 39 towns in Windham County, New London County, and Tolland County:

Ashford	Franklin	New London	Sterling
Bozrah	Griswold	North	Stonington
Brooklyn	Groton	Stonington	Thompson
Canterbury	Hampton	Norwich	Union
Chaplin	Killingly	Plainfield	Voluntown
Colchester	Lebanon	Pomfret	Waterford
Columbia	Ledyard	Preston	Willington
Coventry	Lisbon	Salem	Windham
East Lyme	Mansfield	Scotland	Woodstock
Eastford	Montville	Sprague	

PROCESS

The Executive Directors of the Eastern Regional Mental Health Board (ERMHB), Northeast Communities Against Substance Abuse (NECASA), and the Southeastern Regional Action Council (SERAC) held a planning meeting in June 2016 to identify the top 3 priorities in Region 3 and to determine how to report the information and data gathered from throughout Eastern Connecticut; at this point, the ERMHB was about half-way through its data collection process. After holding a total of fourteen focus groups throughout the region, the three Executive Directors met again in July 2016 to share and consolidate feedback from the various focus groups and to determine how to format the findings and recommendations gathered during this year's process. It was immediately evident that while many of the focus groups garnered very similar feedback, there were also significant differences between feedback from the substance abuse and the mental health communities, which will be reflected in this report's recommendations.

It should also be noted that it was **significantly more difficult this year for provider employees and clients to participate in the Priorities process**, as the impact of budget cuts is already being felt in the region.

- With fewer staff and the need to ensure proper levels of program coverage, client needs made it impossible for many of those who wanted to participate in focus groups to attend scheduled times.
- For clients, lower program staffing levels meant that staff could not be spared to transport clients who wanted to participate in focus groups. With few transportation options available in the region, the result for clients was that they could not attend.

A. ***Regional Surveys***

The DMHAS Office of Evaluation, Quality Management & Improvement developed a web-based survey to capture the perspectives of DMHAS-funded and operated mental health and addiction providers regarding access and barriers to mental health and addiction services. Surveys were sent online to the chief administrators of mental health and/or substance abuse service providers throughout Connecticut.

Providers were asked to fill out the Priority Setting Process Grid (see Appendix A), requiring the respondent to rate the 5 core services identified by DMHAS across 7 service dimensions on a 5-point Likert scale, from Strongly Disagree to Strongly Agree. There were two identical grids on the survey, one for Mental Health services and one for Substance Abuse services.

Unfortunately, none of the providers in Region 3 responded to this survey. It is believed that the process seemed too onerous and time consuming for busy chief administrators, who are already over-burdened by systemic and organizational issues. The ERMHB sought to conduct key informant interviews (see next section) with several of the chief administrators on the survey list in hopes of capturing some of the data that would have been apparent in these survey responses.

B. ***Key Informant Interviews***

The ERMHB conducted a total of seven interviews with key informants in Region 3; interviewees included upper-management-level staff at both LMHAs in our region, three DMHAS-funded private nonprofit mental health service providers, one city Human Services director, and the Executive Director of a homeless shelter. During these interviews, informants were asked to discuss the grid provided by DMHAS, particularly focusing on the following questions:

- Given the state's financial picture, what are the critical areas for the mental health system to protect in the next few years?
- What are the areas that most need to be strengthened in order to meet changing circumstances?
- What are the areas that will require doing business differently, and what models should we consider?
- What issues have been cropping up that are new or difficult to solve?
- Which populations are currently most difficult to serve and what is needed?

C. ***Focus Groups***

A total of fourteen focus groups were held throughout Region 3. Participants included community members, people in recovery, family members, community organizations, clergy association members, and providers of mental health services, with a total of approximately 191 participants.

Focus group participants were given the Priority Grid developed by DMHAS and asked to rate the five core services across seven dimensions; this process was somewhat successful for the RAC focus groups, but was very burdensome and unproductive in the ERMHB focus groups, especially when meeting with consumers. Again and again, the participants in the ERMHB focus groups stated that it was impossible to rate and prioritize the services, as they are all vital and necessary components of the system. Therefore, successful discussions focused on dimensions rather than core services, with participants noting both strengths and unmet needs across the columns of the grid.

Feedback from the eight focus groups conducted by the ERMHB can be found in Appendix B, and is organized by sections that correspond with the sections in this report. Feedback for the NECASA focus groups is summarized in Appendix C.

D. *Evaluations*

Throughout 2015-16, the ERMHB participated in CSP/RP reviews at three agencies within Region 3, conducted site reviews at seven Young Adult Services (YAS) Programs at four agencies in the region, and facilitated numerous discussions at Catchment Area Council meetings regarding barriers and/or unmet needs as perceived by those receiving services or provider staff. The relevant findings of these evaluations are included in this report.

E. *Research*

The ERMHB also conducted an extensive survey regarding barriers encountered through the Department of Social Services (DSS) by clients of DMHAS-funded programs, after extended and consistent feedback from an array of stakeholders that the DSS system is failing to meet client needs. Surveys were completed by 159 clients and 83 staff members of DMHAS-funded programs across Region 3 (**see Appendices D and E**). These findings were consistent with feedback from CAC meetings and focus groups conducted for the Priorities and Planning Process, and therefore were included in this report.

Additional surveys focusing on Workforce and Transportation have been created and are in the process of being administered in the region.

F. *Special Projects*

In the course of creating its film, People Interrupted: Navigating Poverty in Eastern Connecticut, the ERMHB conducted 32 interviews regarding transportation barriers in Region 3; we spoke with clients, staff members, Town CEOs and State Legislators for this project. The stories and information collected during this process were consistent with feedback received at CAC meetings and program evaluations, and were included in this report when relevant.

KEY FINDINGS AND THEMES

Throughout this process, several key themes emerged across the region. The themes discussed in this section do not fit neatly into any one box or column on the Priority Setting Process Grid, but rather highlight over-arching systemic issues felt across agency programs.

I. Gridlock in System

People are "stuck" at every level of the system, which leads to inappropriate use of services, logjams in programs that can't move people on. As a result, people have a harder time achieving their goals and attaining meaningful recovery, and the cost to the state increases.

Services that are impacted the worst are respite beds, outpatient clinical services, and case management (CSP/RP).

- Individuals who need a higher level of care than residential services can offer, but have nowhere to go, are often placed in respite beds because the services they need either don't exist, or there are no available beds.
- Respite beds are also used to fill in when there are no safe or affordable housing alternatives, which places a burden on staff to find these individuals housing in order to free up space for those who need respite care for stabilization or to prevent more expensive hospitalizations.
- Providers report receiving calls from those who are in need of immediate treatment, and all they can do is refer the caller to 211. Some programs are trying to devote more staff to the intake

process, because of back-ups that are weeks long, with an additional wait to see a therapist. However, taking staff time away from seeing clients is a problem, given the inadequate clinical workforce in many outpatient programs.

- Lengthy wait lists for CSP/RP in Region 3 mean that referring programs can't graduate clients because CSP/RP has to prioritize those who have been externally referred. Program staff report having to "triage" those who can't afford to wait, and trying to be creative with their intake processes, which are also backed up.

Mid-care substance use services (including inpatient and partial hospitalization programs): Gridlock at this level prevents individuals leaving detox from being appropriately served, leading to relapse and overdose.

II. Attrition in Services

Services at all levels continue to shrink in the face of years of flat funding, incremental funding cuts, ever-increasing operational costs, and positions left unfilled due to budgetary concerns. As stated in the introduction, this problem was very clearly exemplified in the challenges and barriers experienced by staff and clients who wanted to participate in ERMHB focus groups and were unable to do so.

Agency managers say that the cost of doing business continues to rise exponentially, particularly in the area of health insurance. Over the past few years, one agency reports increases in health insurance premiums that range from 25-35% each year.

In view of the dire budget situation, and warnings that the coming budget cycle will be even worse than the last, many agencies have delayed filling empty positions, or simply chosen not to hire anyone at all.

They just keep asking us to do more with less:

- Direct service staff say that in times past they had greater ability to be proactive in serving their clients, but that now they feel they are forced to be more reactive. Instead of helping to promote and sustain client progress in achieving goals, staff roles are now much more crisis-management focused, due to the much heavier burdens in the areas of number of clients served and documentation requirements.
- Staff also find themselves having to discharge people who are doing well because they're getting what they need, but who will not continue to succeed without those very supports. Programs can't refer clients to other community agencies either within or outside the DMHAS-funded system because everyone is suffering from the same issues. City-operated programs are shrinking, due to cuts in state funding to the towns.

III. Over-regulation of Programs

Paperwork: A common theme across the board was the frustration felt by staff over the time required to fulfill documentation requirements and complete necessary paperwork. One program manager said that if staff didn't have all the paperwork to complete, they might actually be able to serve clients effectively at their current staffing levels.

As a result of the administrative demands placed on staff, clients feel less valued. "I didn't really like the therapist I just went to because all she did was type on her computer and I felt like she wasn't really listening to me…I felt this therapist was focused on the paperwork."

Clients themselves are overwhelmed by the paperwork they have to complete. One homeless outreach program manager said that the housing application his clients have to complete is longer than his own application for U.S. citizenship.

CSP/RP: Staff and managers at all of the Region 3 providers feel constrained by the requirements of the CSP/RP and ACT models.

- Pressure to meet service hours and demonstrate skill-building activities, for example, hurts their ability to foster meaningful and trusting relationships with clients. When staff have to be focused on what they need in order to meet fidelity, they are not able to "meet the client where they are."
- Rather than promoting person-centered planning and recovery-oriented care, providers argue, CSP/RP "forces people into a model." As a result, relationships with clients feel forced, unnatural, and disrespectful of the person's actual needs.
- Managers say that with CSP/RP, of the 31 fidelity items, maybe five or six are really important to prepare for the Medicaid rehab option – the rest are just overlays that take time and paperwork. Fidelity measures need to be re-evaluated to determine whether we're measuring something that isn't helping people, so that services can be "client centered, instead of bucket therapy."
- It's harder now for staff to serve on internal agency committees due to the demand to meet service hours, but such opportunities promote staff morale and benefit the clients. The same is true for collaborative client meetings or extra-curricular/training activities. Shared experiences with clients in the community are harder to support because they don't fit the model, but these experiences are invaluable to building a relationship with the client, which is foundational to engagement.
- **Directors like idea of fidelity; it gives a mission to the program, but they would like some creativity and flexibility built into process.** The people that need services the most also need the most creativity and the most outreach, and this needs to be incorporated into productivity.

IV. Chronic Underfunding

Private nonprofit agencies say they their programs are working with the same budgets they had as many as 30 years ago, and that it is only their ability to be creative that keeps those programs alive. They also make the argument that they've been doing this for so long that decision makers now take it for granted that they can keep absorbing cuts indefinitely. However, they are now at a breaking point, particularly since state operated agencies have been hit with lay-offs and a freeze has been imposed on hiring for unfilled positions. Cuts to state programs are accompanied by an increased burden on private nonprofit programs, including local homeless outreach and employment teams. Meanwhile in the past 20 years, staff have had less than a 1% cost of living increase, while inflation has been in the neighborhood of 25%. Private nonprofit staff are relying on some of the same state benefits as some of the clients they serve in order to survive.

Staff say that inequitable funding and distribution of resources leads to clients getting "the short end of the stick. Being asked to do more with less and coordinate with other services leads to burnout of staff and managers.

With a 1980's level of funding, managers have to spend more time writing grant proposals in order to offer clients decent quality of life, and interaction in their communities.

V. Discrimination and Stigma

A. *Public Education*

Despite the dwindling of resources, providers continue to work within their communities to increase understanding of mental health issues and build acceptance and tolerance. They participate in the arts

communities, Chambers of Commerce, Councils of Governments, and more. Their clinicians provide free trainings to town employees, including local library staff, community groups, and businesses.

The Eastern Regional Mental Health Board has a strong history of working with local media, which promotes positive coverage of mental health issues, and has had numerous op-eds and letters to the editor published in local newspapers. The ERMHB also hosts community events, and sponsors special projects intended to increase community awareness about issues affecting those with mental health challenges (see **Appendix G** for ERMHB Annual Report)

These community outreach efforts constitute a huge strength of the DMHAS-funded system in Region 3, and will be restated in the next section.

However, discriminatory attitudes in the community persist, particularly with regard to the myth about mental illness and violence. And this misconception worsens each time a mass shooting or other act of violence is reported in the media, and communities and politicians call for mental health reform. The linking of violence with calls for reform reinforce the idea that providing services will end the violence, offering false hope, and traumatizing those living with mental health issues.

Calls for mental health reform need to be separated from discussions about gun violence. The DMHAS-funded community can help prevent perpetuation of myths through continued public education, interaction with the media that promotes positive coverage of mental health issues, and finding ways to tell personal stories of recovery in venues outside the mental health system.

B. ***Medical Professional Education***

- Provider staff and clients alike report discriminatory treatment in primary care and hospital settings. When clients present with medical concerns and their psychiatric/substance use histories become known, their medical issues are trivialized or dismissed, resulting in negative health outcomes, and sometimes even death. This perpetuates the horrifying statistic of those with serious mental health issues dying 25 years early than those in the general population, largely from treatable medical conditions.
- Providers report that their residential clients have increasingly complex medical needs and that they are willing to integrate medical staff (e.g. APRNs) into programs to ensure that their clients continue to receive appropriate mental health services. They also say they would like to partner with nursing homes in providing badly needed mental health expertise in those settings.
- There is little awareness in the medical community at large about the proven connection between trauma during childhood and chronic "physical" health conditions during adulthood. Medical providers generally don't have trauma-informed training and don't ask about childhood trauma, and consequently can interact in negative ways with clients who have a history of trauma, making the people they serve less likely to share information or trust them and perpetuating poor health.

C. ***Opioid Crisis***

Public education regarding the underlying causes of the opioid epidemic, and how to get help is desperately needed, as is greater awareness of how untreated mental health issues contribute to addiction. Continued misconceptions about addictions and persistent beliefs that it can be overcome with strength of will, faith, or prayer need to be addressed with information about addiction as a disease. Misconceptions also lead to unfair practices like discriminatory disability benefits practices towards those who have alcohol related diseases.

In addition, misconceptions abound that medication assisted treatment (MAT) and Narcan availability simply enable drug users, rather than helping them. Public education is needed in these areas regarding the benefits of both.

SYSTEM STRENGTHS

It is important to note that our data collection revealed several strengths of the mental health system in Region 3.

I. ***Behavioral Health Homes***

The Behavioral Health Homes allow providers to address complex medical needs alongside mental health concerns, better coordinating the services that clients are receiving. This model acknowledges the reality that "the mind is connected to the body," and providers have found it to be immensely effective in treating high-needs clients. Additionally, the BHH model allows some flexibility in treatment options, allowing agencies to "look at a person holistically." That said, some providers have said that a number of the individuals identified for the BHH through their Medicaid spend have been difficult to engage, given that they haven't historically been strongly connected to the DMHAS-funded system.

II. ***Town Substance Use Prevention Coalitions***

The Substance Use Prevention Coalitions gather key stakeholders to the table when setting goals and planning prevention activities; this collaborative approach strengthens town-wide responses to drug use and abuse, ensuring that the measures adopted are tailored to the community needs. There are concerns, however, that some of the coalitions don't have a robust understanding of the connection between mental health and substance use issues, and the value of early identification and intervention during childhood when mental health concerns are present.

III. ***Clubhouses and Social Programs***

Recovery supports are an essential component to the mental health service system, and clubhouses and social programs in particular are vital parts of consumer recovery. Clubhouses allow members to "develop relationships on a social rehab level and… make friends with other people that also receive services." Additionally, the support received at the clubhouse helps clients to adjust to living in the community, teaching practical skills and offering opportunities to engage in community activities. Focus group participants agreed that the clubhouses provide vital support that keeps them out of inpatient care. "It's the people, they can lift me up when I need it."

IV. ***Collaboration***

Collaborative models allow for service coordination within and across agencies. These approaches are incredibly effective; examples such as Community Care Teams, all-agency team meetings, and DMHAS-funded Network-wide meetings in Catchment areas 11 & 12 were noted as being incredibly beneficial to providers and clients. However, due to decreased funding and fewer available resources, agencies noted that there is increasing difficulty in releasing staff from daily duties in order to attend these kinds of meetings.

V. ***Resource availability in Substance Abuse Prevention***

Where additional resources are available, towns in Region 3 are seeing increasingly good outcomes in substance abuse prevention. One such example is Putnam, which has a Drug Free Communities Support

grant, a STOP underage drinking grant, and is pursuing additional funding this year. Putnam's recent survey data is showing good results, largely due to this increased resource availability.

SYSTEM GAPS

Key informants and focus group participants identified several gaps in the system, where particular populations are not able to access the services needed. We recommend that DMHAS take the necessary steps to address these gaps and to better serve these populations.

I. *Service Needs in Rural Northeast*

Region 3 is geographically the largest and the most sparsely populated of the five DMHAS regions. In particular, the northeastern corner of Connecticut, consisting of Catchment Areas 13 and 14, is a unique region; although it is largely a rural and sparsely-populated area, it lacks the resources necessary to meet the needs of those living with mental illnesses. The cost of doing business in the Northeast is greater, as well. Clients are more spread out and further flung, meaning that for staff whose roles include working with clients in their homes, more time is spent traveling and more miles are traveled. Funding levels for comparable programs are lower in the Northeast than in the Southeast.

A. ***Lack of Appropriate Services*** - The rural Northeastern corner of Connecticut lacks many of the basic services found in other parts of the state: local crisis respite, brief care, young adult services, sober housing, and an overall lack of mental health beds. Clients must travel to other parts of the region to access these services, resulting in an increased burden on both consumers and providers.

B. ***Lack of Adequate Transportation*** - Additionally, the rural Northeast lacks adequate public transportation, making it difficult for consumers to access the services that are available to them, or to travel to other parts of the region to access services. Several towns have no bus service at all, and many focus group participants report that Logisticare and Medcab services are unreliable.

II. *Co-morbid Health Issues*

While the Behavioral Health Homes are proving to be a successful model, this program is not sufficient to deal with the many critical health issues seen by providers. Feedback indicates that there are not enough levels of care in residential programs where residents have medical issues, young adults are presenting increasingly serious health concerns, and that there is a critical need for holistic care for the older adult population. "The medical piece is missing from our care; it needs to be infused in all areas, not just the behavioral health homes."

III. *Young Adult Population*

The young adult population presents needs that are different from other groups: the clubhouse environment is less effective, employment services often are not adequately meeting the needs of this group, and many young adults also have chronic medical conditions that can be difficult to manage, such as diabetes and asthma. Additionally, there is no YAS program in the Northeast, which constitutes a huge gap in services. In Substance Abuse services, there is an over-reliance on the 12 step, Alcoholics Anonymous model of intervention, which may turn off younger clients. A more age- and culture-appropriate intervention is needed.

IV. *Senior Population*

An increasing number of elderly individuals have substance use problems, often co-occurring with behavioral health issues, dementia and serious physical health problems, but according to those in our region who work with seniors, there is a serious lack of appropriate geriatric services. Often these individuals are physically unable to remain in their homes, but facilities won't take them because of the behavioral health issue. In addition, many seniors still have high level of discomfort discussing and/or accepting the possibility of a mental health issue. The loss of the Gatekeeper program is detrimental to this population.

V. ***Latino and other Non-English Speaking Populations***

Although multiple towns in Region 3 have large Latino populations, providers noted that this is a difficult population to engage in services due to agencies having great difficulty retaining Spanish-speaking clinicians. Additionally, with the casinos nearby, the Norwich area has a high concentration of immigrants who speak a language other than Spanish; local providers find it difficult to meet the needs of this population.

VI. ***Transgender Adults***

There continues to be a lack of appropriate services for transgender adults in Eastern Connecticut. One provider noted that out of 34 actively engaged young adults, 5 were in gender transition, highlighting the need for appropriate medical treatment for this population.

VII. ***Homeless Population***

Participants in Region 3 focus groups continue to express that there is a lack of safe and affordable housing option for low-income individuals. Additionally, the gridlock in the service system creates a lack of capacity in residential services, resulting in too few beds available for those who need them. One provider staff noted that the agency had given out 6 tents to homeless individuals in the last few months and that, "in the winter there won't be enough beds." Homeless outreach programs have been cut or reduced due to lack of funding. Homelessness interrupts service continuity for the individual and can also create barriers to receiving other benefits and entitlements.

VIII. ***Criminal Justice System***

While there is an excellent veterans' jail diversion program at the Southeastern Mental Health Authority, and a number of town police departments have CIT trained officers, provider staff, along with those receiving services and their families, say there is still a great deal of fear among those with severe mental illnesses of law enforcement; they fear encounters that they believe will inevitably lead to arrest and incarceration. Providers also report that because it is increasingly difficult for people to access mental health and substance abuse services, more people with mental illnesses and substance abuse disorders are being incarcerated instead of receiving the services they need. Additionally, with reduced funding to the Department of Corrections and fewer services available in correctional facilities, it is even more important to prioritize keeping people with severe mental illnesses from being incarcerated.

The reduced hours in Mobile Outreach Team (MOT), or mobile crisis response, located in Southeastern Connecticut, results in a higher volume of calls to 911, and a corresponding increase in police involvement, with a greater risk of crisis escalation, negative interactions, and criminal justice involvement for those experiencing mental health crises. This is aggravated by the fact that many towns in Eastern CT have no police departments, and rely on the State Police, which historically has fewer officers trained in the highly effective Crisis Intervention Team (CIT) model. Even though local departments have done an excellent job getting officers training, turnover and lack of funds for training make it difficult to maintain a sufficient level of CIT trained officers.

IX. ***Veterans***

Those working with active duty military members, veterans, and members of law enforcement are concerned about the suicide rate, which is exacerbated by the culture of not seeking help in these communities; when the "helpers" need help; it is still seen as a sign of weakness. There is still a strong fear, based in reality, of losing career advancement opportunities if a behavioral health issue becomes known. This is exacerbated by the 2013 law that prohibits a person from holding a gun permit if they voluntarily enter inpatient psychiatric treatment.

X. ***First Responder Needs***

It can be difficult for first responders to access mental health services. They are at particular risk for substance abuse and mental health disorders due to the repeated exposure to traumatic experiences. The current system of EAP services and debriefing is a short term service that does not address the population's needs over time. The population is particularly at risk for alcohol and prescription drug misuse, overdose, and suicide. Specialized treatment professionals are needed for first responders because of their unique needs in trauma informed care. The current capacity and workforce is limited and many first responders will not seek treatment because of the lack of a qualified service provider. Local initiatives have explored peer to peer service models. Suggestions have also been made to integrate a preventive model within their place of employment to include ongoing services and support for trauma.

XI. ***Sex Offenders***

Sex offenders who have mental health concerns are very difficult to house, due to legal restrictions regarding where they are allowed to live. Interviewees who work with homeless individuals noted that this population has become a serious concern. Without housing, it is nearly impossible to find and maintain employment and stability, typically leading to worse mental and physical health outcomes.

XII. ***Co-occurring Disorders***

Many feel that mental health and substance abuse services need to be more connected and streamlined. Silos still exist between the two systems, which is not helpful when so many people with substance use issues have an underlying mental health problem. Provider staff and clients alike said that those with co-occurring disorders often don't get appropriate treatment and/or medication from primary care providers or doctors in the emergency rooms, due to fears of prescribing medications to those with a history of addiction. We heard stories from several consumers who live with chronic and severe pain but can't get relief because of addiction histories, some of which are in the distant past.

EXTRA-SYSTEM CONCERNS AND ISSUES

Focus group participants and interviewees often raised concerns over issues that are not directly related to the DMHAS-funded service system, **and these issues are raised year after year**, without any sense that things are improving. However, we recognize that components of the state-funded systems often overlap and that DMHAS clients frequently face difficulties in multiple areas of their lives simultaneously. Addressing the following issues would allow people with mental illnesses and substance abuse disorders to more easily access DMHAS services and more successfully meet program requirements and goals. In addition, agencies would be able to more effectively use their DMHAS funding for helping clients meet recovery-oriented goals that promote independence and self-sufficiency, rather than spending valuable service hours solving problems with other state agencies.

I. *Lack of Adequate Public Transportation*

Region 3 continues to lack adequate public transportation, particularly in the more rural towns in the Northeast. Lack of bus routes, issues with Logisticare and Medcab being unreliable, with disrespectful and unsafe drivers, and the high cost of taxis are all significant barriers that prevent people with mental illnesses from accessing the services they need to maintain their lives in the community. In every evaluation, interview, and group discussion, transportation is consistently noted as a barrier in Region 3.

II. *Lack of Adequate Housing*

Region 3 continues to lack enough affordable housing to meet the needs of residents. Feedback indicates that where affordable housing exists, it is often inappropriate or unsafe. Participants noted that apartments with cheap rents are typically in unsafe neighborhoods, where crime and drug use are present and may negatively affect a person's mental health or sobriety. We have heard stories of negligent landlords who discriminate against people with Section 8 vouchers. Alternatively, affordable housing that is deemed "safe" is often located in more rural communities, outside of the public transit purview. Participants also mentioned a lack of handicap accessible housing that is affordable.

III. *Lack of Adequate Employment*

Focus group participants noted that employment opportunities are not adequate to their or their clients' needs. Low wage jobs do not provide a livable salary, and for many jobs in Eastern Connecticut, new employees start on second or third shift, which can make it impossible for a person reliant on public transportation to keep the job.

IV. *DSS*

Providers and consumers reported numerous issues related to services received through the Department of Social Services. The most common issues were spend downs that create barriers to medical care, redetermination paperwork being lost or late, and an inability to reach someone when calling DSS; these findings are consistent with the findings of the DSS Services Barriers Surveys conducted by the ERMHB this year. When DMHAS clients are unable to resolve problems with DSS services, it is the DMHAS-funded program staff members, typically case managers, that assist the clients and ultimately spend the time and resources to fix the problems, thus further burdening the mental health and substance abuse service system. Additionally, these issues cause stress for DMHAS clients, which can exacerbate their mental health symptoms and hinder their recovery.

V. *DDS*

Due to funding cuts and layoffs at the Department of Developmental services, providers are now seeing an influx of DDS-suited clients in residential programs; these clients require a higher level of care than is found at the residential homes and need "more maintenance-type environments," with staff take more responsibility for day-to-day tasks. This mismatch of services places a burden on the staff to meet increasingly difficult needs.

VI. *211*

Focus group participants, particularly provider staff and clients, report that calling 211 is stressful and burdensome; the wait time is too long and often the operator is unable to help the person calling. One provider staff commented, "I think it's a necessary tool, I think you need it, but it needs time and money." As a single point of access, the system has potential to be successful, but is overwhelmed and unprepared to meet the needs of the community.

VII. *Town and City Funding Cuts*

Town and city budgets have not been spared in the recent funding cuts; one town Human Services Coordinator reported that due to cuts to the budget, 2 case management positions had been eliminated, leaving the department with only one case manager. Severe cuts in these areas will result in additional burden being placed on DMHAS-funded agencies, which will be forced to "pick up the slack" in service delivery.

PRIORITIES AND RECOMMENDATIONS FOR BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES

The feedback received by the ERMHB and the RACs in Region 3 indicated that while there are certainly unmet needs and barriers in specific services, these issues were often persistent across all 5 core services. Thus, we have chosen to focus on four of the seven dimensions outlined on the Priority Setting Process Grid, ranked in order of frequency and severity. It should be noted that at times, the feedback received by the ERMHB was inconsistent with the feedback received by the RACs, indicating a difference between services in the mental health and the substance abuse arenas. **Please note that recommendations are at the end of each section, and are listed together in Appendix A.**

I. Workforce

The dimension that was brought up most often in our focus groups and key informant interviews was workforce problems: organizations are understaffed and unable to address the needs facing them; private nonprofits are unable to adequately compensate direct service staff; there is a high rate of staff turnover and burnout; direct service staff members are inexperienced and lack access to necessary training; there is an increased burden on employees; and there are concerns with the Peer Support model. In the updated Priorities and Planning Report submitted in 2015, it was noted that workforce issues were worsening in our region; the findings of this report are consistent with last year's report.

A. *Understaffing*

All agencies in Region 3 are feeling the effects of the budget cuts, and decreased funding has led to significant understaffing in necessary programs. Multiple agencies have reported that they are unable to hire new employees to fill vacant spots in their organizations and programs; hiring freezes will eventually lead to programs being unable to serve clients with the same level of excellence in previous years.

In particular, Southeastern Mental Health Authority has found it necessary to lay off multiple employees, which has placed an increased burden on remaining staff members, as well as the local nonprofit agencies, to maintain the core services. These layoffs have had ripple effects in the community, hurting morale among employees and causing increased anxiety in clients. Clients have shared stories of being unable to access services, such as therapy or mobile crisis interventions, due to decreased staff, as well as noting that programs are not running as efficiently as they have in the past.

B. *Low Wages*

The private nonprofits have not received sufficient cost of living increases in their funding over the years and, as a result, are currently unable to provide adequate compensation to their direct service staff. Feedback from staff members indicates that their wages are not enough to live on: many are forced to turn to state benefits, such as Medicaid and SNAP, to meet their most basic needs. Multiple sources

shared that direct service and entry level employees need more than one income to get by. "The working poor are staffing the non profits." Staff indicated that high insurance deductibles make medical care too costly. Additionally, positions requiring advanced degrees do not offer a high enough salary for employees to repay their school loans. The low funding levels make it impossible for nonprofits to offer competitive wages or benefits, resulting in high turnover of quality employees.

C. ***Turnover and Burnout***

The low funding levels make it impossible for nonprofits to offer competitive wages or benefits, resulting in high turnover of quality employees. Nonprofit managers noted that many clinicians take higher-paying positions once they are able to get their licenses. This high rate of turnover interrupts the therapeutic relationships with clients, who shared that they feel discouraged when they are forced to begin a new relationship with a new therapist every few months.

The understaffing and low morale places undue burden on remaining employees, which in turn leads to burnout or compassion fatigue among staff. "Being asked to do more with less and coordinate with other services leads to burnout of staff." Staff reported feeling tired and overwhelmed by the increasing pressure and level of need, and agencies do not have the time or funds available to care for the emotional needs of their staff members. Moreover, managers feel doubly challenged and burdened by the struggle to meet client needs and support stressed staff members. At the same time, they say they have nowhere to go for support.

D. ***Inexperienced Professionals/Training Needs***

Feedback from focus groups revealed that direct service staff members are not receiving the training necessary to be truly successful in their positions. Agencies have limited funds for training purposes, and it can be difficult to find coverage for programs, especially residential programs, in order for staff to attend trainings. High rates of staff turnover also play a role in this problem – highly qualified and fully trained staff members are leaving the nonprofits for better paid positions, requiring the organizes to retrain new team members at an impossible rate. Additionally, organizations are worried about the cuts that have been made to the DMHAS training catalogue, as this resource will no longer be available to their staff. The effects of inexperienced staff are felt by clients, whose needs may not be met in the most appropriate way.

E. ***Increased Burden***

As funding is cut across the board and positions are not able to be filled, there is an increased burden placed on the remaining employees to maintain the core services. "They just keep asking us to do more with less." The local agencies report that their staff and management are able to adapt and meet the needs in increasingly creative ways; "we do such a good job being creative, and we will keep on keeping on, but we're not getting the help that we need." Organizations are almost punished for their innovation and creativity, as they are given more responsibility but fewer resources. This increased burden contributes to low morale and burnout, which in turn negatively affects clients of these agencies.

F. ***Peer Support Staff***

Peer Support staff is not adequately funded, nor is it meeting the needs of the peers or agencies. Agencies have reported that the training is not preparing peers for the realities of working in case management positions – Recovery University graduates are not prepared for the onerous paperwork and documentation required of them. It was also reported by one agency that Recovery University has not

been offered for over nine months. Feedback suggests that there is a mismatch between the expectations of the peers and the needs of the programs that must be addressed.

Due to low funding and understaffing, there is also very little support available for Peer Support Specialists, which leads to high turnover and can have negative effects on the peer's mental health.

RECOMMENDATIONS:

- Ensure appropriate levels of funding for the private nonprofits to maintain staff quality of life, including adequate Cost of Living increases.
- Equitable distribution of resources between state-funded and private agencies.
- Expand training opportunities available to nonprofit staff, both within the Region and elsewhere, including resources for preventing "compassion fatigue."
- Create mechanisms within agencies, including but not limited to making it easier to use EAP resources, that offer improved supports for employee stress management.
- Incentivize sharing of existing agency-run professional development resources.
- Ensure integration of Peer Support Specialists at every level of DMHAS-funded services.
- Put support systems in place for Peer Support Specialists to reduce turnover
- Address lack of appropriate/available training for Peer Recovery Specialists.

II. Capacity

Capacity issues were noted across most of the core services, but here the feedback from the ERMHB focus groups and interviews differed drastically from the feedback received by the RACs. ***The ERMHB found that capacity problems in the mental health system were most pressing in outpatient services, while the research done by the RACs indicated that capacity issues in the substance abuse system are most critical in Inpatient Services.*** Brief Care, Respite, and Residential Programs were chosen as the second priority in this dimension by both the ERMHB and the RACs.

A. *Outpatient Services*

The focus group participants and key informants interviewed during the ERMHB's research found that Outpatient services had the most difficulty with capacity issues; "our outpatient volumes are off the walls." All agencies noted that outpatient services have long waiting lists, with one nonprofit staff member sharing that there is a currently a three week wait just for intake, with an additional waitlist to see a therapist; "this is the system breaking." Clients shared that they have had to wait to see their therapists, or are only able to see their therapists once a month. Other clients told us that they are now in group therapy, rather than individual therapy, because agencies do not have enough clinicians to meet the demand.

B. *Inpatient Services*

The focus group participants for the RACs reported that Inpatient services are currently having the most problems with capacity, that there simply are not enough inpatient beds for clients that need them. Participants in the ERMHB focus groups also noted this lack of inpatient services, stating that it is incredibly difficult to get clients into these services. This reality is especially true of substance abuse services – there are not enough inpatient beds to meet the demand, creating long wait times for people who "want to get clean." Providers noted that there is a small window of time in which clients are willing to engage in services, and when they are unable to get a bed at the time that they want it, it significantly hinders their recovery. A long waiting list may quite literally be "a matter of life or death."

C. ***Brief Care/Respite/Residential***

For both the ERMHB and the RACs, residential services were seen as the second priority when examining issues with capacity. Region 3 does not have enough service-related housing options for people with mental illness or substance abuse histories. There is a need for more residential homes, as well as more respite beds to be available. Brief care has been described as a "holding place," for people when there are no beds available for them in more appropriate settings, and there is no brief care setting available in the Northeastern corner of Region 3.

RECOMMENDATIONS:

- Incentivize same-day access programs, which several agencies have found helpful.
- More respite beds to alleviate capacity issues in other residential levels.
- Create Rapid Intake procedures to mitigate long waits during intake process
- Funding for more outpatient clinicians and inpatient beds

III. Accessibility

The third dimension of services that needs to be addressed in Region 3 is that of accessibility; even though many excellent programs exist in our region, it is often difficult for clients to access these programs and services when they need them. The most common barriers are transportation, insurance issues, and Medicaid spend-downs.

A. ***Transportation***

Transportation is consistently noted to be the most common barrier to accessing services in Region 3. While there are bus systems in the more urban parts of the region, clients living in rural towns have no ability to access the local bus system; this issue is particularly true of Catchment Areas 13 and 14 in the Northeastern corner. Additionally, many clients and providers cited issues with Logisticare services, stating that drivers are late and unreliable. Some clients also report unsafe driving and poorly maintained vehicles. There is little to no awareness of how to file a complaint, and in any case, clients believe they will be punished if they do complain.

The ERMHB has launched an advocacy and public awareness project around the topic of transportation in Eastern Connecticut, and has created a short video documenting the stories of people who struggle with these problems. The series is called People Interrupted: Navigating Poverty in Eastern Connecticut and will eventually encompass several issues. The film has been premiered at one agency already, and is scheduled to be shown at two local Rotary clubs in the near future; the goal of this video project is to educate the community and to empower people to share their stories.

B. ***Insurance Barriers***

Focus group participants noted that confusion about insurance coverage is often a barrier to getting necessary services, as clients may not know where to find services that are covered by their insurance plan. Additionally, interviewees reported that sometimes there are inpatient beds available, but the client does not have the right kind of insurance to be able to access that bed and is turned away. "When people want a bed, there should be a bed. Insurance issues should be figured out afterwards."

C.***Spend-Downs***

Medicaid spend-downs are confusing for clients in mental health services and often create an insurmountable barrier to care. We have heard many stories of people forgoing medical treatment because their spend-down is too high and they cannot afford the medical bills. Additionally, clients report going without their prescribed medications because of their spend-downs. These sacrifices are

detrimental to the clients' physical and mental health, lead to serious health crises and increased emergency department use and inpatient hospitalizations, and could prove to be exponentially more much costly in the long run than eliminating spend-downs altogether.

RECOMMENDATIONS:

- Enforcement of contracts with med-cab providers. DMHAS assistance in promoting contracts with med cab providers that treat consumers with respect.
- DMHAS assistance in addressing the multiple issues at 211 that create barriers to accessing appropriate and timely services, including increased staffing levels, reduction in phone wait times, and trainings for 211 operators that promote positive interactions with those in crisis or who may have a history of trauma.
- DMHAS assistance in removing regulatory barriers cited by Logisticare as a reason for not requiring certain postings in cabs about how to make a complaint, etc.
- Duplication of Reliance House model that allows clients to purchase inexpensive "punch cards" for a specified number of rides that can be used to meet any of their needs.
- Encourage substance abuse and mental health providers to share existing transportation resources to support all clients of state funded providers.
- Provide supports and resources to support client-owned and operated "limousine" services.
- Promote public/private partnerships with entities such as Uber or Lyft to expand the range of transportation options for DMHAS clients (**see Appendix F**)
- Work with local towns to leverage existing town vehicles as a means for residents to connect with local transit.
- One provider said that it would be helpful to have a "mobility coordinator" position within each agency to alleviate transportation issues that are barrier to engagement in services.
- Advocate for legislative reform around insurance barriers, particularly reluctance to accept Medicaid.
- Increase asset limitations for spend downs, or just eliminate this altogether as it's unrealistic and harmful.
- Lengthen redetermination periods to one year rather than six months.
- **The Eastern Regional Mental Health Board will continue to increase awareness of Transportation issues within Region 3 by:**

    - Holding Community Forums on Transportation in multiple locations and including Logisticare, SEAT, DSS, Eastern CT Transportation Consortium, providers, and citizens in the process.
    - Disseminating the People Interrupted: Navigating Poverty in Eastern Connecticut video throughout the region in community settings and on social media to promote buy-in by the general public to a sustainable solution to the region's transportation barriers.
    - Promote special presentations by transportation industry representatives to increase understanding and awareness regarding available transportation options.

IV. Coordination

The final dimension that was noted as a particular area of concern was coordination. Across the grid, coordination between services, programs, and various agencies has deteriorated as funding has been cut, due to agencies having limited resources to spend in collaboration. Below are the key areas where coordination is breaking down.

A. *Discharge Planning*

Discharge planning was brought up multiple times when discussing coordination of services. Key informants and staff said that they consistently have problems when clients are discharged from hospitals: they are released without enough medications, without a way to fill prescriptions, and without appointments for outpatient services. While agencies have taken steps to improve discharge planning, such as sending staff to check in with hospitals on a regular basis, this collaboration is time-consuming and onerous for underfunded and overburdened organizations, and still does not always prevent arbitrary discharges on weekends when no agency staff are available to consult or provide support.

The other population for which discharge planning is inadequate is people being released from correctional facilities. Due in part to decreased funding for Department of Corrections programs, incarcerated people with mental health concerns often are not connected with community-based programs upon release; long wait times and lack of awareness about existing programs make it hard for them to make those connections upon reintegration. Staff members expressed concern that these formerly incarcerated people are often caught in a cycle between program wait lists and jail, unable to access the services they need to be successful.

B. ***Multiple Funding Sources***

Staff at every agency noted that the paperwork they are required to complete is often duplicative due to multiple funding streams – every funding source has its own reporting requirements and its own system for recording information, requiring staff to spend valuable time writing and rewriting their reports. A streamlined system would increase staff efficiency and allow them to spend more time with clients. Sometimes, as with the Coordinated Access Network, placing a client within one "silo" of services limits their options. "There's no way anyone who is homeless is going to get into a residential setting."

C. ***DDS Clients***

Multiple agencies mentioned the overlap between DDS clients and DMHAS clients – often clients who qualify for DDS services could be benefited by mental health services as well, such as clubhouse activities. Due to funding restrictions, these clients are kept in silos, putting stress on agencies that are trying to meet their needs.

Alternatively, when DDS-suited clients are placed in residential settings that are inappropriate and unable to meet their needs, staff members must spend more time and resources to meet the level of care they require. Better coordination is needed between the DDS and DHMAS systems to ensure that all clients are receiving services that are appropriate and helpful.

D. ***DSS Services***

Clients and staff members alike bemoaned the myriad issues faced when dealing with the Department of Social Services: long wait times when calling, lost redetermination paperwork, and complicated rules and paperwork requirements. Because the DSS system is complex and difficult to navigate, case managers at DMHAS-funded mental health agencies often have to mitigate these issues on behalf of their clients, spending their valuable time dealing with the problems in this system. In our research, the ERMHB discovered that a number of staff members believe that their clients could possibly be discharged from mental health services if these barriers to DSS benefits were removed (see Appendix E).

E. ***Duplication of Services***

Staff members at DMHAS-funded agencies reported that some of the services they are providing are being duplicated, leading to confusion for both staff and clients. One example that was given was Value Options

ABH case management: case workers are sent into Emergency Rooms to see high-needs patients, but often those patients are already receiving case management at a local agency.

F. ***Regional Human Services Coordinating Councils***

The Councils of Governments have received a legislative mandate "to encourage collaborations and foster development and maintenance of a client-focused structure for the health and human services system in the region" (Section 17a-760 - CGS). This is quite similar to the mission of the Regional Mental Health Boards, which have been in existence since 1974, and are ideally suited to conduct this process, which will occur through an entirely separate and parallel structure called the Regional Human Services Coordinating Councils (RHSCCs).

The ERMHB is concerned that the Regional Boards were not considered as a venue for this process, or at the very least, included as a mandatory member. We find it disturbing that the SCCOG is receiving $150,000 in new money--more than our entire annual budget--to conduct this process in the Southeast, while the Regional Mental Health Boards have been fighting possible elimination since early 2015. While the RHSCC's mission is to find and make recommendations for eliminating duplication of services, they are themselves a duplication of activities that don't utilize existing resources and expertise, but instead begin a new process from the ground up. Furthermore, the RHSCCs have a notable lack of inclusion of the people who actually receive the services that will be studied, whereas our inclusion of all stakeholders in our activities is quite possibly our greatest strength.

RECOMMENDATIONS:

- Create a streamlined reporting system for all state agencies, in order to maximize staff time and resources.
- Expand jail diversion programs in Eastern Connecticut.
- Promote greater consistency in the court system; better education among judges about the benefits of jail diversion.
- Expand substance use treatment options to prevent incarceration of those with co-occurring disorders.
- Improve and strengthen discharge planning from emergency departments, hospitals and the corrections system to prevent recidivism and increased costs to the system.
- Mandate and provide funding for State Police and local police departments to support training of at least half of their current forces
- Expand the RMHBs' funding and mission to include review and evaluation of all human services, not just DHMAS funded services **OR** amend the statute to require appointment of RMHB representatives to the Regional Human Services Coordinating Councils as mandated participants in their process.
- DMHAS should advocate with other executive branch departments for the improvement of services to shared clients, in order to ensure that mental health service dollars are being spent on promoting client recovery goals, rather than on addressing system barriers.

CREATIVE SOLUTIONS AND PROMISING INITATIVES

I. ***Collaborative Team Approaches***

A. Community Care Teams (CCTs)

Community Care Teams are proven to be successful in preventing homelessness for high risk individuals and fast-tracking those who are already homeless into housing. Southeastern Connecticut, with its New

London and Norwich CCTs, has been a trendsetter statewide, and has provided a great deal of assistance to communities seeking to set up their own CCTs. With the participation of all providers that may be involved in a person's care, and agency releases in place for all shared clients, these groups facilitate the unobstructed flow of information regarding shared clients and promote creative brainstorming that minimizes the impact of homelessness on individuals, the system, and the taxpayer.

However, with recent budgetary impacts on staffing, this promising model is in serious jeopardy. CCTs are already seeing lower attendance levels, as agencies are forced to tighten their belts and focus on internal staffing and service needs.

The Windham area has struggled for quite some time to establish a Community Care Team, but the high turnover rate at Windham hospital has been a serious barrier.

B. Network Meetings

In Southeastern Connecticut, the LMHA, the Southeastern Mental Health Authority, provides excellent leadership and support, promoting a collaborative culture among DMHAS-funded agency network in Catchment Areas 11 and 12. A variety of client centered meetings take place on a regular basis, allowing agency staff to coordinate services and minimize service barriers and risk for shared clients. Teamwork, collegiality and respect are promoted within these settings, and efforts by the leadership at SMHA to provide resources and technical assistance whenever possible are greatly appreciated by private nonprofit managers in Southeastern Connecticut

II. *Holistic Wellness Approaches*

A. *InSHAPE*

United Services was one of 48 agencies chosen nationwide to participate for the past year in the In SHAPE Implementation Project, a project of the National Council for Behavioral Health and Dartmouth College. The program was created in recognition of the significantly reduced life-expectancy--by 25-30 years—of those living with severe mental illnesses (SMI), and the doubled obesity rates among persons with SMI compared to those without SMI.

The In SHAPE wellness program was designed to improve the physical health and extend the lifespan of people with serious mental illness through a combination of fitness, nutrition, social inclusion and community engagement. The program began at The Lighthouse in Willimantic and experienced such overwhelming success that the agency used existing resources to expand it to Welcome Arms in Putnam last spring. Collectively over the life of the program, several hundred pounds have been lost by clients. Feedback on the value of the program thus far includes:

- "Some of our folks when they have anxiety, they've found the InShape program as a good means of relieving stress."
- "Part of the programs is around exercise, but the other part is around nutrition. We get to eat healthier now, healthier meals. The foods have changed; they've stopped the sodas."
- "We have to form community partners for InShape. We're partnering with Big Y because they have someone on staff that can do a grocery store tour for us."
- "When I started at InSHAPE, they take your blood pressure, weigh you, take the inches around your belly, teach you about healthy living and healthy snacks, help you with labels. It's good learning, I'm at that age where I have to change my lifestyle and to have someone right there is good, to have that support."
- "The trainer is great because I tend to overdo it, and she helps me to continue my day and do my chores."

- "I'm working on quitting cigarettes and that's going good. There's always a lot of positive reinforcement, I think of this place as my home."

B. ***Older Adult Needs***

United Services was also competitively selected to launch a new demonstration project, called Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), to help assess and assist seniors in need of behavioral health services and foster improved physical and mental wellness. Healthy IDEAS is an evidence-based program that integrates depression awareness and management into existing case management services provided to older adults.

Unfortunately, this came on the heels of the state's elimination of the Gatekeeper Program, a free, voluntary and confidential referral and consultation service for seniors (ages 60+) operated for Region 3 by United Services. The program's purpose was to identify seniors in need of medical, social or other services, and connect them with those services to ensure their continued health, safety and independence.

Natchaug Hospital has also recently opened a program that serves adults 55 and older who have mental health or substance use concerns. Treatment is designed to address the unique needs and challenges faced by older adult patients in a group therapy environment. The program descriptions says that

> Natchaug offers a holistic approach to treatment with multiple ways to engage clients in the treatment process. Older adults in the program will participate in a number of treatment approaches with a primary focus on intensive group therapy. Groups are primarily education, experiential and didactic with topics such as:
>
> - Stress management
> - Loss resolution
> - Life skill development
> - Relapse prevention
> - Medication education
> - Chronic illness management
>
> In addition, older adults in the program may participate in:
>
> - Individual and family therapy sessions
> - Recreational and expressive therapies
> - Stress management
> - Development of coping skills
> - Medication management
> - Grief work and recovery
> - Patient education
> - Aftercare and discharge planning

It remains too early to assess the impact on older adults in Region 3, given the critical lack of mental health resources for older adults in Eastern Connecticut, but ***through the Eastern Regional Mental Health Board's continuing Community Conversations on Older Adult Mental Health, we will provide ongoing feedback to DMHAS, lawmakers and the public.***

C. ***Windham Facility***

United Services has been awaiting Connecticut Bond Commission assistance to enhance, expand and consolidate child and adult behavioral health services in the Windham region since 2011. The project, which has been shovel ready since 2012, needs only the state's contribution of capital funds to begin construction of a new consolidated and expanded Windham Region Behavioral Health Center. United Services' existing Willimantic clinic was constructed in the mid-1950s, and is not ADA compliant, making it very difficult to accommodate individuals with mobility issues.

In addition to a need for modern facilities to meet new state and federal standards, United Services has also seen their volume of outpatient behavioral health services—more than double since 2007, increasing 248%, making the building unsafe, compromising client rights to privacy, and damaging staff morale.

Last year's evaluation of United Services' Outpatient Clinical Program, along with a letter written to Governor Malloy by the ERMHB (see Appendix H), called upon the state to support United Services' request for Bond Assistance to help construct a consolidated and expanded Windham Behavioral Health.

Managers say that there is also no way to lock down the Willimantic site in the event of a crisis.

In the face of the Bonding Commission's failure to act on the bonding proposal for the updated building, United Services has discovered an alternate route for jumpstarting construction, and plans a September groundbreaking, which the agency says will happen before bids have even come in, given the overwhelming need for an appropriate space in which to serve their clients. The agency is interviewing primary care doctors for the facility, which will promote integration of care, and is looking at local doctors that serve the clients and have had positive interactions with them. These doctors are also interested in being part of a team that takes a holistic approach to services.

III. ***Open Access Days***

Mental health providers, both state operated and private nonprofit, indicate that the most common reason for missed appointments is transportation issues. Several agencies, in an attempt to mitigate this problem, and to address damaging missed appointments policies, are testing the efficacy of same day access. This model allows people to appear for services without scheduled appointments.

The Southeastern Mental Health Authority has an open access model through Mobile Outreach (MOT), which has limited ability to use MOT staff for intake and get people right into services. We do not yet know how scheduling cuts to MOT have impacted this effort to streamline access, but encourage DMHAS to promote same day access models that improve and streamline engagement of clients in services.

Many provider staff have reiterated the crucial importance of being able to engage people in services when they are ready. Forcing them to wait leads to increased distrust of and disappointment in the system, making people less likely to come back a second time. It is also of critical importance that clients not be penalized unduly for missing appointments, particularly when the cause of the missed appointment is beyond their control.

IV. ***Open Access Center for Young Adults***

Young adults do not want to attend the traditional psychosocial clubhouses, e.g. Teamworks, Oasis, the Lighthouse & Welcome Arms. They don't want to be identified as being "part of the system," and they want a more age-appropriate, dynamic setting that caters to their interests. The AXS Center, now in its third year at Sound Community Services, was created in partnership with Connecticut's Department of Mental Health, and is one of three such programs that opened in the wake of the Sandy Hook tragedy. Its

intent is to engage young adults who are not engaged in services, don't have diagnoses, and may have "fallen through the cracks."

The program is effective because its staff already have strong ties to the New London community and the high school, have an excellent understanding of their local community and the needs that young adults face: teen pregnancy, drugs, gangs, violence, and dropping out of school. They use those community ties to reach out in meaningful ways. An outreach worker spends his days visiting low income housing, basketball courts, and soup kitchens to tell the community about the AXS Center, to engage individuals in conversation, and to invite young people to participate.

Other strengths of the model:

- It considers the needs of the entire family
- Offers an inviting and nonthreatening environment, including staff that dresses casually and converses in the language of the young adult. The draw of video games, recording studio, basketball court, and pool table facilitate open communication.
- A sense of ownership among clients, including a leadership board, and a membership that uses word of mouth and leads by example to influence the community and build membership.
- Parenting Education and Supports
- Vocational and Educational Supports
- Referrals to services when needed

Open Access centers like AXS would be invaluable in providing support to young people who would not otherwise be likely to engage in services, and they need to be available in other towns like New London across the region, including Norwich and Willimantic.

Reliance House, at the request of the Statewide Director of Young Adult Services, has already submitted a proposal for an open access center in Norwich. We urge DMHAS to approve and fund the project.

V. ***Medication Assisted Treatment Modalities***

Local providers are beginning to discuss the expansion of medication assisted treatment. There is still a debate on the efficacy and ethics of this model, but providers are beginning to understand the need for various treatment options. There is a slow increase in the access to outpatient medication assisted treatment. Also providers have begun to explore the increase in medication options outside of Methadone, including Suboxone and Vivitrol.

VI. ***Backus Pilot Program***

W. W. Backus Hospital and the Southeastern Mental Health Authority embarked on a collaborative project this year to engage people in treatment following opioid overdoses, after noting that people were returning to the emergency department with multiple overdoses, sometimes in the same day, after Narcan reversals. No additional funding was provided for this pilot; existing resources and staff were used creatively.

The pilot provides for members of the Mobile Outreach Team (MOT) to be called by Backus emergency department staff when someone presents with an overdose. MOT clinicians visit the person at the ED, and attempt to engage the person in services, or to at least ask for permission to follow up with them

after their release. Anecdotal reports suggest that this engagement is working. We would like to get more information about outcomes from this pilot, particularly in view of the recent cutbacks to MOT, and to look at the feasibility of implementing these practices on a more widespread basis.

VII. ***Diversified Funding Streams***

Throughout the region, we are seeing an increased ability of private nonprofits to diversify their funding streams in the face of the continued state budget crisis. The level of creativity and dedication demonstrated by agency managers in seeking grant funding that allows them to serve their clients in innovative and holistic ways is to be commended, particularly given increased responsibilities for all staff at all levels as resources shrink.

EMERGING TRENDS

I. ***Opioid crisis***

Data compiled by SERAC and NECASA shows an increase in prescription drug misuse (pain medications, downers, uppers, and tranquilizers). Opioid overdoses are on the rise in the region, but at the same time, there has been in increase in the availability of naloxone (NARCAN)

Factors to consider in addressing the opioid epidemic include:

- Prescribing practices: even with the new law that was passed last legislative session implementing restrictions to opioid prescriptions, there are several issues of concern. There is increasing evidence that opioids are not the most effective tool for pain management, but they continue to be the first avenue of treatment for many primary care doctors. Due to productivity demands placed on doctors, there is little time to ask about addiction history or brainstorm on other pain management strategies, and follow-up/continuity can be poor at best.
- There have been numerous community forums on the Opioid Crisis, but as a state and as a region, we still have no coordinated strategic plan for addressing the opioid crisis. We are hopeful that the soon-to-be released plan of the Alcohol and Drug Policy Council will be a significant step in this process.
- A great deal of public education on addiction is needed; for example, many faith communities are still being told that addiction is a sin or a moral failing, and that with enough faith and prayer, it can be overcome. This sets families and individuals up for failure, and also creates a sense of shame that prevents people from reaching out for help.
- The failure in many areas of the community to understand addiction as a medical issue also leads to a continued push for criminalization of drug use, which is not only ineffective, but is discriminatory toward the poor and people of color.

A. ***Legislative Impacts***

We will continue to monitor the impact of the new Opioid law passed during the 2016 legislative session, including how prescribing practices are impacted, whether doctors are verifying prescribing history for their patients, and the requirement for Narcan (naloxone) to be carried by all first responders (which may be complicated by the cost increase for the drug).

B. ***Yale Strategic Plan***

The Alcohol and Drug Policy Council (ADPC), which includes the leadership of all state departments dealing with the issues, continues to meet at its various committee levels. The Executive Director of NECASA sits on the Prevention and Education Committee, representing the Connecticut Prevention Network, along with two other Regional Action Council directors. The committees have sent their recommendations in to

the main ADPC. In collaboration with the ADPC, Yale University will create the strategic plan at the request of the Governor's office, and it is due this fall.

C. ***Backus Pilot***

Since no additional funding was allocated for this pilot, it remains to be seen whether the success of this effort can be sustained and expanded to other towns.

D. ***Law Enforcement and the Gloucester Model***

There is great interest in the model developed by the Chief of Police in Gloucester, Massachusetts, which streamlines access for care/services. The model allows those with substance use disorders to comes into the Police Department and ask for help, at which point an officer will take them to the hospital, where they will be paired with a volunteer who will help guide them through the process. Individuals who have drugs or drug paraphernalia with them will not be arrested, charged or jailed, and the police department will dispose of the items. We have been informed that barriers to legislative implementation of this model exist in Connecticut, and encourage the state and local communities to work toward eliminating these barriers.

Other suggestions for streamlining access to care include establishing this model through human services departments or other community agencies if the police departments are unable to take on this type of initiative. However, a serious, and potentially disabling, barrier to implementation of the Gloucester model in Eastern Connecticut is the severe lack of inpatient services in the region. Streamlining access is pointless if the services don't exist. The "grid-lock" after detox for mid-care (inpatient programs and partial hospitalization) addictions programs is noted earlier in this report, and the lack of capacity for this level of care has been an ongoing issue.

II. ***Marijuana legalization***

It is anticipated that with the current budget shortfalls, the pro-legalization forces will again bring the issue to the legislature in 2017. A legalization bill died in committee last year, and the Governor made it clear that he was against legalization. An anti-legalization group called STOP POT CT has begun to meet. Data from the Colorado and Washington State experiences has emerged (HIDTA reports-High Intensity Drug Trafficking Areas) that shows increased social costs of legalization. But it should be noted that we can expect the potential tax revenue from marijuana legalization to be touted as a way to mitigate Connecticut's budgetary problems.

III. ***Holistic Approaches & Integration of Care***

Private nonprofit mental health providers note that increasing attention will need to be paid to integration of behavioral health and primary health care in all settings. They have been innovative and creative in finding diverse funding streams to promote these efforts, but more support is needed from the state to promote consistency and availability of resources across the region. Reliance House managers say they see a growing number of individuals in their residential programs that hover on the edge losing their independence because of highly complex medical issues. They would like to be able to integrate skilled nursing care at all levels of service in order to help people remain in less restrictive settings.

United Services also plans to integrate primary care physicians into services provided to clients at its updated Windham facility, slated for groundbreaking next month. Doctors being interviewed already work with clients and are committed to holistic approaches to care.

The Behavioral Health Home (BHH) initiative is well underway in the region, and initial reports are positive. We look forward to being able to better assess its efficacy in the coming year. The initiative resulted from health insurance reform, and is intended to improve health care experiences for clients, improved overall health, and reduce per capital costs of health care. The target population is those served by Medicaid who had 1-6 diagnoses and $10,000 or more in combined services costs in 2012.

IV. ***Transgender Populations***

One program noted that out of 34 active participants, five were in gender transition, but added that there is a serious lack of supports in this region for people who are identifying with a different gender. Agencies have been creative, hosting LGBTQ support groups, and actively seeking resources from LGBT groups in the community. Thus far, there has been positive feedback from facilitators and participants, but these are merely stopgap measures in addressing a system-wide need.

CONCLUSION

The Eastern Regional Mental Health Board, the Southeastern Regional Action Council, and Northeastern Communities Against Substance Abuse are grateful for this opportunity to participate in the Priorities and Planning Process, and to serve as a means for providing vital feedback from all stakeholders, including those living with mental health and substance use issues, family members, service providers and their staff, and concerned citizens. We are committed to ensuring that all local communities and their residents have a voice in determining how and where behavioral health and addictions services are provided in their towns. We look forward to working with DMHAS in the coming year to promote solutions to barriers and unmet needs, and to strengthening our state's mental health system.

Appendix A

PRIORITIES & PLANNING PROCESS RECOMMENDATIONS 2016

I. Workforce

- Ensure appropriate levels of funding for the private nonprofits to maintain staff quality of life, including adequate Cost of Living increases.
- Equitable distribution of resources between state-funded and private agencies.
- Expand training opportunities available to nonprofit staff, both within the Region and elsewhere, including resources for preventing "compassion fatigue."
- Create mechanisms within agencies, including but not limited to making it easier to use EAP resources, that offer improved supports for employee stress management.
- Incentivize sharing of existing agency-run professional development resources.
- Ensure integration of Peer Support Specialists at every level of DMHAS-funded services.
- Put support systems in place for Peer Support Specialists to reduce turnover.
- Address lack of appropriate/available training for Peer Recovery Specialists.

II. Capacity

- Incentivize same-day access programs, which several agencies have found helpful.
- More respite beds to alleviate capacity issues in other residential levels.
- Create Rapid Intake procedures to mitigate long waits during intake process
- Funding for more outpatient clinicians and inpatient beds

III. Accessibility

- Enforcement of contracts with med-cab providers. DMHAS assistance in promoting contracts with med cab providers that treat consumers with respect.
- DMHAS assistance in addressing the multiple issues at 211 that create barriers to accessing appropriate and timely services, including increased staffing levels, reduction in phone wait times, and trainings for 211 operators that promote positive interactions with those in crisis or who may have a history of trauma.
- DMHAS assistance in removing regulatory barriers cited by Logisticare as a reason for not requiring certain postings in cabs about how to make a complaint, etc.
- Duplication of Reliance House model that allows clients to purchase inexpensive "punch cards" for a specified number of rides that can be used to meet any of their needs.
- Encourage substance abuse and mental health providers to share existing transportation resources to support all clients of state funded providers.
- Provide supports and resources to support client-owned and operated "limousine" services.
- Promote public/private partnerships with entities such as Uber or Lyft to expand the range of transportation options for DMHAS clients (see Appendix ____)
- Work with local towns to leverage existing town vehicles as a means for residents to connect with local transit.
- One provider said that it would be helpful to have a "mobility coordinator" position within each agency to alleviate transportation issues that are barrier to engagement in services.
- Advocate for legislative reform around insurance barriers, particularly reluctance to accept Medicaid.
- Increase asset limitations for spend downs, or just eliminate this altogether as it's unrealistic and harmful.
- Lengthen redetermination periods to one year rather than six months.
- The Eastern Regional Mental Health Board will continue to increase awareness of Transportation issues within Region 3 by:

- Holding Community Forums on Transportation in multiple locations and including Logisticare, SEAT, DSS, Eastern CT Transportation Consortium, providers, and citizens in the process.
- Disseminating the People Interrupted: Navigating Poverty in Eastern Connecticut video throughout the region in community settings and on social media to promote buy-in by the general public to a sustainable solution to the region's transportation barriers.
- Promote special presentations by transportation industry representatives to increase understanding and awareness regarding available transportation options.

IV. Coordination

- Create a streamlined reporting system for all state agencies, in order to maximize staff time and resources.
- Expand jail diversion programs in Eastern Connecticut.
- Promote greater consistency in the court system; better education among judges about the benefits of jail diversion.
- Expand substance use treatment options to prevent incarceration of those with co-occurring disorders.
- Improve and strengthen discharge planning from emergency departments, hospitals and the corrections system to prevent recidivism and increased costs to the system.
- Mandate and provide funding for State Police and local police departments to support training of at least half of their current forces
- Expand the RMHBs' funding and mission to include review and evaluation of all human services, not just DHMAS funded services OR amend the statute to require appointment of RMHB representatives to the Regional Human Services Coordinating Councils as mandated participants in their process.
- DMHAS should advocate with other executive branch departments for the improvement of services to shared clients, in order to ensure that mental health service dollars are being spent on promoting client recovery goals, rather than on addressing system barriers.

Appendix B: ERMHB Focus Group Notes

The ERMHB conducted 8 focus groups with 129 participants across Region 3. Four groups comprised mostly clients (with a few direct-service staff present); three groups were made up of management-level staff; and one group was made up entirely of members of a local Clergy Association. Two groups took place in Northeastern Connecticut; six groups took place in Southeastern Connecticut.

I. KEY FINDINGS AND THEMES

A. *Gridlock in System*

- A majority of the people that come to brief care come because they have no place else to go. Puts a burden on brief care to try to find housing, it locks up the service for other people that might need it for stabilization or step-down from hospital. It creates a log jam.
- Example: Got a call from an eighteen year old not directly in our catchment area, their principal had been in the training. This person had major issues at home, homeless, probably needed MH services but that wasn't the initial call. Gave him some numbers to call. A call comes through, but because of the recent cuts, the follow up that might have been done two months ago was cut way back. We're glad you called, but there isn't much we can do, call 211
- (Referring to wait lists:) The referrals don't stop coming in.
- Between waitlist and people that would normally get discharged to other programs that can't, they have to go somewhere. We're somewhat triaging so they don't have to wait, accepting them and trying to do something with them, so they don't have to wait. We have 8 people doing intake, and we're backed up 3 weeks for just intake, and then there's a wait list to even see a therapist.
- This is the system breaking.
- The jam at CSP goes down the line and affects other programs.
- Brief care has over a year, while crisis respite is 3 weeks per month – being used inappropriately, so much pressure to move people out of these beds. We have gaps.
- Inpatient services—would like to see increase in size of Brief Care. At 15-day mark of inpatient, Brief care always at capacity and patients are denied step-down. They get put right back into program, even if hospital doesn't deem them stable.
- Even more pronounced if someone stepping down to shelter level of care.
- Capacity across the board is an issue. Anywhere you go there is a long waiting list. The amount of people in need of any resources outweighs what is available. Getting worse since budget cuts, though it has been a long downward trend
- People are eager to get services, but they just aren't there
- The supply doesn't meet the demand because of the lack of funding. It is even more of a revolving door.
- When we have new people, we try to have a transition. Sometimes people come and say I have to be here; they feel they don't really have a choice. If you have an open bed, it's getting filled, whether or not the person is appropriately placed. Trying to get them to a more appropriate service takes a very long time because of waiting lists. Even if they've graduated and are ready to go out into the community.

B. *Attrition in Services*

- "They just keep asking us to do more with less." We've been saying that for such a long time.
- A real strength of [organization] was continuity of care – I could house them and get them case management so they wouldn't be homeless again, but we're losing that. We have to discharge folks who are doing well because they are getting what they need, but then they struggle when they don't have the supports to keep succeeding.

- I didn't really like the therapist I just went to because all she did was type on her computer and I felt like she wasn't really listening to me. I was used to my other therapist, she never did that. She listened to you, she was focused on you. I felt this therapist was focused on the paperwork.
- They don't understand the services, but have to take whatever is available, because they won't get anything else.
- We see a lot of hospitalizations because of lack of appropriateness.
- Budget cuts have heightened problems short-term but will cost us more in the long run, waits, inappropriate placements, delay in engagement, etc. increases revolving door to hospital, ED and prisons
- The current set-up is perpetuating costly interventions and costing the taxpayer more money
- You're talking ED visits, criminal justice activity, corrections system, impacts the whole spectrum

C. *Over-regulation of Programs*

- CSP and the ACT model are all very time limited… The difference between how we used to do it, we used to take as much time as necessary, it changes the relationships that can develop. 10 years ago we had clients that were really connected, not so much anymore.
- Long ago there was a thing – individualized plans, can't force people into a model, but now we're back there.
- I think a solution is in the middle, the old days of intense case management where we did it for you, and now where we teach you to do it for you. Helping with medical, rides, need someone to sit with you.
- We're short on the number of people we're signing up and showing the most hours per client, better outcomes but lower numbers of people served.
- Fidelity review for CSP/RP – there's a core of the 31 fidelity items, maybe 5 or 6, that are really important to prepare for the rehab option – the rest are just overlays that take time and paperwork. Basically said to staff, I care about these 5, if you don't score well on the rest, I don't care about them. They're stressed about all of these items… If it doesn't work for client service, don't do it!
- CSP/RP no one ever takes anything off the list, no one ever looks to see if we're measuring something that isn't helping.
- Forcing people to do it even though it doesn't help. Instead we should simply meeting with clients to see what their needs are.
- Client centered instead of bucket therapy.
- Our agency, management, staff know what need to be done, knows how to provide individualized services. The system does not support that. We know what our clients need, but we don't have the ability and flexibility to do that.
- With CSP/RP, relationship feels forces and doesn't feel respectful of person's needs. If you have capacity, have to stick with capacity. Waiting list right now. Staff are very flexible and try to accommodate the best they can. Teams are taking on clients as needed. This affects report card. For someone in CSP/RP don't always hit top threshold. This starts to hurt fidelity.
- Measurement ought to be are we meeting needs not are we meeting the hours. Clients can move back and forth between levels, and this interferes with tracking. Lose spontaneity and relationship.
- **"I didn't really like the therapist I just went to because all she did was type on her computer and I felt like she wasn't really listening to me. I was used to my other therapist, she never did that. She listened to you, she was focused on you. I felt this therapist was focused on the paperwork."**
- Staff won't be doing billable activities, but shared experience is invaluable. Doesn't fit boxed in definition of what we are supposed to be doing.

- **Directors like idea of fidelity. Gives a mission to the program. But would like some creative and flexibility built in to process.**
- The people that need our services the most need the most creativity and the most outreach. How do you incorporate this into productivity?

D. *Chronic Underfunding*

- Now they're cutting state positions, we don't have that support and are taking on that burden. Not even 1% cost of living increase in the last 20 years, with inflation of something like 25%. We haven't had a COLA, none of our programs with budgets set 10, 20 years ago, and those budgets have never been increased. We have programs with budgets from 30 years ago, trying to make it work with creativity.
- The inequitable funding and distribution of resources, and our clients get the short end of the stick. Being asked to do more with less and coordinate with other services leads to burnout of staff. We have great staff, great managers.
- 80's level of funding. Spend some time writing grants. We have to look for other funding so that people can have experiences in the community.

E. *Discrimination and Stigma*

I. *Public Education*

- Discriminatory attitudes; we try to develop relationships with community
- First Friday led to it. People all over the community trying to bring in art and make Norwich better.
- "Social services should move out of town." Making great effort, go to Chamber events, after hours, etc. First Friday's enable us to open the door and just be a gallery. Don't identify whether artists are clients or community members.
- What are the reactions in the community going to be about mental illness in the wake of the Orlando shootings?

II. *Medical Professional Education*

- Hospitals look at substance abuse and addiction rather than the medical issues. When folks go to primary care or ED, as soon as it's known they have psychiatric issues, their medical problems are dismissed. That's why they're dying earlier.
- A gentleman went from [group home] to ER, having difficulty, but they discharged him. Went to a different ER then next day, admitted for kidney failure. We've been talking about integration of care for a long time, but statistics aren't changing. We need to show that it's not just the right thing to do, but the smart thing to do.
- I had problems with the psychiatrist. At [hospital], I kept going back again and again, they said there's nothing wrong with you. [At another hospital] it took a while but they were willing to work with me, figure out my medication, got me stabilized.
- Nursing homes don't have training to deal with mental health, residential programs have a lack of medical services. Want to be able to keep people there.

III. *Law Enforcement Education*

F. *Opioid Crisis*

- Heroin epidemic an issue. 2-3 people impacted. We need to look at untreated mental health issues.

II. SYSTEM STRENGTHS

A. *Behavioral Health Homes*

- "BHH is helping with complex medical needs." I think we've had no problem meeting the numbers, it's engaging individuals into services because they can say no.
- "A real need to coordinate services, the mind is connected to the body."

- They have really worked, we have nurses doing discharge planning.
- Seeing the benefit to that. Have the fluidity to do this on our own and not be dictated to. Can look at person holistically… Meets the needs of the person as they are presenting.

B. ***Town Substance Use Prevention Coalitions***

C. ***Clubhouses and Social Programs***

- Recovery supports, so many of our people, developing relationships on social rehab level… People found that very helpful to make friends with other people that receive services..
- They do a good job here at Teamworks.
- It helps people to become better, if you take something that helps people, it helps people evolve and get back to their potential, and without it they could be in jail, you can't cut those that are doing good and helping to make a difference, instead of cutting those that aren't helping.
- I'd be roaming the streets, getting in trouble, they help me a lot through the years, I've been coming 8 years, and I love it here.
- I've been coming twice, I've learned there is word processing available as long as you're showing up, they also help me out with education.
- I need to get a couple of groups/activities a day, coffee talk, men's group, relaxation group, smoothie group, it's not just the fun things, it's also for me to learn, I know a lot about mental health now, I get the services here that are required and I need, I feel that I can give back a little bit now that I've been under the help from other people.
- I see people that haven't given up yet.
- This place helps you adjust to the community, I've been under care for quite a number of years, very different from what you might have in the hospital. You are encouraged to do things on your own. It's good to have the training, you get help learning how to pay your bills, I know how to do that but it doesn't hurt to have a refresher course, everything is more expensive.
- **Favorite things about the [clubhouse]: it's all the people, they can lift me up when I need it.** I like all the people, the activities they provide get you out on the weekends, not only is it fun but it gets you going. Had social phobia, I don't talk much, but they get me out. We go to farmers markets on the weekend, we get vouchers, we've gone to truck races, we've gone bowling, car shows, swimming, movies, new Britain bees.
- I feel that all their services here, it gives you a sense of who you are and the activities here let you feel relaxed, the leisure, so you're not pressured for whatever reason to get back into the paid system. Less stress, happiness, it really makes you be aware of who you are. Stress is number 1 for a lot of people, it makes you more comfortable.
- Is the clubhouse as important as medication and therapy? More so! Without the lighthouse, we don't have transportation, we don't have cars, we wouldn't be able to get around. There isn't much in our area.

D. ***Collaboration***

- Support from [LMHA] is notable; feel tremendously supported. When there is need, we're allowed to be relatively creative. Great leadership at [LMHA]
- in past 6 months to increase collaborative efforts with other intra-agency and community programs. Challenges in coordinating everyone's time and availability. Risk meeting, etc. other community meetings are harder to schedule because fewer staff and resources.
- Unfortunately collaborative team meetings that could help, have to go by the wayside, because we need to serve the client first. Balancing the needs of the clients with the needs of our staff. With residential can't leave programs unattended.
- To get a meeting with case manager at LMHA when there are shared clients is difficult because they are busy and stretched too thin.

E. ***Resource availability in Substance Abuse Prevention***

III. SYSTEM GAPS

A. *Service Needs in Rural Northeast*

I. *Lack of Appropriate Services*

- local crisis respite. A lot of the people we send to the hospital would be more willingly admitted if they knew we had a step-down program here like in the SE. We've put in for this program for intense support to transition back into the community, it would be a clinical program and also a hospital diversion program. That would impact the local hospital.
- There's no intermediate program here. Number of people not hospitalized or quickly discharged is very high, it's not a Day Kimball issue, it's a community supports and a system issue.
- There aren't enough choices in various level of care
- A sad suicide last week, very smart and bright, had only been with us 5 weeks. If we had a supervised apt program where he had support and flexibility, he had good family involvement, in [a residential] for more complex needs, if we had a different type of program he wouldn't have felt so desperate, he might have felt there was a solution.
- No YAS in this region, the solution from the state is that they can go to Willimantic. It's a fearful thing to go from a setting like the NE to a bigger city like Willimantic, it's a scary place with gangs and violence. You're the much more vulnerable and at risk.

II. *Lack of Adequate Transportation*

- No YAS in this region, the solution from the state is that they can go to Willimantic. It's a fearful thing to go from a setting like the NE to a bigger city like Willimantic, it's a scary place with gangs and violence… it's a hard thing to go far and lose family and friend ties, away from natural supports. You can't even take a bus between the two areas. It's like saying that in order to get the care you need, you have to give up everything that makes you feel whole.
- Reliance on Logisticare for clubhouse members – several issues with Logisticare.
- No bus in Moosup

B. *Co-morbid Health Issues*

- There aren't enough levels of services in residentials. We could definitely use a medical residential program. It's something we've been talking about for 5 years. We've had several people have to leave our residential programs to go into nursing programs, and several of them have passed away after they leave. We'd love a residential house with a medical focus, maybe with a few respite beds, I've gotten calls from hospitals asking if they can use our respite beds for their patients.
- We have a guy with cancer in my home. Diabetes, dialysis, kidney failure. We have one person living in a nursing home because he needs dialysis.
- To hire an RN and have someone on site that would understand the critical-ness of their health, maybe have a 20 bed site to be there for them. When they move out of residential, they may be distraught, it's been their home for a long time.
- On both ends of medical and behavior health, it's acuity – the intensity of needs have gone up.
- YAs – a lot have very serious asthma, she has to manage a lot of the nebulizer. If you go to stay with a boyfriend for a night, you miss treatment, get an attack. Skin issues, eczema, etc. A number are losing hair. Not heart disease, but they are things that make interacting with other people in the community uncomfortable. Dealing with them on how to manage this stuff and appropriately use medications; it's not something they remember, you get flair ups. A little bit of child diabetes.

- Residential clients have high medical needs and they are willing to put medical in, so that mental health services are appropriate. What if we could go into nursing homes and provide mental health assistance. Get a call from a gentleman in a nursing home every day. De-escalate, explain. Nursing homes don't have training to deal with mental health, residential programs have a lack of medical services. Want to be able to keep people there. DMHAS has done a great job of enhancing dollars to provide help to get man to dialysis.
- Medical piece is missing from core services. Needs to be infused in other areas besides BHH

C. *Young Adult Population*

- Young adults in the Northeast, there's some tension with services in the Southeast. They're going to Natchaug's partial program, then they're sending them to where they know there's resources. They are more likely to go to the Southeast than to Willimantic area, going to Voluntown and Griswold so they're not too far away.
- If we had one up here, it might be something a little bit different. They said we don't believe in clubhouses for young adults, but that's the one place everyone goes. I almost need that more than I need residential, though I do need a safe respite place.
- It's a population that doesn't have a lot of stability before they come to us. Sometime we have to let things happen, the ability to say yes, try it. Try things and if it doesn't work, we're here for you.
- We don't need a huge residential program, but we need something. You need 24/7 help someone on the phone. If you have a fight with your boyfriend, that's where they go. This is part of the wraparound. It's another grounding place for them.
- The clubhouses don't fit well for YAs – the young adult we tried to integrate into [clubhouse], it doesn't work. They have very different needs and attitudes.
- Pending proposal to expand supported education program. Young adult needs not being met through YAS.
- Young adults—if it's not accessible then and there, they might get caught up in something else within a few hours. If they can't get into IOP, and they have to sit through a 1.5 hour intake, we lose them. Some can't even sit still for a 5-minute conversation.

D. *Senior Population*

- A lot of people who left the NSH are seniors, we have a lot of seniors. If they cut back at SMHA, we pick up some of those people, we're blessed to have outpatient services and someone who can prescribe.
- In the population that we work with, we're seeing senior issues much earlier in life, like 40s and 50s.
- Gatekeeper program was lost, still doing Healthy Ideas. Designed only for seniors with depression. EBP is with depression. We're seeing more seniors with substance abuse and maybe early dementia. They need wraparound but without SPMI diagnosis they don't get case management.
- More isolation, more depression cycle. Gatekeeper was identifying them and had ability to do some case management.

E. *Latino and other Non-English Speaking Populations*

- Monolingual Spanish clients down in Willimantic, have some contractual clinicians to respond to them but there's a pretty intensive need there, do end up doing family therapy, it's a different approach
- Underserved populations we're doing a good job meeting, seeking additional funding to expand integrated care for Latino population in Willimantic area. Our % of Latino Spanish-speaking clients in Willimantic exceeded % of the population that identifies as Latinos. We have a strong reputation and are doing a good job of outreach and service

- Population may have a higher level of need.
- Health disparities in Latino population are significant, mental health and all other aspects of integrated care. Amount of resources needed are not available.
- Hispanic population, nobody out there who is bilingual to treat them

F. *Transgender Adults*

- 34 active YAs, 5 are in gender transition.
- Lack of supports in this region for people who are identifying with a different gender. Host an LGBTQ support group, and transgender support, staff are interacting with these supports.
- We went out of our way to interact with LGBT groups in the community. Positive feedback from facilitators and participants. Group started as meeting once a month, then once a week, increased demand and desire.

G. *Homeless Population*

- We have people with high needs, high crisis, they really need to be in residential setting. There's no way anyone who is homeless is going to get into a residential setting. Only if they get hospitalized. If they're in active psychosis or bouncing in and out, and then there's the waitlist, they sit in brief care. Come winter time, we will be stressed. Its fine in the summer to give up tents, but in the winter there won't be enough beds. My fear is something serious is going to happen on the streets, or the blame is going to fall on the shoulders of someone who is already overworked.
- I've given out 6 tents in the last few months. The HOAP team got cut, so we're the only outreach team.
- CCT talks about homeless people in community every week. Review about 68 people/week. 2 people went into CVH; but 15 have gone to jail when they really needed hospital.
- Someone went to jail on trespass charges. Every place he went there was ruckus. What he really needed was inpatient treatment/ worked with court. He was offered this in jail, but wouldn't go to psych evaluation. 3-4 others should be in a hospital with a day pass. Shouldn't be homeless. One guy has a problem with water, and causes damage and leads to eviction. Not a danger, on his meds.
- We said we were going to provide for people, but they're homeless. Many people on SSI but homeless. They need a payee; don't want a payee, can't manage money, not required to. Double billing system—getting benefits and using shelter system. Even mandated to have a payee, will get check after 60 days.
- Homeless outreach team at SMHA to be pared back. There won't be enough people to engage homeless individuals where they are. Other agencies don't have capacity and don't do that work… Won't see certain levels of care. Have addressed people that can be rapidly re-housed.
- Can't house a guy with $210 SAGA cash. Process of getting people on social security—well over a year. That's with good medical stuff.
- Many people have work skills; health and transportation big issues. Linen company wants people to start with 3rd shift. Doesn't work for those who need to sleep in daytime and are homeless. Background issues a problem
- Will be feeling the hit with cuts to employment services and homeless services at [LMHA]. CABHI funding will help, but only a 3-year program specific to housing and homelessness. Housing specialist, peer support and employment specialist and entitlements person on team. Very intensive team approach. Started 9/15, and in 3 years funding will end. Then what happens?
- Many in BHH still homeless. Housing stability services are needed. A lot of it is in the permanent supportive housing world. PSH has a lot of information. Rapid Re-housing—critical time intervention. Methodology for people going into housing to get them linked with short term

resources. We hope state will expand Medicaid to allow the state to bill for housing stability services. You can't get SSI based on substance abuse.

- Chronic Homelessness is the priorities. Documentation has to be just so to meet the definition. So some people with situational homelessness would have priority. Rapid Rehousing dollars through TVCCA, etc. . Diversion dollars administered through [LMHA]—assist someone on as needed basis to prevent them from becoming homeless.
- CAN is wonderful as gateway, but has been hard to monitor Community providers' level of engagement. Interim case management missing; it's a resource issue. MOT used to have interim case management attached to MOT. While intake, eligibility assessment taking place, someone would be handling this. Intake person does their best, but there's no body doing one-on-one. Things are constantly changing.
- City of NL needs a person to do the work and the navigation. [Staff] used to help people with entitlements, provide interim case management. [Staff] has a wealth of knowledge but her role does not include case management; $100K in person that brings all the agencies together to better coordinate services. Purpose is not to provide services but to coordinate and identify issues on a higher level. A lot of energy on making sure we're not duplicating.
- DMHAS in funding homeless outreach and PATH—goal is to engage individuals who have mental health needs who are homeless in the community who aren't connected but could benefit are going to be harder to serve. We are no longer prioritizing them, just those who are already in system. Feel like we're turning a blind eye. Is it our charge to continue to engaging those that aren't engaged?
- Some people getting into housing, we've been talking with them for years. Even harm reduction approach is working. Our region is getting close to ending chronic homelessness. We've done a good job of engaging. Those that aren't engaged aren't going to come here. What about the creativity in engaging. Can't quantify success. Studies of supportive housing—decrease in ED use.
- People are very transient in an increasing level. Services not available in your town, you can't get what you need, so you go to another town, then you fall off the grid. Going from place to place looking for something that's not there. You might be going just because you need a bed, and you're interrupting all of your services

H. ***Criminal Justice System***

- More people ending up in the correction system. Once they shut down the hospitals it increased. It's not the right place for them, staff aren't trained in the services they need. There was a time that I was getting a ton from DOC, but not so much anymore. They've cut those positions, they don't have the person in corrections to make those referrals. Again, it's systemic, the connections are falling apart.
- DOC is pulling out all their grants in corrections. CSSD pulling back their contracts. Judge order treatment, DOC orders treatment, Jail diversion orders treatment, but it's ordering the client to treatment, not ordering us to treat them. Clients are resistant to treatment. Mandatory treatment comes with a whole host of issues. They were being seen at places that were set up for that kind of population, here they get mixed with a very vulnerable population. The number of trauma survivors is increasing in our population. The acuity and level of violence experienced in past and present, coming in with a knife, threatening the clinicians and doctors. We haven't seen these clients in the past, a lot more angry and aggressive and more oriented toward having weapons, trying to get their way through threats. A lot more difficult.
- Inpatient service very hard to get for people. Too many people go to jail because they can't get hospital. No other place, because people aren't' appropriate to be in community. Someone needed to be in a state hospital.

- Prison release—this is the mental health asylum of current day. People come out without prescriptions, linkages follow up... DOC has limited, but needs not getting met. Some people closest to recovery is prison. Leave regimented environment without follow-up and income, it doesn't take long for some people to decompensate. Well over 50% have history of engagement with Criminal Justice. Every week a few people come direct from prison.
- Program to jail, program to jail. Need more transitional resources for a more effective integration back into community.

I. *Veterans*

J. *First Responders*

K. *Sex offenders*

- Sex offender population—they are bhomelsss and aren't supposed to be. They can't go into shelters because of record. Can't get job. Will be living in violation and can't register because they don't have an address.
- Sex offenders—some kind of MH issue? They are almost impossible to house (have 5 now). Someone just had open-heart surgery, can't get him housed. No sober houses, probation doesn't want more than one offender living in same place.
- On a state committee about registry. Trying to come up with a mechanism where can come off registry. 80-year old needs to be in convalescent home, no capacity to hurt anyone.

L. *Co-occurring Disorders*

- DMHAS ha not concentrated enough on addiction services. Rare that someone that just has addiction problems gets what he/she needs. They don't get referred to DMHAS; are managed by other agencies. Sense is that DMHAS only looking at co-occurring disorders.
- Looking at co-occurring disorders—still a problem to get quality appropriate services for those experiencing this. An integrated approach to looking at system. What is behavioral health? We have no purview/oversight. Rhonda monitors DMHAS funded SA providers. [LMHA] has no real oversight on SA. No way to integrate. Would be helpful to know findings. No access to data, contacts, no of beds. Would have to go to Rhonda to find out what we fund at SCADD. DMHAS does site reviews of MAT, methadone, but [LMHA] not involved
- Would be more cost-effective. LMHA in the community with SCADD and methadone maintenance clinics. Would make more sense for LMHA to monitor contracts.
- Failure to recognize in the system that all of the sober houses, recovery houses are not monitories, state supported, ATR dollars, etc. Anyone can do this.
- Will CCAR model help with this? Desperation is a problem for people who need
- What about those with co-occurring disorders and primary issue is SA that are going to come in the front door?

IV. EXTRA-SYSTEM CONCERNS AND ISSUES

A. *Lack of Adequate Housing*

- They need to fix my apt but they want me to move out in order to fix it, the landlord is being lowkey and taking his time. I have two cats and I can't give them up because if I do I'll end up in a crazy house, they keep me going. I'm frustrated because I'm paying and they won't fix it.
- Sober houses. Availability of rooms. Individuals transitioning from homelessness and are working but can't get out of homelessness.
- Sober houses are not always good. Even then a struggle. People actively using in bad ones and people will relapse.
- Some of the houses not even livable. Can't imagine referring anyone there

B. *Lack of Adequate Employment*

C. *DSS*

- DSS: You have to fill out all this paperwork all the time. I only get $19 and I get paperwork 6 times a year. My benefits just got canceled. I had sent all my paperwork, they canceled my food stamps in July because they didn't get one of my forms, they didn't call or notify me that they needed it, just canceled it when I went to use my card. I sent them an email but they never told me. I didn't get my food stamps until the middle of the month, so now I only get my food stamps at the middle of the month and that throws everything off.
- Our lives would be easier if there was less paperwork (everyone raised hands).
- They say then need paperwork by July 2nd, so you send it in, but they don't do it and send you a notice that they didn't get it and your benefits will be cancelled, so you have to call and tell them and then they look for it and find it and give you your benefits. This happens every time I get redetermination paperwork.
- It takes me 15minutes to an hour to get through to a real person. It takes a long time, I've never gotten a real person yet. I let my caseworker do it. This adds stress to me. It's supposed to be every 6 months but I get it all the time.
- **You get depressed and discouraged.**
- I think things are getting worse. The only thing we're ever told is that the state is behind on their paperwork. Sometimes Medcab is the same way, they're overloaded so you're late and it really hurts the people that need to be there at a certain time. It's really hard.
- With the state it seems like every 6 months you get redetermination, either for medicine or food stamps. With housing I get it once a year, but with DSS, they said they don't receive the paperwork even though I brought it down to the office, she said she had it and I was all set. They're losing it. We have to fill it all out, with all the information, but they lose it, it's ridiculous. Why do you keep sending it, why can't you receive it, I'm on the phone for hours waiting for someone. Too much paperwork in the mail.
- They're either the same as 4 years ago, or worse than last year. Now you can't call your worker, but if you go down there, but even then they might lose your stuff.
- It's a confusing system.
- I found out if y our paperwork is not on a computer, then it doesn't exist. It could be sitting there on a desk, but it's not there! I had to sit there for 30 or 45 minutes, and they still lose it. If you send it in, you know it's going to get lost. Some people have accused them of throwing things out. Every 6 months they get a letter saying they didn't do it, but you can't forget doing it because it takes a while, it's so detailed.
- A few days ago I got a letter from DSS, they discontinued for not completely the form. A month before that I called and got a pin number over the phone, they looked me up, said I was all set and they continued it. This has been going on ever since I got involved in giving testimony, **it makes me paranoid, it's really frustrating, it makes our condition worse, we get angry.**

D. *DDS*

- DDS: In addition to any layoffs that DMHAS has been through, layoffs in DDS has caused us to see a big more of an influx of people who require more maintenance environments, not recovery environments, and our services are not a great fit. There aren't residential programs that really meet their needs. They're not able to be independent in the community. We're facing some challenges finding those folks adequate residential services that fit. We have a few of these clients right now. People don't really get placement through DDS at this point unless they lose a caretaker or if they meet a very high risk criterion (forensic, for example). DMHAS will see more of these clients come through the door.
- How can I teach someone basic living skills if they have a cognitive deficit, and he can't learn? We can't micromanage every part of his life. Can't have someone with such broad limitations in the program—this person can't even read. Not in resident's best interest.

E. ***211***

- I personally have called 211 with a client and sometimes the wait has been incredible, literally hours. It was quite frustrating and I understand how our clients feel.
- It's been utilized by more state depts across the board. We're doing it, other departments are doing it, it's not a big enough resource to handle all the people calling and it lacks the one-to-one relationship.
- I get many calls that say, "I called 211, they told me to call you."
- I think it's a necessary tool, I think you need it, but it needs time and money. I wish they would integrate services.

F. ***Town and City Funding Cuts***

- Human Services has been cut back, we're getting more referrals because they would do the 211 intake. We've been approached to take on the intake, trying to figure out how to do that with no money and no staffing.
- We can't send them to community agencies anymore, can't refer to Human Services. We're getting calls from them, from the soup kitchen.
- City is cutting budget; had one staff meeting about what will be eliminated. 3 caseworkers to one as of July 1st 70% won't be able to get services. Norwich has the first ever Republican majority council. Won't raise taxes. Community attitudes very negative towards those who are disabled.
- Efforts with homelessness enabled us to close winter shelter. If we don't get grants for those programs, it will fall apart, and city will have to reopen shelter, or inundate New London shelter. New London will be angry. Not most cost effective or humanitarian
- Every provider has a funder that comes with a target population. Some people may not be able to pay rent in NL, then they need to navigate all the agencies to see if they match the eligibility.
- Case Management: Even one part time person could help with this. And stay with someone till they got where they needed to go. NHS does this, but losing 2 staff. Unable to participate as intake providers as part of CAN process. There are three places that do intakes. SVDPP, NLHHC in collaboration with Covenant. A homeless person will have to go all the way to NL to get intake. How can we maintain a small piece of intake process in Norwich?

G. ***Transportation Barriers***

- Logisticare; if you live on a bus line, and you have more than one issue, they still direct you to bus line, there might be issues—anxiety, stress. Severe anxiety while riding bus and feel paralyzed by anxiety and will miss stop.
- Have to wait 2 hours after.
- Drivers are not very aware of issues about mental illness. Some drivers are loud and not respectful. Logisticare drivers are rude, and yell; they are going to do that anyway; the drivers from Norwich Cab
- One time the cab driver started yelling at me, and I didn't do anything to get yelled at.
- Haven't been riding medcab because the drivers are sometimes really nasty. I was getting picked up from the hospital, and the cab driver pressured me
- Medcab drivers threaten to put you out of cab. You are right. And they are wrong. They are disrespectful, belittling. Late, driving unsafely. Have to hear about the last few passengers.
- Some people don't want to deal with the medcab, can get stressed out by being verbally abusive
- Very rigid about times they will pick me up; didn't want to change it, so I didn't get to see my doctor. Needed sleep medication, but am still waiting

V. PRIORITIES & RECOMMENDATIONS FOR BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES

A. ***Accessibility***

I. *Transportation*

- Logisticare: They're always late. Yesterday they picked me up 5 minutes before my apt starts, I was 20 minutes late. I still got to see my psychiatrist, but it wasn't good and there's nothing I can do. With some people at United Services, if you're 10 minutes late you lose your appt. Some people will still see you. It's nerve wracking, you want to get home, it's been really hot lately, you want your cab there and you don't want to wait. When they tell you they'll show up at a time and they're still 45 minutes late. It happened to me when they came early and they called my appt. and they agreed to wait for me because they were early.
- Sometimes it depends who the driver is.
- Three times they picked me and dropped me off at my appt way early, you're sitting there all by yourself and the building isn't open and it's scary being alone. They got to fix things a little bit to make us more comfortable. Not getting there on time really upsets me. It's nerve wracking. They have to accommodate the people more.

II. *Insurance Barriers*

- Inpatient: Acute level beds wouldn't get reimbursed.
- When people want a bed, there should be a bed. Insurance issue should be figured out afterwards. Often turned away because they have the wrong insurance for the open bed.

III. *Lack of Opportunities (Employment/Housing)*

IV. *Spend Down Barriers*

- I just went back to therapy because I was in the hospital, I just went once, but I can't go back until August because I'm on a spend down. Most of my services are every three months, but I have to wait until I make my spend down.

B. *Capacity*

- Capacity across the board is an issue. Anywhere you go there is a long waiting list. The amount of people in need of any resources outweighs what is available. Getting worse since budget cuts, though it has been a long downward trend
- People are eager to get services, but they just aren't there
- The supply doesn't meet the demand because of the lack of funding. It is even more of a revolving door.

I. *Outpatient Services*

- With outpatient treatment we have a lot of difficulty getting people in in a timely manner
- Some affiliated agencies are really struggling with long waiting lists.
- We're getting waitlists, programs are on waitlists. People are getting so desperate that they're calling the programs directly. CSP/RP – capacity of 116, everyone is making their service hours, they are using the program. 14 on the waitlist… SSAP just started a wait list, too. The referrals don't stop coming in.
- Between waitlist and people that would normally get discharged to other programs that can't, they have to go somewhere. We're somewhat triaging so they don't have to wait, accepting them and trying to do something with them, so they don't have to wait. We have 8 people doing intake, and we're backed up 3 weeks for just intake, and then there's a wait list to even see a therapist. **This is the system breaking.**
- If I didn't have a case manager, I'd be in the hospital, I'd be confused, I can't do paperwork because I'm illiterate so without them I can't figure it all out. Sometimes these cuts, there's another program or resource out here that a person can be switched to, but without a case manager they wouldn't be able to do that.
- Our outpatient volumes are off the walls. [Other local agencies] have stopped admissions right now, we are absolutely slammed.

- You have an assigned caseload and assigned program. When someone comes to front door, agencies try to be creative. There doesn't seem to be dedicated staff to assist the front door referrals.
- Wait list for individual therapy. Can't replace clinicians. Some people want therapy, can't go back to person in community. No-shows. A lot of providers can't afford to continue seeing these people. We try to pay attn. to revenue and use resources wisely. We have more flexibility to serve people that have a hard time engaging. Will do due diligence, phone calls, MOT, etc., before we discharge.
- Offering groups to people on wait list, getting creative. About 20 last check. Were up to 40 at one point. People who want individual not groups. Can't serve as many people, may have to offer more groups, due to lack of resources.
- Not having the availability within the program. There is a specific time when you have to engage them to get them into recovery. If you fail to do that, you lose them. If it isn't not available then and there. There's a small window of opportunity to hold them at the level they are at, but if you don't, they will relapse
- Young adults—if it's not accessible then and there, they might get caught up in something else within a few hours. If they can't get into IOP, and they have to sit through a 1.5 hour intake, we lose them. Some can't even sit still for a 5-minute conversation.
- Individual therapy—there is a waiting list everywhere How do you get to the core of the issue without it. Group therapy alone isn't enough for some people
- State budget cuts have put a huge damper on YAS from 6 clinicians to 3. Clients were consistently getting one hour/week for years. Now cut down to biweekly or 10minutes/ visit. Clients now see this as worthless because they struggle to get there, spend half a day and only see clinician for a short period of time.
- Trying to provide more hours. Already a waiting list for this. The downfall is that now I have to come up with a way to provide support. Clinicians meeting with people one time/week after intake. Provides support, but not support person was assessed at. If we can't offer the right service, should we offer anything?
-

II. *Inpatient Services*

- Reluctance on the part of community inpatient facilities, as opposed to DMHAS funded, to take individuals who will not be able to be discharged in 3-4 days. History of longer hospitalization to be stabilized, they don't want them. We have folks that are waved off multiple times. In the last month, we had at least one suicide of someone who we sent to the hospital 3 times and wasn't admitted, suicided after the last time.
- Inpatient service very hard to get for people. Too many people go to jail because they can't get hospital. No other place, because people aren't' appropriate to be in community. Someone needed to be in a state hospital.
- Started doing updates on addiction beds available. Feedback is that people get it and beds are full. Not always helpful. Have to call places at 8:30 for numbers to be accurate. Good reminder for people about agencies that provide services. [Human Services] is on an update list—ABH
- Wait for a heroin bed is ridiculous. [Staff] had a person that called 44 days in row. There was no hospital ability to hold her until she could get into a bed. Continued to use. When people want a bed, there should be a bed.
- Substance use inpatient treatment. Is there such a thing—long term? There's detox, residential, but that is an area of need; also referral to stepdown services after detox.
- Unacceptable to have to take someone who is injecting heroin on a daily basis and try to keep alive for two weeks while we wait for a detox bed.

III. *Brief Care/Respite/Residential*

- My biggest concern is residential services, we are really somewhat deficient in having availability. A close second is respite services, wanting to develop more respite beds. Homeless shelters are very overcrowded and overwhelmed, and are serving many of our clients, which pose challenges for them. This could be offset by more respite beds.
- It's more apparent than it was, it's going in a negative direction.
- In YAS, residential need.
- Some of the referrals in residentials are not our traditional referrals, people who are homeless, people who have substance abuse, calling and referring to Joe's Place but it's not the right place, but it's a bed. They don't meet the criteria, but we are tweaking things and stretching things to keep people housed.
- Respite—had some good luck with mobile—they came out and helped. Has not always been the case. No more 24/7. We see problems during hours of operation
- What we think is a crisis in community they don't always think is a crisis; we don't over-react, but when we call, we need them to check situation. Had a case where guy ended up in Whiting, but mobile had refused to come out and see him.
- Demand for group home level of care high. No waiting list now, but this is unusual.
- MOT isn't 24 hours. 2 shifts, 7 days a week till midnight. Then phones roll over to brief care
- Inpatient services—would like to see increase in size of Brief Care. At 15-day mark of inpatient, Brief care always at capacity and patients are denied step-down. They get put right back into program, even if hospital doesn't deem them stable.
- Even more pronounced if someone stepping down to shelter level of care.
- Residential standpoint is that young adults if they haven't been engaged right away by SMHA YAS, they will lose enthusiasm and interest by the time SMHA YAS ready to engage. Then we lost him because he started engaging in negative behaviors. One individual committed suicide. This is the system; not anyone's fault
- Brief care. There's nothing to do, and there's only one group. Not enough time with coordination counselors
- They always seem too busy with new clients, and not enough time for old clients.
- Need help with laundry, shopping, like to attend AA, and laundry days are sometimes so backed up that I can't go

C. *Workforce*

I. *Understaffing*

- [LMHA] is running a budget $1million less than this time last year. We've done all the consolidation we can possibly do without cutting core services. I would imagine staff have pretty much moved into only doing what they can and not being able to do what they want to, what they valued, what gave their jobs value to them. They don't have the time to sit with them and really explain why you want them to do something. Start barking out orders.
- Increased burden on services here as a result of state layoffs.
- Now they're cutting state positions, we don't have that support and are taking on that burden. Not even 1% cost of living increase in the last 20 years, with inflation of something like 25%.
- Overtime. US dept of labor has changed the class for managers to be exempt, not getting overtime. We now have a whole class of our supervisors that we will have to pay overtime, so now we have to decrease their hours, less support for programs.
- [LMHA] put together a budget and CFO CEO attended B1 meeting. Had a percentage cut. No more layoffs between now and November. [LMHA] incorporated additional cuts within the new budget recognizing that position will be lost. Also putting forward requests for positions that will be needed. Have two in the pipeline. Housing coordinator, deaf and hard of hearing interpreter.

Have had to pay for an interpreter to come in and this comes out of a different line item. Operations.

- Other staffing shortages are in job classes versus actual positon: Clinical Social Worker, Mental health Assistants. Have lost a couple of nursing positions. Overtime on ACT team MOT, brief care. Not being able to plug holes. Homeless Outreach staff temporarily assigned to other programs. 2 to ACT, 2 to Housing. HOAP not officially closed but as of 7/8 nobody in office. 2 staff will carry some of that function, continued collaboration with CAN and CCT.

II. ***Turnover and Burnout***

- Data statewide for YAS, non profits pay so little to their direct service staff, there's incredibly high turnover, and it has caused a huge problem for building relationships.
- Turnover – we're seeing people leave a lot this summer, mostly due to finances.
- Two staff took other positions in the agency and left. Staff turnover.
- I see a lot of turnover with my clinicians and interns at United Services.
- As soon as they get that license, they're gone and they don't come back.
- It's hard to build relationships. With me with my doctors each doctor thinks differently. We have to tell new people all about ourselves and our mental health issues and hope that our medicines will stay the same. This clinician knows all about us, then we have to do it over.
- My therapist that I've had for years didn't have an opening. I didn't really like the therapist I just went to because all she did was type on her computer and I felt like she wasn't really listening to me. I was used to my other therapist, she never did that. She listened to you, she was focused on you. I felt this therapist was focused on the paperwork.
- You don't know if the new person will be as good as the therapist that we love. We're worried that we won't get someone as good. We're trying to stay healthy mentally if we can.
- Being asked to do more with less and coordinate with other services leads to burnout of staff. We have great staff, great managers.
- Morale is not great; wasn't great before. Layoffs made it worse. I worry about staff providing the best services they can. How can I meet their need; how can I help them put selves in the driver's seat. Staff are tired, overwhelmed; there's a shift in thinking about willingness.
- Morale problems/attitudes of state (direct service) workers create an "us vs. them" mentality towards PNP workers, and attitudes are still very patriarchal.
- Dealing with a lot of people at [another agency] whose spirits are crushed. Morale is low; it's unrealistic what they have to do now.
- In this field, staff need more attention; we're not punching numbers, we're working with real people. We witness unfortunate situations, and deal with impact of terrible stories; vicarious trauma. Less ability to do for staff what needs to be done to prevent burnout. Our staff need way more attn., deserve way more attention. Hard to find time to meet with staff to conduct necessary supervision because I have to work so hard to meet client needs. How to prevent managers from getting burnout.
- Sometimes I feel really burned out, but feel as a supervisor I can't say that. Can't let upper level managers know because that might reflect on me. I want to be available for staff. My mind constantly going and it wears you out. You worry about 14 clients plus your staff. Are they going to show up are they going to be on time. We're basically a band aid.

III. ***Inexperienced Professionals/Training Needs***

- The waiver thing – they're putting staff into people's apartments, hearing that staff are really overwhelmed by very difficult clients, and we're sending in paraprofessionals to deal with them and having bad outcomes. Need more training, better compensation.
- We're required by DMHAS to have trainers who have gone through the cultural cohort – we're in a good place right now with 6 people, but with the turnover, will we be able to keep that up.

Turnover – we're seeing people leave a lot this summer, mostly due to finances. How will we meet this standard if these people leave and the training is unavailable? Again, we'll have to take on the burden without extra funding.

- We used to use DMHAS catalog quite a bit. Will spend money to do trainings. [Agency] allows us to send staff to internal trainings. [Second agency] has done a training with us.
- CPI—very critical, very expensive
- MI we will train internally and is the most important thing to have. Need to understand the spirit and the techniques
- We used to be before the budget cuts on doing a lot of proactive training in MI or CPI, we're doing more reactive stuff than proactive and providing more support for staff. More in terms of lots of small crises good job, but it's a struggle.
- It's important to take into account that residentials have to be staffed 24/7, even when someone is getting training. Sometimes just one person gets left behind and burden is heavy.

IV. *Increased Burden*

- Director of intake, a lot of referrals from the state, coming from an ACT level of care to [agency], but we need to be talking about step-downs, other level of care. We're getting an influx from community programs. Used to do it by myself with the help of one person, but I can't imagine doing that with the volume of calls we're getting.
- The paperwork that is required is duplicative. Every funding stream has its own particular needs and wants, there isn't one good system. The intake form for a homeless person is longer and more complicated than the form to become a US system. We have enough people and enough resources, take away the paperwork and we could do more in services with what we have.
- "They just keep asking us to do more with less." We've been saying that for such a long time.
- Now they're cutting state positions, we don't have that support and are taking on that burden. Not even 1% cost of living increase in the last 20 years, with inflation of something like 25%.
- **We do such a good job being creative, and we will keep on keeping on, but we're not getting the help that we need from the State.**
- LMHA nonprofit – having all of the responsibility but none of the authority or resources to do what needs to be done.
- Getting the treatment team together is something we do well, but we can only do so much as an outpatient clinic.
- The biggest struggle is finding ways to support staff when a placement is inappropriate. We have to have a paper trail to show they are not a good fit for our program, even when everyone knows this to be true. My staff deals with the brunt. Coming up for plans when behaviors happen, making sure they feel supported.
- Unfortunately collaborative team meetings that could help, have to go by the wayside, because we need to serve the client first. Balancing the needs of the clients with the needs of our staff. With residential can't leave programs unattended.

V. *Low Wages*

- Data statewide for YAS, non profits pay so little to their direct service staff, there's incredibly high turnover, and it has caused a huge problem for building relationships.
- Recruitment, we're a top workplace, we don't pay what we should be paying or what our competitors are paying. We're seeing more and more folks coming out of college with higher debt. They cannot pay their loans on our wage. We're seeing an increase in effort on how we recruit. The state can't pay their bills if people aren't working and we're seeing people on state benefits, draining the system, which hurts our economy. PNP employees are the working poor. It adds a stressor, when they're at work are they able to fully focus on the member, or are they worrying about their finances? Recently the poverty level was decreased by a lot to access to

Husky. A lot of staff are working two jobs now, how much energy is being used working 16 hours. People who work here with only one income, it's impossible. Need two incomes to survive.

- Other ways that non-state workers are paying more – parking fees, deductibles for health insurance, quality of care. We can't afford mental health care, can't afford to see a therapist. I have to pay $1700, $3000 in a deductible, I don't know how families do it. What husky did, dropping threshold to qualify, devastated us. On the salaries we're making, you can't do it. I have 3 incomes coming in, and I'm just getting by. I can't imagine a family really surviving, unless one has a better income. The working poor are serving the working poor.
- A high percentage have gone to state colleges, and are the working poor and trying to pay off the student loans.
- **The working poor are staffing the nonprofits.**
- Health insurance becoming unaffordable because it keeps going up. Every year have high utilizers. Last year BCBS came back with a 40%increase. Couldn't manage this and broker got Harvard Pilgrim, a slightly different plan.
- $900/month for family with $6K deductible. Some people are going without insurance. Some qualifying for HUSKY. If you're offered an affordable health plan, you don't quality for subsidies that go along with state plans. We are offering a plan. Some companies won't bid on us. Keep adding money from agency to pool so that it doesn't impact the employees too much.
- There will be a breaking point. Some people just can't stand the poverty anymore and they leave. Lots of passion and experience lost and relationships with clients negatively impacted
- People need help to survive on their salaries.
- PNP salaries: still too low for direct-service staff to live on; however, upper level management salaries are quite high and are out of proportion to the lowest paid positions; very little transparency regarding what actual salaries are.

VI. ***Peer Support Staff***

- peer staff is really not funded. There was some idea that peers could replace case managers in providing CSP/RP. In some things they can, in some things they can't. It's not the same service, there's a different approach, it's not a 1-for-1.
- We are hiring people who are not AU certified, because they aren't dong the training anymore. We have to say, we'll hire you, we'll do whatever we can. We have to take people's word for it that they're peers, sometimes they're not, or maybe peers but not the way that we'd like. We can't ask the right questions because we're prohibited by federal law. AU could ask the questions and tell us if they meet the criteria.
- DMHAS pulled back AU money, no training in the past 9 months. Not offered around the state, so transportation issue.
- For the most part, case management is not what they want to do. They want to be more of the family and the support, struggle with teaching the skills because it's not where their heart is. End up with the numbers issue, not meeting numbers because someone is doing peer support not CSP/RP stuff. See themselves as advocates, not service providers. End up with boundary issues.
- A lot of turnover, that's not what they want to do, don't want to do goals and objectives. There's a role for both, peers are great for helping to figure things out, a long-term relationship but not long-term supports. Being able to do those things that are supportive but not necessarily care driven.
- It's hard to get the positions filled because we're defining the wrong position, maybe because there isn't money for them to do what you need them to do, to be less judgmental and less measuring, to provide support and friendship.

D. *Coordination*

I. *Duplication of Services*

- Value Options ABH case management is a duplication of other services. It appears to be case workers go into ERs and they're seeing frequent flyers. A lot of time those FF are with us or [LMHA], so they try to give them case management, but it's repetitive. They end up referring to us, but we already know and work with these people. They already have those services, we meet with people at [hospital] to talk about these. It's a different funding stream, so it's a duplication. Money is being wasted.
- The paperwork that is required is duplicative. Every funding stream has its own particular needs and wants, there isn't one good system. The intake form for a homeless person is longer and more complicated than the form to become a US system. We have enough people and enough resources, take away the paperwork and we could do more in services with what we have.

II. *Multiple Funding Sources*

- Because homeless services their own thing, there is DPASS. We have own medical record which is uploaded. HMIS also and the systems don't talk to each other. We need a computer guru who can figure this out. How do we put information into both systems that is respectful of staff time? Communication breaks down. Do the majority of information into HMIS. It doesn't necessarily have to all get into Avatar. But if person moves, then we have to start fresh. If person in both programs, then other program can't see what is in HMIS, because it's separate.
- Every provider has a funder that comes with a target population. Some people may not be able to pay rent in NL, then they need to navigate all the agencies to see if they match the eligibility. Even one part time person could help with this. And stay with someone till they got where they needed to go. [Human Services] does this, but losing 2 staff. Unable to participate as intake providers as part of CAN process. There are three places that do intakes. SVDPP, NLHHC in collaboration with Covenant. A homeless person will have to go all the way to NL to get intake. How can we maintain a small piece of intake process in Norwich?

III. *DDS Clients*

- Some clients have both DDS needs and mental health needs. Can't blend the two services. Can't let a DDS clients go to [clubhouse program]. DDS funds us for some services. They are really their own entity and do their own programs out of their site. They seem to be isolated based on diagnosis. Have tried to offer services and billed DDS for enhanced services. Two supported living programs (Supported living 1) day time needs. SLP is forensic and no overlap with DMHAS services.

IV. *DSS Services*

V. *Councils of Government*

- Dept of Housing is doing outreach with providers to help comprehend and better understand the resources here. NECCOG's Human Coordinating Council. They're trying to coordinate the existing services but we don't even have the services to coordinate. How to do more with less. Homeless council, the facilitator said NW had listed this many, but you've only listed 50 – that's the point! We're not hiding them. Let's list what's not here in comparison to other regions. The mandate is to do more with less. We're going to these to not take our front-line staff out of office for these meetings. Benefits of community coordination and collaboration, but not paying for these meetings.

VI. *Discharge Planning*

- It depends on who is making the decision about discharger, whether its social workers or doctors. [Hospital] is staffed, want to get people out in 4 days. Sometimes we talk about a discharge plan for the following week, but then we get there and they're gone. Dr. So-and-so we've never heard of decided they could be discharged, sent home in a cab. One person had a

conservator that was angry, the client was sent home in a cab, landlord had changed the locks, conservator showed up, she was on the front step crying, got the place opened up, didn't have meds, didn't have food. She had scrips but no meds, no way to get to a pharmacy, no food. Conservator calls us ripping, we had a plan but the doctor discharged her sooner. If we have adequate time to plan it works okay.

- We have staff that go up to [hospitals] almost daily if we have someone up there. Most of the time the hospitals tell us when we have someone and helping with planning.
- It happens more than it used to, often enough that we know about the problem. Working with [Hospital]. Trying to put together a community care team, multiple admission people are not psych admissions, medical admissions with psych history, e.g. a diabetes client, we can't manage that but we can help with food and keep an eye on him. Trying to get a CCT together in Willimantic, but so much turnover at [hospital].
- A lot of inpatient is hugely expensive. Discharge people back to street, no prescriptions, and no services.
- Prison release—this is the mental health asylum of current day. People come out without prescriptions, linkages follow up... DOC has limited, but needs not getting met. Some people closest to recovery is prison. Leave regimented environment without follow-up and income, it doesn't take long for some people to decompensate. Well over 50% have history of engagement with Criminal Justice. Every week a few people come direct from prison.
- If someone is inpatient and looking for a residential placement, client isn't aware what kind of programs they are and what the benefits are. When I go in, they don't even know who I am or what the program is. They don't understand the services, but have to take whatever is available, because they won't get anything else.
- Program to jail, program to jail. Need more transitional resources for a more effective integration back into community.
- It's really gone south the past year. I'm used to being on an inpatient setting where people are supposed to have an appointment set up before they leave. At every level of care, there is no provider-to-provider hand-off, and not just with inpatient.

VI. CREATIVE/PROMISING INITATIVES

A. *Collaborative Team Approaches*

- MOT—still trying to hold onto the role they play in pre-crisis work. Integration into community. Participating in N/NL CCTs. Going out to NL public library, collaborating with providers as a presence. Used to go to Housing Authorities to discuss what is going on at Colman St. High rise. Ability to do this now limited due to resource problems and lost positions.

I. *Community Care Teams*

- Trying to get a CCT together in Willimantic, but so much turnover at Windham hospital.

II. *Network Meetings*

B. *Holistic Wellness Approaches*

I. *InSHAPE*

- Some of our folks when they have anxiety, they've found the InShape program as a good means of relieving stress. Part of the programs is around exercise, but the other part is around nutrition. We get to eat healthier now, healthier meals. The foods have changed, they've stopped the sodas.
- We have to form community partners for InShape. In early July, we tried to partner with Big Y because they have someone on staff that can do a grocery store tour for us.
- When I started at Inshape, the take your blood pressure, weigh you, take the inches around your belly, teach you about healthy living and healthy snacks, help you with labels. It's good learning,

I'm at that age where I have to change my lifestyle and to have someone right there is good, to have that support. The trainer is great because I tend to overdo it, and she helps me to continue my day and do my chores. And I'm working on quitting cigarettes and that's going good. There's always a lot of positive reinforcement, I think of this place as my home.

- Wellness group on Wednesdays, sometimes they have topics they cover. It's part of inshape and really helpful. For diabetics, we have to learn to read our labels, what type of things to look out for. I'll take ground turkey over beef, I don't eat bread anymore.

II. *Windham Facility*

- Need for expanded facility in Windham. 241% increase since 2007 – we don't have the capacity, it's not safe. We're hoping for a groundbreaking in September… Interviewing primary care doctors for the facility. Looking at local doctors that know the clients, have the clients now and are really good with them. Interested in being part of a team that does holistic medicine. Both locations.

C. *Open Access Day*

- SMHA - we've developed through mobile outreach an open access day that has been really successful, helped integrate people into outpatient services a lot faster.
- We created a limited same day access, because of no-shows taking out clinician time. Individuals having too long of a wait. MOT serving as intake. Every Weds, have SDA component.
- Sound's open day, no appointment necessary helps negate other barriers, like transportation and child care – saw a drop off in no-show rate.

D. *AXS Center for Young Adults*

- Need an open access center in Norwich. Skateboard shop, police department, NFA all potential connections. Police would like to be able to come in and interact with teens on a non-confrontational basis. Wrote a proposal. Lots of people have great ideas.

E. *Medication Assisted Treatment Modalities*

- As a lay person, feel MAT is something that works. If addiction is a disease, people should have a right to treatment.

F. *Backus Pilot Program*

- Backus pilot—didn't get additional resources or staff to do this, was a creative use of resources. Still going out to engage people and do follow up. Need in NL; would live to replicate at L&M, but no resources. Still have CIT staff who ride around in NL and try to engage.

G. *Diversified Funding Streams*

VII. EMERGING TRENDS

A. *Opioid crisis*

I. *Legislative Impacts*

II. *Yale Strategic Plan*

III. *Backus Pilot*

- Backus pilot—didn't get additional resources or staff to do this, was a creative use of resources. Still going out to engage people and do follow up. Need in NL; would live to replicate at L&M, but no resources. Still have CIT staff who ride around in NL and try to engage.

IV. *Law Enforcement and the Glouchester Model*

B. *Marijuana legalization*

C. *Medical Expertise*

D. *Transgender Populations*

- 34 active YAs, 5 are in gender transition. Lack of supports in this region for people who are identifying with a different gender. Host an LGBTQ support group, and transgender support, staff are interacting with these supports. We went out of our way to interact with LGBT groups

in the community. Positive feedback from facilitators and participants. Group started as meeting once a month, then once a week, increased demand and desire.

Appendix C: Notes on Northeast Focus groups for 2016 priority planning process

NECASA

Focus groups took place at three substance abuse agencies with clients.

May 25, 2016 at Natchaug Day Treatment program in Dayville

May 26, 2106 at Perception Programs in Willimantic

June 10, 2016 at CHR in Putnam

31 clients in total attended and 30 filled out survey grids, of those, 15 were female and 15 were male.

The following service needs and gaps were indicated by the clients:

Mental health- Accessibility- Residential and recovery supports- housing (lack of affordable and safe and handicapped accessible), rural transportation difficulties were found and insurance coverage was spotty with medicab vendors unreliable.

Mental health-services match- A Methadone bias (not wanting to have medication assisted clients) seems to still be an issue at times.

Mental health- Workforce- Inpatient, Residential and recovery- need for better trained staff and some understaffing. Also, employee burnout was mentioned.

Substance Abuse-Capacity- Inpatient, Residential and recovery- Long distance to find treatment, delays and waiting lists.

Substance abuse- Accessibility-Inpatient, Residential and recovery- Lack of affordable, safe housing, confusing Husky Insurance types, rural transportation issues, lack of sober and halfway housing, too much reliance on the 12 step AA model turns off younger clients, delays in getting treatment, medicab vendors unreliable.

Substance Abuse- Workforce- Need for more experienced staff in addictions and more people in recovery to be counselors, employee burnout and understaffing mentioned. DCF workers most poorly trained.

Eastern Regional Mental Health Board

The Citizen's Voice in Mental Health Policy

DSS SERVICE BARRIERS

STAFF DATA—DMHAS FUNDED PROGRAMS

Preliminary Report: April 7, 2016

Survey Conducted by the Eastern Regional Mental Health Board, Inc.

401 W. Thames Street, Campbell Building, Unit 105, Norwich, CT 06360
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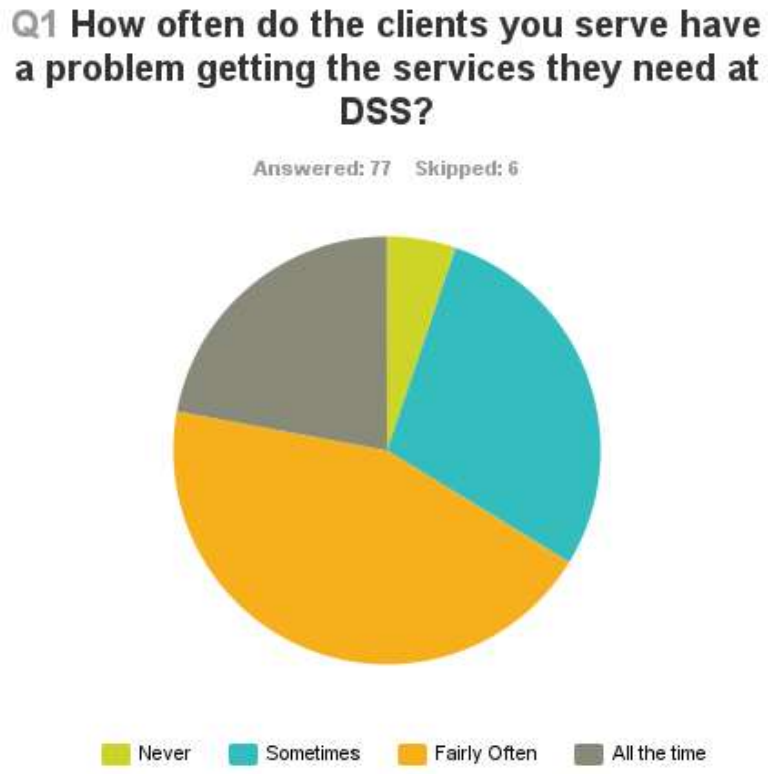
INTRODUCTION

The Eastern Regional Mental Health Board has consistently heard from community members that the DSS system is failing to meet client needs. In response to the numerous stories and anecdotes collected, the ERMHB launched a preliminary survey to collect both quantitative and qualitative data regarding service barriers for clients of DSS.

During the process of collecting surveys, feedback from program staff indicated that our data might be incomplete. Staff members stated that oftentimes they intercede in the DSS process on behalf of the clients, mitigating the issues and barriers the clients would otherwise face themselves. Several staff members at Reliance House in Norwich expressed the desire to give feedback about DSS from a staff point of view. Therefore, the ERMHB created and distributed a staff version of the DSS barriers survey to the DMHAS-funded programs in Region 3. (Please see **Appendix 3** for staff survey).

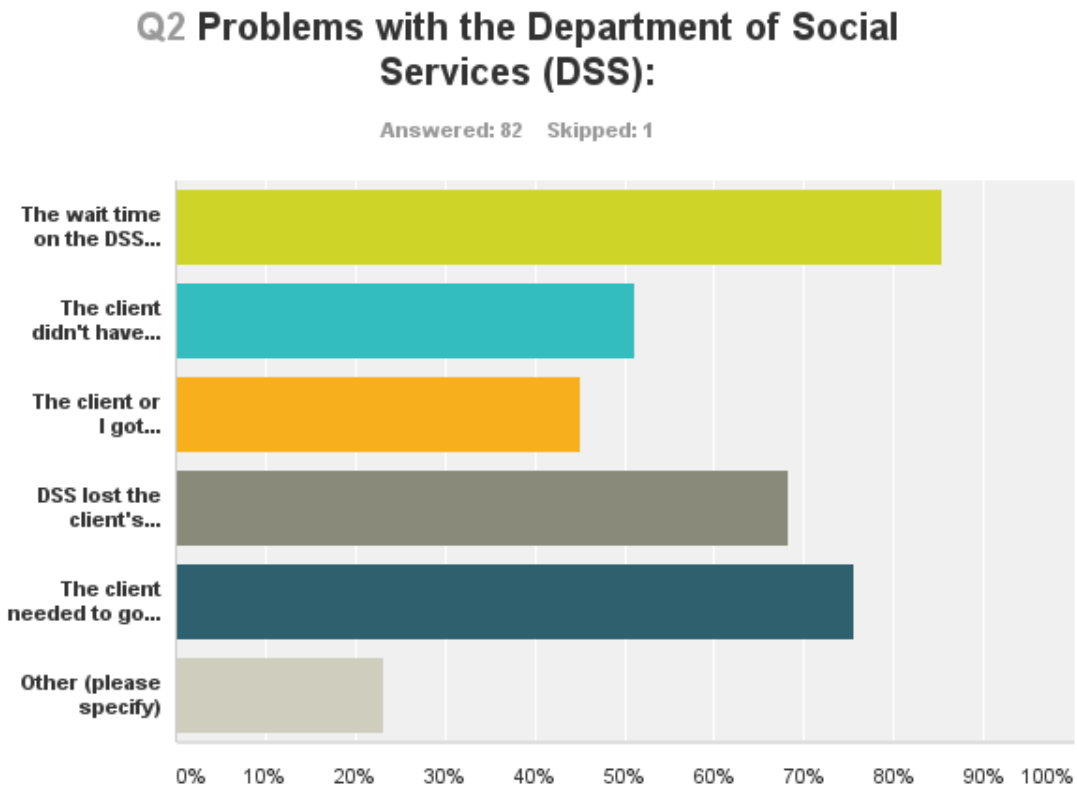
Data was collected in two formats. An electronic version of a paper survey was distributed to agency management, and then printed and distributed to direct service staff at agency programs. Agency staff was also provided with a link to an identical internet-based survey. All paper responses that were collected were later entered into the online survey, in order to keep data in a single location.

Below are the initial findings of the survey. As of Thursday, April 7, 2016, 83 staff persons at DMHAS-funded programs had responded to the DSS Service Barriers Survey, either online or via a printed survey. The survey is still available to be completed, and we anticipate continuing to collect additional data in the future.



Question 1: The most common answers to Question 1 were "Fairly often," with 44% of respondents choosing this option, and "Sometimes," chosen by 28% of respondents. Only 5% responded that their clients "Never" have problems getting the services they need.

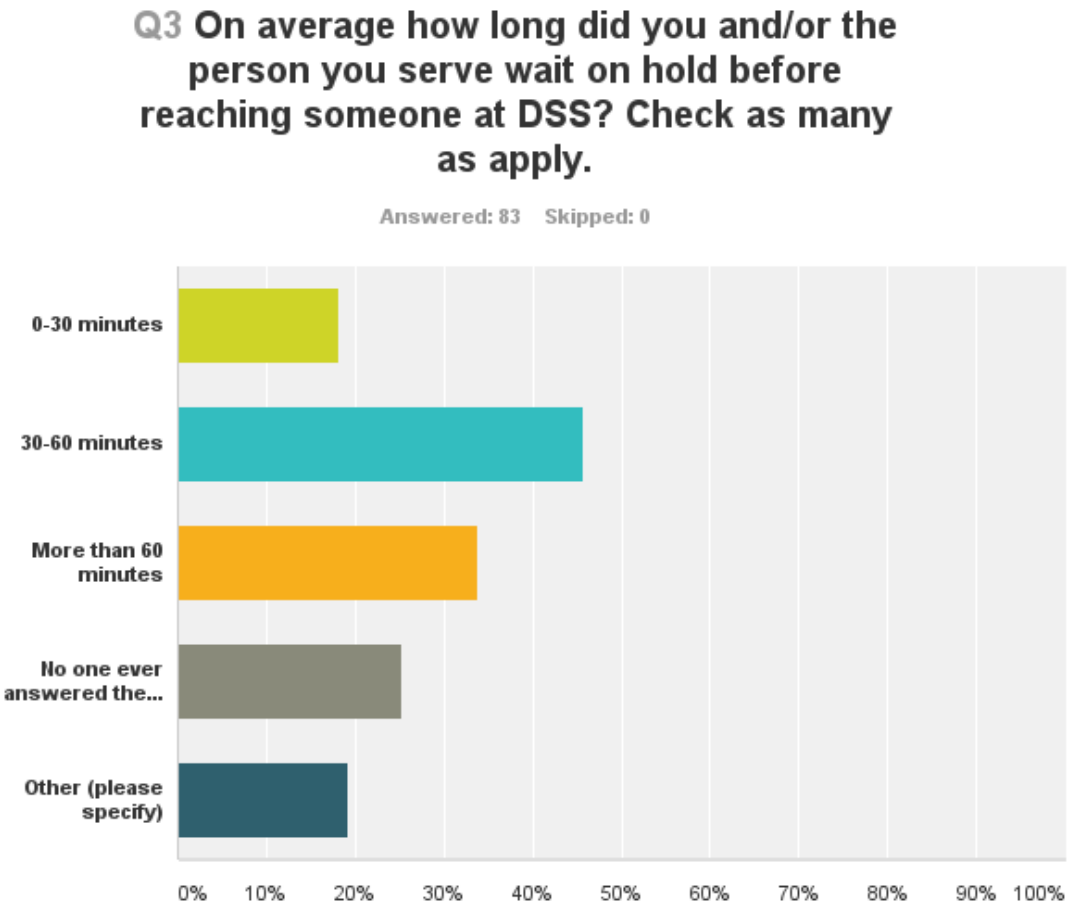
According to this data, about 95% of respondents report their clients having at least occasional problems accessing services at DSS.



Question 2: The most common issue reported on this survey was that "The wait time on the DSS call in line was too long for them to wait," chosen by 85% of respondents. 76% of respondents indicated that the clients needed to go to the DSS office in order to take care of issues. These two responses were also the most common responses in the Client Survey. Additionally, 68% of staff respondents noted client redetermination paperwork being lost.

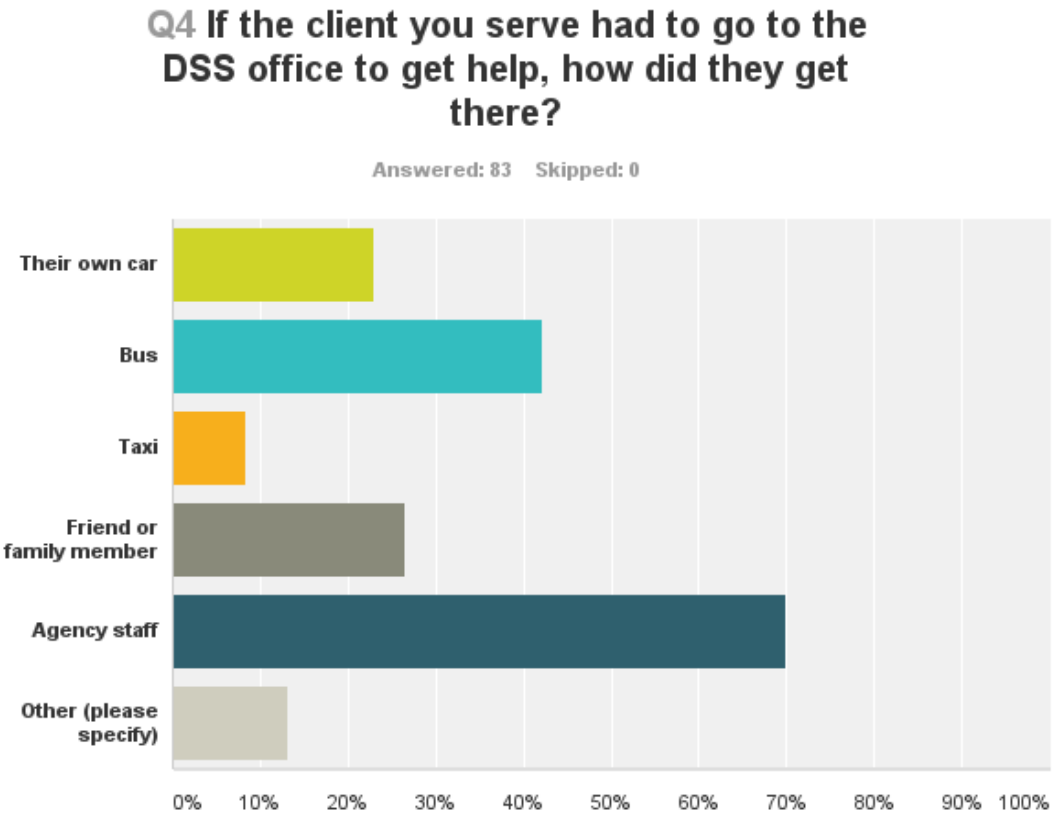
A variety of other issues were reported in the "Other (please specify)" category, such as lack of transportation to the DSS office when needed, inconsistency in staff knowledge and helpfulness, the scanning center is inefficient and loses paperwork, and receiving paperwork with past-due dates (e.g. receiving a form on 2/22 that was due on 2/18).

Note: only one staff respondent stated that their clients had never had problems getting services at DSS, as opposed to 21 client respondents that said the same.



Question 3: 18% of respondents noted that their call or their client's call was answered in less than 30 minutes. 80% of respondents or their clients waited more than 30 minutes (combined choices 2 and 3).

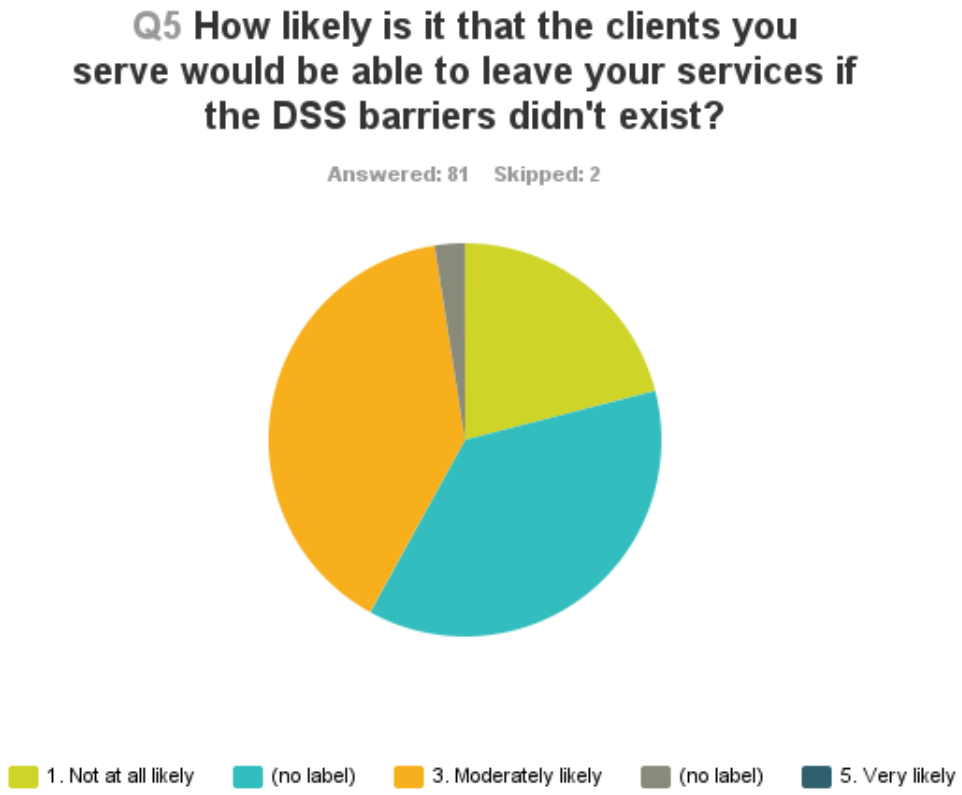
Note: In the "Other (please specify)" category, 5 respondents (6%) noted that they never call DSS and simply go to the office to receive assistance. Only 3 respondents (4%) indicated that they never have issues with the DSS call-in line when they call.



This question was included to assess the means of transportation used by clients to get to the DSS office. 70% of respondents indicated that the clients rely on DMHAS-funded agency staff to make the trip to DSS, possibly indicating a stress on the agency providing mental health services.

4 respondents (5%) stated that the clients walk to the office in the "Other (please specify)" category, while 2 respondents (2%) stated that clients have missed appointments due to lack of transportation to the DSS office.

Note: In the pilot-test phase of the Client Survey, Reliance House clients overwhelmingly indicated relying on agency staff to help overcome transportation barriers. The responses to this staff survey support this early finding.



Staff respondents were asked to rate the likeliness of the clients they serve being able to leave their services if the problems with DSS could be resolved on a 5 point scale, with 1 being "Not at all likely" and 5 being "Very likely." This question was not included in the client survey.

40% of respondents believed it to be moderately likely that their clients would be able to leave services if DSS barriers did not exist.

58% of respondents rated this likeliness as either 2 or 1 (Not likely at all).

Although this data does not overwhelmingly support the theory that clients would be able to leave mental health services if DSS barriers were eliminated, it does indicate the possibility that a small number of clients are only receiving DMHAS-funded services because of their inability to navigate the DSS system and access necessary services on their own. It is possible that if the DSS processes were simple and efficient, these clients would be able to leave DMHAS services.

ADDITIONAL FINDINGS

Respondents were asked if they'd be willing to talk with us about the problems they or their clients face; 18 respondents (22%) provided us with contact information for this purpose. Our hope is to conduct phone interviews with these clients in the coming months.

Several staff respondents provided written feedback about their own or their clients' experiences with DSS. Please see **Appendix 1** for confidential written testimony.

The ERMHB also asked staff to comment on the structure of the survey. A few respondents indicated that the issues at DSS run deeper than the questions asked by this survey, which focuses on the barriers that hinder clients' access to necessary services. Please see **Appendix 2** for this feedback on issues that are beyond the scope of this survey.

DSS Survey for Staff

Q8 You can type your story in this box.

Answered: 12 Skipped: 71

#	Responses	Date
1	DSS - There is inconsistency with staff following protocols. Some will approve paper others will not (with the same data).	4/6/2016 11:30 AM
2	The major problem with DSS is the inconsistent knowledge of the DSS staff and the "conflicting information" given by different DSS staff to clients. The second problem with DSS is DSS' own internal rules which defy common sense and cause clients to make repeated trips to a DSS office - which is not efficient for either DSS staff or its clients. DSS needs a thorough clean-out of its policies and procedures using LEAN methodology. On a positive note, almost all DSS staff are polite and professional.	3/31/2016 10:06 AM
3	I prefer using the DSS Internet Service, but even so the members still	3/31/2016 10:02 AM
4	I have had to bring individuals there due to fear of lost paperwork. Individuals are encouraged to utilize an office phone found in a Counselor's office to avoid using their minutes. There have been some reports of being on hold for up to 45 mins.	3/14/2016 8:55 AM
5	This is confidential I work as a Service coordinator locally. I have 1 building that has both disabled and elderly. Some have Mental Health issues and are disabled. One such person was in crisis a few days ago. Another resident needed hospitalization. He himself is legally blind and has multiple medical problems. He assists the other disabled resident with meals and is company for her. His departure from the building has left her anxious and worried. She herself became so worried that her health care provider called 911 and took her to the hospital she was threatening to hurt herself. She was treated overnight and came back to her apartment the next day. I assisted her with calling her Health Care providers. Her case manager left a message that a Nurse would make a visit in the morning. She will have a increase in home care services. With added home care services she will adjust to the new situation. The barriers to receiving service to the disabled for their specialized power wheel chairs are constant. It takes several calls to having anything fixed. Some have neurological problems and are not able to sign of fill out their paperwork that is where I can assist them.	3/10/2016 4:32 PM
6	I have personally heard workers speak to clients in a demeaning, judging manner. They ask questions regarding their past and level of motivation that have nothing to do with meeting criteria for services. Further more, child support enforcement could be more aggressive in seeking payments from non custodial parents to eliminate the need for clients to have to use TANF benefits at all. A few suggestions, non-custodial parents that aren't paying child support should have to work with JFES as well as custodial parents. Custodial parents are being penalized for seeking cash assistance in lieu of child support owed to them. Also, clients on state medical exempt are on this program for years, they start the Social Security application but there is no follow up by DSS staff to ensure they are actively pursuing it or there disability forms are completed by primary care physicians for mental health diagnosis, instead of a counselor AND a clinician.This creates abuse of the system .	3/10/2016 10:53 AM
7	31 years of history on DSS and problems clients experienced	3/10/2016 9:59 AM
8	Working in a residential setting, most of our clients utilize DSS benefits. Clients and staff have had extreme difficulty making contact with DSS via telephone. Have been recommended to call first thing in the morning and be prepared to wait an hour to actually speak to a DSS member. Our staff team has had to set up transportation to DSS for clients to actually have contact with a DSS worker, which may take away from a client participating in the scheduled treatment. The wait time is often long for a mother with her child/ren.	3/9/2016 11:03 AM
9	9 times out of 10, paperwork is sent to scanning center and not scanned on time so members benefits are stopped. This takes not only member time but provider time to either call or go to DSS to fix. There is two reasons I have been to DSS: to support a member having benefits/ sign up for benefits (just out of hospital or jail) or to fix a scanning center mistake.	3/2/2016 11:55 AM
10	Calling takes TOO long. We never mail anything in anymore because it ALWAYS gets lost. We get good service when we go to DSS.	3/2/2016 11:30 AM
11	I've been helping our members with their redeterminations since 2006 I can count on two hands the amount of times I DIDN'T have any problem with DSS losing the paperwork. It would come down to going to the office to see a worker to ensure the entitlements were restored.	3/2/2016 11:27 AM
12	If you have to made or if you need instructions, you can't get through to get help. Having the workers phone number and/or extension does not help. Then you have to go to the office (DSS) and according to the time and day you may have to wait for an hour or more.	3/2/2016 11:24 AM

DSS Survey for Staff

Q9 Do you have any feedback about the structure or design of this survey?

Answered: 19 Skipped: 64

#	Responses	Date
1	Design of survey is ok. I would like to have feedback from DSS as to how and when they plan to alleviate these issues. Thank you.	4/6/2016 11:24 AM
2	Question 5 was difficult to understand. Paper survey had two question 5s.	3/31/2016 10:09 AM
3	This survey does not address the major problems with DSS.	3/31/2016 10:06 AM
4	NO	3/16/2016 4:23 PM
5	I think it is good to have a way to share information that is confidential. The state of CT does better than most others, that is why so many want to make CT a good place to live.	3/10/2016 4:32 PM
6	No	3/10/2016 4:13 PM
7	Survey covers only a tip of what happens. How about manner in which the client was treated when they did get a DSS worker. There is nothing about that. Also, when they finally reach their destination is there a welcoming environment? The DSS bus should be out there more to make the process easier. It could be in supermarket parking lots or on main streets. DSS has plenty to do! I interviewed several years ago for a position and even the two, especially 1 of the 2, was condescending in her manner and actually rather mocking. I am a professional social worker. Imagine how our clients feel!	3/10/2016 1:00 PM
8	Things really need to be addressed quicker and giving people more time to get all the information needed in. They expect us to get all the stuff they need in less than a months time then take two months or even longer at times to even get back to us	3/10/2016 12:05 PM
9	This survey seems only concerned with phone times.You have bigger problems than that.	3/10/2016 10:53 AM
10	DSS NEEDS TO HIRE MORE HELP THAT ANSWERS THE PHONES TO ASSIST CLIENTS WITH THEIR NEEDS NOT CUTTING BACK ON HELP!	3/10/2016 9:59 AM
11	Very easy.	3/9/2016 2:54 PM
12	It was very short and to the point and user friendly.	3/9/2016 11:04 AM
13	Thank you for our supporting our clients in the SE region	3/9/2016 11:03 AM
14	This survey covered the most common issues encountered when working with DSS	3/2/2016 12:02 PM
15	The multiple choice answers made this form easy to use.	3/2/2016 11:51 AM
16	N/A	3/2/2016 11:50 AM
17	Thx	3/2/2016 11:39 AM
18	This survey was structure very well.	3/2/2016 11:24 AM
19	Not at this time.	3/2/2016 11:03 AM

Eastern Regional Mental Health Board

STAFF Service Barriers Survey—DSS

In order to educate and inform our policymakers, the Eastern Regional Mental Health Board is collecting information regarding specific problems with access to DSS services. Please share your experience as a staff member assisting clients navigating the DSS system.

All of your information will be kept confidential in order to protect your privacy.

1. How often do the clients you serve have problems getting the services they need at DSS?

Never	Sometimes	Fairly Often	All the time
○	○	○	○

2. Problems with the Department of Social Services (DSS):

Below is a list of common problems that have been reported to us. Check the problems that you have encountered with your clients. (You may choose more than one.)

- ☐ The wait time on the DSS call-in line was too long.
- ☐ The client didn't have enough cell phone minutes to wait on the call-in line.
- ☐ The client or I got disconnected from the DSS automated call-in line and had to start over.
- ☐ DSS lost the client's redetermination paperwork.
- ☐ The client needed to go to a DSS office to get help because we couldn't reach anyone by calling.
- ☐ Other (please specify):

3. On average, how long did you or the client you serve have to wait on the call-in line?

(Check as many as you need to.)

- ☐ 0-30 minutes.
- ☐ 30-60 minutes
- ☐ More than 60 minutes.
- ☐ No one ever answered the call.
- ☐ Other (please specify):

4. If the client you serve had to go to the DSS office to get help, how did they get there?

- ☐ Their own car.
- ☐ Bus.
- ☐ Taxi.
- ☐ Friend or Family Member.
- ☐ Agency Staff.
- ☐ Other (please specify):

5. How likely is it that the clients you serve would be able to leave your services if the DSS barriers didn't exist?

Not likely at all		Moderately Likely		Very likely
○	○	○	○	○

Survey continued on back

Eastern Regional Mental Health Board

Service Barriers Survey—DSS

Page 2

5. Would you be willing to share more about your experiences helping clients with DSS?

All information and experiences shared will be kept confidential. Further, you will not be asked to divulge client names or details, but rather to share anecdotal stories to illustrate common DSS barriers that you and your clients experience.

- ☐ Yes.
- ☐ No.

If yes, please leave your contact information so we can follow up with you. (Or, you may write your story, using the bottom of this page and attaching additional pages as necessary.)

Name:_____ Phone Number:_____

6. Do you have any feedback about the structure or design of this survey? Please write comments in the box below.

Thank you for your time in completing this survey.

Eastern Regional Mental Health Board

The Citizen's Voice in Mental Health Policy

DSS SERVICE BARRIERS

CLIENT DATA—DMHAS FUNDED PROGRAMS

Preliminary Report: April 7, 2016

Survey Conducted by the Eastern Regional Mental Health Board, Inc.

401 W. Thames Street, Campbell Building, Unit 105, Norwich, CT 06360
Ph: 860-886-0030
www.changingmindsct.org

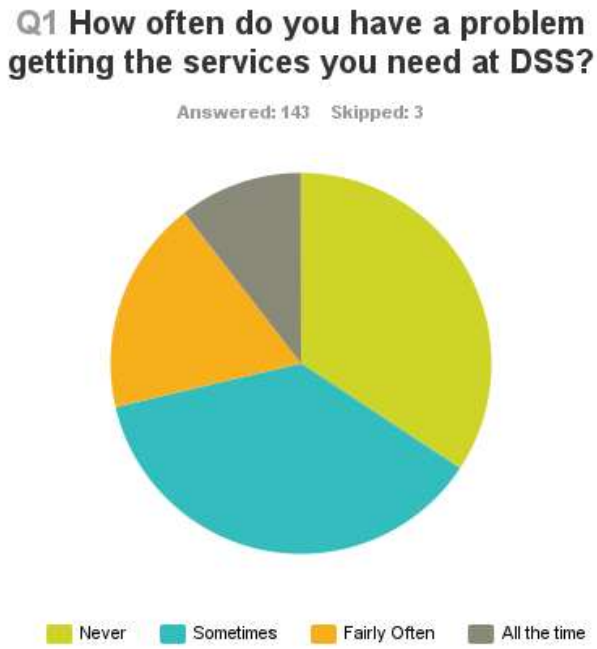
Introduction

The Eastern Regional Mental Health Board has consistently heard from community members that the DSS system is failing to meet client needs. In response to the numerous stories and anecdotes collected, the ERMHB launched a preliminary survey to collect both quantitative and qualitative data regarding service barriers for clients of DSS (Please see Appendix 2 for client survey).

Data was collected in two formats. An electronic version of a paper survey was distributed to agency management, and then printed and administered by direct service staff at agency programs. Agency staff was also provided with a link to an identical internet-based survey. All paper responses that were collected were later entered into the online survey, in order to keep data in a single location.

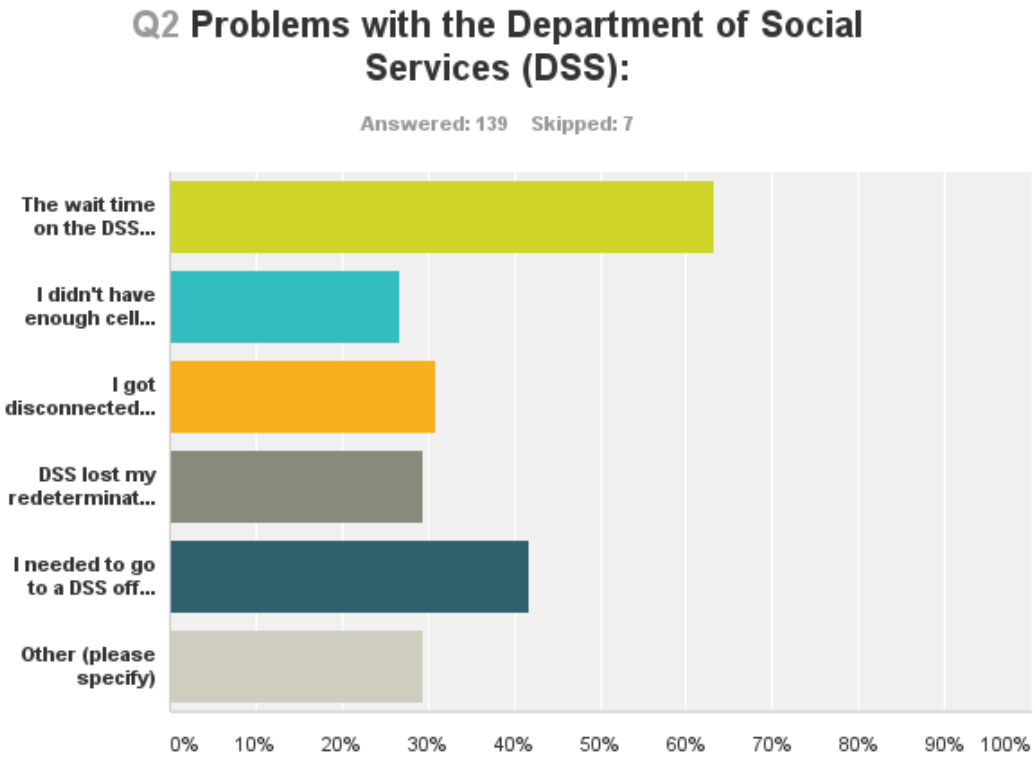
Below are the first findings of the survey. As of Thursday, April 7, 143 clients of DMHAS-funded programs had responded to the DSS Service Barriers Survey, either online or via a printed survey. The survey is still available to be completed, and we anticipate continuing to collect additional data in the future.

Note: This survey was pilot-tested with Reliance House before being released to other DMHAS-funded agencies. The overwhelming response by Reliance House members in the early stages may contribute to a data bias, with over-sampling from this population.



Question 1: The most common answers to Question 1 were "Sometimes," chosen by 37% of respondents, and "Never," with 34% of respondents choosing this option. According to this data, 65% of respondents have at least occasional problems accessing services at DSS.

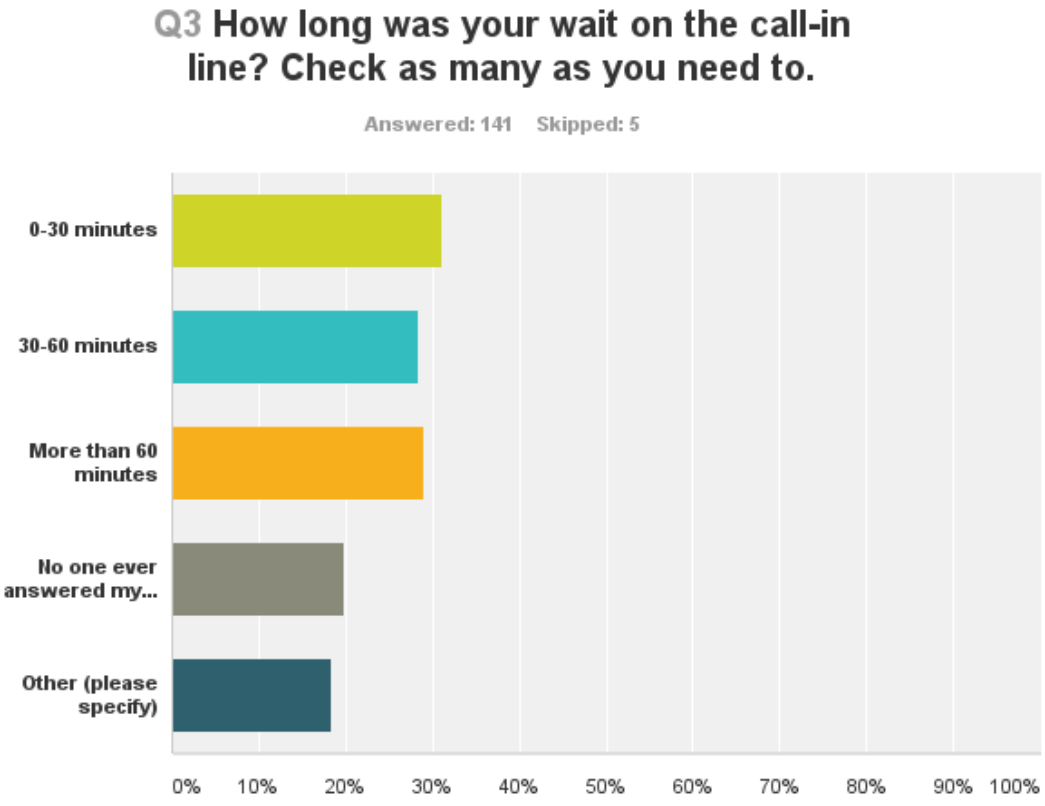
Note: We believe that the scale format of this question may have been confusing to some respondents. We received several paper surveys where the respondent selected "Never," for question 1, but then selected one or more of the problems listed in question 2, indicating that perhaps they had misread one of the questions. However, this theory only accounts for a portion of the responses to this question, and it must be noted that several respondents have never had issues with DSS.



Question 2: The most common issue reported on this survey was that "The wait time on the DSS call in line was too long for me to wait," chosen by 63% of respondents. More than 40% of respondents indicated that they needed to go to the DSS office in order to take care of issues.

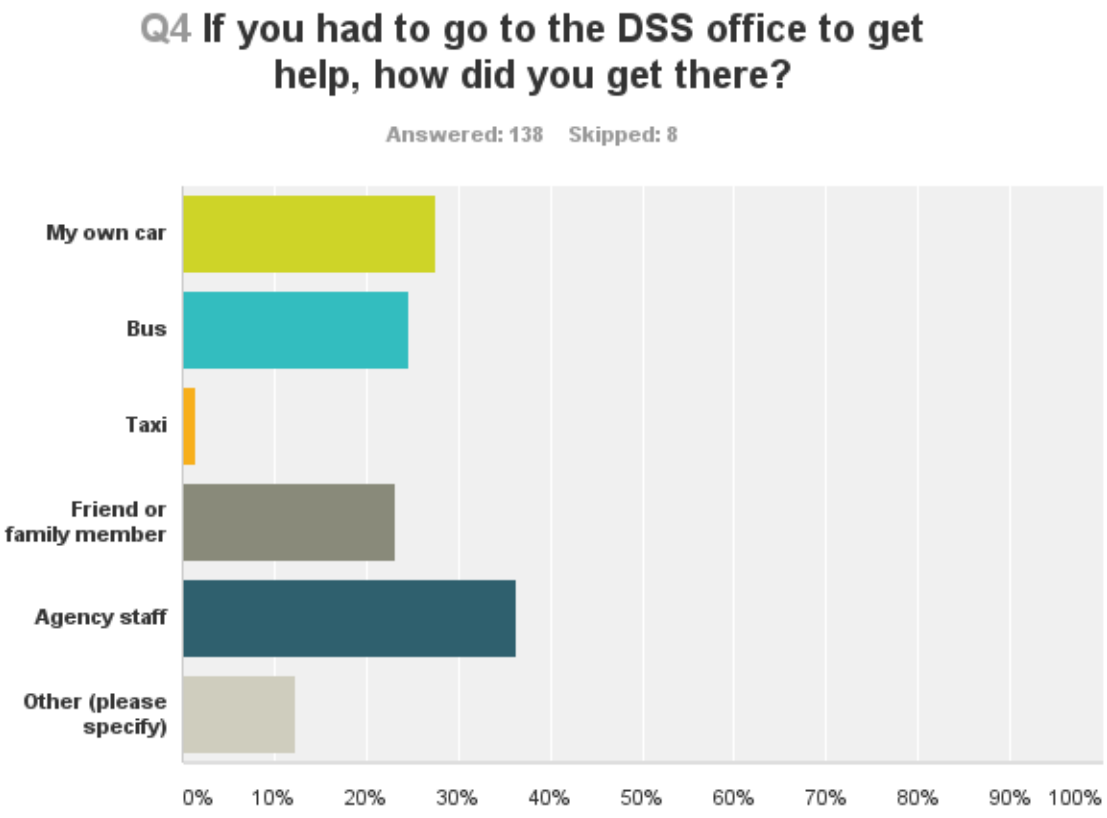
A variety of other issues were reported in the "Other (please specify)" category, such as getting incorrect or outdated information, being treated with disrespect or prejudice, and paperwork being received but not processed, among others.

It should be noted that 21 respondents (15%) indicated that they have never experienced problems with DSS when selecting the "Other (please specify)" option.



Question 3: Only 31% of respondents noted that their call was answered in less than 30 minutes. 57% of respondents waited more than 30 minutes (combined choices 2 and 3).

Note: In the "Other (please specify)" category, 6 respondents (4%) noted that they never call DSS and simply go to the office to receive assistance. 12 respondents (8.5%) indicated that they never have issues with DSS and therefore do not call.



This question was included to assess the means of transportation used by clients to get to the DSS office. 36% of respondents indicated that they rely on DMHAS-funded agency staff to make the trip to DSS, possibly indicating a stress on the agency providing mental health services.

8 respondents (6%) stated that they walk to the office in the "Other (please specify)" category.

Note: In the pilot-test phase, Reliance House clients overwhelmingly indicated relying on agency staff to help overcome transportation barriers. The responses to this question have seemed to even out with clients from other agencies participating in the survey.

Additional Findings

Staff feedback about this survey indicated that oftentimes direct service staff mitigates client issues with DSS by dealing with problems for the client – the staff person waits on the phone, deals with lost paperwork, etc. In these instances, clients may not realize the full extent of their struggles with DSS barriers. This feedback prompted the creation of a separate survey for staff members. See "DSS Service Barriers Report – Staff Survey" for preliminary findings.

Respondents were asked if they'd be willing to talk with us about the problems they face; 39 respondents (27%) provided us with contact information for this purpose. Our hope is to conduct phone interviews with these clients in the coming months.

Several clients provided written feedback about their experiences with DSS. Please see Appendix 1 for confidential written testimony.

DSS Service Barriers Survey

Q7 You can type your story in this box.

Answered: 16 Skipped: 130

#	Responses	Date
1	I think you should change the name of the mental health building. There was a period in my life when all the people in my housewhole... my two children and my mother whom... I had lived with for my 32 years of age in New London CT... all seem to disappear.. I was attending school and was trying to apply for Federal State Family Food & Cash Assistant because I was a single person and a mother: trying to be a student getting my education at even the age of 30... Problem: 1. having a drivers license and going to run to catch a bus; 2. No one to watch my children; 3. Not having any family group settings; 4. Living with person who had a handicap.	3/23/2016 12:19 PM
2	During the last year I needed to make a couple of calls for Residents or inquire as a Staff Member and have no specifics to report I find this survey to be cumbersome as it has no ability to use "N/A" and its desired population is not clearly defined ..i.e. is it to be filled out by an Employee of and Agency that serves folks who need DSS Services or the people themselves?	3/22/2016 5:08 AM
3	I have	3/14/2016 1:40 PM
4	Some of your staff at the DSS office in Norwich are friendly and polite, they seem passionate about their work and my community. But some of your staff specifically the "Latino Woman" at the front window is very rude, I always hesitate to go to her because of her poor customer service and attitude. Please note that I am also Latino and is very frustrating to feel like I am bothering her anytime I go to the DSS office to resolve an issue or to help a fellow friend with translation or support.	3/14/2016 10:49 AM
5	Working on behalf for my Father in Law who gave me written permission that I hand delivered to DSS with him present, I am constantly being told it is not on file, having to ask for supervisors to then get approval to have someone speak with be as his advocate. he is 92 years old and I recently got him some DSS support. We received information in Spanish not English, then told they could not read it to us or mail us the information in English. We are not able to get medical offices to accept his connect card for co pay and tried to find out if it was because he has AARP supplement. We requested a separate connect card from the EBT and were told after we called that it would be mailed. We did not receive it and 5 calls later were told DSS no longer mails out separate connect cards. We understand the many people who call yet even when the phone prompt says the system will call you back it does not. Thank You For Your Time	3/14/2016 12:58 AM
6	Please contact by phone	3/11/2016 10:47 PM
7	They told me that I was NOT able to have help with Snap Benefits because I was not 22 years old, and then when I was finally "old enough" to receive help with the snap benefits, they cut me down quiet a bit when I have two children . They are really not that friendly, especially the staff in the Torrington DSS office.	3/11/2016 2:44 PM
8	lost paperwork - again	3/10/2016 9:55 PM
9	Difficulties every year when it is time to mail out the annual Husky A redetermination. You receive your redetermination 2 weeks prior the due date. You send you redetermination a week in advance. You get a letter stating that they would discontinue services because they haven't received redetermination. You call DSS Norwich to problem solve and there are no options to be transferred to any of the on site staff. You call your DSS worker's direct phone line and you can not leave a message because their voicemails are always full. You go to DSS Norwich in person to check your status, and while they are very corteous and polite, sometimes the waiting time can be between 30 mins to up to 2 hours. Most of the times the discrepacies are, from what I am being told, is that DSS and Access Health sometimes are not communicating, so they have different updates on status of your recertification	3/10/2016 3:27 PM
10	Every time I've ever had to call it's always a long drawn out process. Redetermination a have caused me to give up because they "lose" my information and paperwork often or send me to other numbers which send me back to them. They've cancelled my benefits before when I've had everything in on time and correct and when asked why that happened the only explanation I could get was they didn't get to it in time and had to cancel me to save their own backs. It's excrutiating to go through them and makes me want to give up and deal with the struggle. But I can't survive without the benefits so them getting their act together would help a lot of struggling families.	3/10/2016 11:52 AM

DSS Service Barriers Survey

11	I have had to use DSS for services and am still using them for services. There has been a few "frustrating moments". But that was due to my mis-understanding and maybe not enough clarification with the call association because I did not know whmis-undat questions to ask. I was overwhelmed with my situation at first so I did not know what to ask and what to do to get my necessary services. After some time the right associates did lead me in the right direction. I don't think it is a matter of pointing the finger at the DSS services or the Call Associates. You are either part of the problem or part of the solution. And if there is a problem, to make complaints is not a solution. To articulate your complaints or mis-understandings at the time of the services so they can be used for future improvements or "what not to do" best practices I think is a better solution. I am a person who makes mistakes in my own life and previous employments as well so when it was brought to my attention and it was used as a gauge to better improve my job performance and the service I was able to provide for the customers I was servicing than it was a better experience and more positive outcome and more positive growth occurred on the companies side as well as the customers side. So I would not have any negative to say about DSS or their services that I would not have to first take accountability for my own actions or lack there of. Thank you for allowing me to complete this survey and realizing that I too play a part in helping DSS being successful at whey they do already do and can do still do in the future.	3/10/2016 10:05 AM
12	I can't think of a time in the last five years that my papers have been received and processed. This last time, this past week, I got the lecture "you need to understand that we have no staff to process this stuff". Please understand that the chick telling me this had just closed her conversation about her personal business the night before. The time before then... Well, let's skip over that guy....	3/9/2016 5:42 PM
13	He qualified and a year later he could not get service. Some stays home a lot because we can't afford camps and getting to those places	3/9/2016 4:51 PM
14	Renewing for a life long disease every six month	3/9/2016 3:27 PM
15	When reporting changes on the website on Connect they do not review and call individuals for another phone interview. They do nothing unless you follow up with them after you submitted changes. This should be handled in a different manner.	3/9/2016 2:50 PM
16	I do not call DSS because there is too much automated lines and I feel that I just get sent around in circles, so I typically just go to the office for faster service.	11/19/2015 2:04 PM

Eastern Regional Mental Health Board

Service Barriers Survey—DSS

The Eastern Regional Mental Health Board helps people in Eastern Connecticut share information with lawmakers about problems with services in order to improve them.

All of your information will be kept private and confidential, so you won't get in trouble for answering any of these questions for us.

1. How often do you have a problem getting the services you need at DSS?

Never	Sometimes	Fairly Often	All the time
○	○	○	○

2. Problems with the Department of Social Services (DSS):

Below is a list of common problems that people have with DSS. Check the problems that apply to you. (You can pick as many as you need to.)

- ☐ The wait time on the DSS call-in line was too long.
- ☐ I didn't have enough cell phone minutes to wait on the call-in line.
- ☐ I got disconnected from the DSS automated call-in line and had to start over.
- ☐ DSS lost my redetermination paperwork.
- ☐ I needed to go to a DSS office to get help because I couldn't reach anyone by calling.
- ☐ Other (please specify):

3. How long was your wait on the call-in line? (Check as many as you need to.)

- ☐ 0-30 minutes.
- ☐ 30-60 minutes
- ☐ More than 60 minutes.
- ☐ No one ever answered my call.
- ☐ Other (please specify):

4. If you had to go to the DSS office to get help, how did you get there?

- ☐ My own car.
- ☐ Bus.
- ☐ Taxi.
- ☐ Friend or Family Member.
- ☐ Agency Staff.
- ☐ Other (please specify):

5. Would you be willing to tell us about the problems you listed? Your answers will be kept confidential because we won't tell anyone your name.

- ☐ Yes.
- ☐ No.

If yes, please leave your contact information below so we can call and talk with you. (Or, write your story on the back of this paper.)

Name:_____ Phone Number:_____

6. How easy was this survey to fill out?

Not at all	Kind of	Very Easy
○	○	○

SFGATE http://www.sfgate.com/business/article/Uber-and-Lyft-offer-free-rides-to-work-or-6623496.php

Uber and Lyft donating rides to work or interviews for veterans

By Julie Balise Updated 7:23 am, Wednesday, November 11, 2015

In this July 15, 2015 file photo, Uber driver Karim Amrani sits in his car parked near the San Francisco International Airport parking area in San Francisco. The company announced it is donating 10,000 rides to veterans. (AP Photo/Jeff Chiu, File)

Uber and Lyft are donating thousands of rides to homeless veterans who need transportation to jobs, interviews and employment events.

The ride-request companies are teaming up with the White House on the program, which will be administered by employment counselors who work with veterans. Finding transportation to and from work and job interviews is a challenge for homeless veterans, according to Col. Nicole Malachowski, executive director of the Joining Forces Initiative.

"If a veteran is working a night shift or employed in a remote area of a city, public transportation is not always a viable option and there is limited funding available for alternative transportation," she said in a statement.

"Today, the First Lady and Joining Forces would like to thank ride hailing companies Uber and Lyft for stepping up to help address this problem."

Uber committed to donating an estimated 10,000 rides over the coming year across five veteran organizations working with the U.S. Department of Labor's Homeless Veterans' Reintegration Program. Lyft has not said how many rides it will donate.

On Veterans Day, Uber riders can donate $5 toward a ride for a homeless veteran by shifting their app to VETS DAY mode, riding in an UberX, then responding YES to an SMS text message from Uber at the end of the ride. Anyone who donates, will receive a receipt. Drivers can donate as well.

In a blog post, Uber thanked veterans and their families for their service.

"It takes tremendous sacrifice and commitment to be a service member," the company wrote. "We're proud to strengthen our commitment to you, and we salute you this Veterans Day and every day."

Eastern Regional Mental Health Board 2015-16 Year in Review

Thank You!

to all who have helped us over the past two years in the face of repeated attempts to eliminate the Regional Mental Health Boards. Countless advocates urged state legislators to preserve our funding, and those same legislators worked tirelessly to protect the RMHBs and the state's safety net. The danger's not over, though, and we're likely to have another fight on our hands in 2017. Please continue to support our work!

#SaveOurVoice

Gratitude is the fairest blossom which springs from the soul.
~Henry Ward Beecher

Fulfilling Our Mission

EVALUATION ACTIVITIES

- **2** Outpatient program review & evaluations
- **7** Young Adult program review & evaluations
- **5** Special CAC presentations

COMMUNITY NEEDS ASSESSMENT

- Conducted 2015 & 2016 Priorities & Planning Process (PPP) (required to apply for federal funds of $23M/year--2 year process)
- Interviewed **5** Key Informants to gather information for PPP
- Conducted **4** focus groups to gather feedback from all stakeholders for PPP

MEMBERSHIP

- **54** Volunteers active during the past year
- **6** New Catchment Area Council members recruited
- **4** New Board members recruited

ADVOCACY

- 4/18/16 Legislative Breakfast: **7** legislators, **6** legislative staff attended; **3** nonprofit agency managers & **11** clients spoke about vitally needed services in Eastern CT
- **2** staff & **7** members testified at DMHAS Budget Hearing advocating for preservation of funding

COMMUNITY EDUCATION

- Worked with **4** towns in region to have Proclamations issued in observance of Mental Illness Awareness Week (October 4-10, 2015), and got coverage in local media
- See next section for details on other activities

Special Projects

TRANSPORTATION VIDEO PROJECT

- Completed 'People Interrupted: Navigating Poverty in Eastern CT,' a feature-length film on transportation barriers to recovery for individuals with mental health issues
- **2** filming dates, with **32** interviews conducted, including **2** local legislators
- Premiered a "First Look" at 4/18/16 Legislative Breakfast
- Future plans include the creation of a YouTube Channel to display videos; creating variety of short, topical videos; and additional filming dates in the fall and winter
- Strengthened relationships with key transportation industry entities

NORWICH HOSPITAL ORAL HISTORY PROJECT

- **7** interviews recorded (former patient, agency executive, former nurse, amateur historian, etc)
- Fun Fact: one interviewee worked filling vending machines at the Norwich State hospital, and later became a clinician as a result of his experiences
- Future Plans: will continue to seek former patients & family members to participate, to capture a balanced portrayal of the Norwich Hospital era

SURVEYING OUR STAKEHOLDERS

- Surveyed **160** clients and **85** staff regarding DSS Service Barriers Survey
- Identified key barriers in the DSS System: long wait times, conflicting information, and lost redetermination paperwork
- Anecdotal stories provided by **16** clients and **12** staff
- Created a Workforce Assessment Survey currently being tested with local agencies
- Planning a Transportation Barrier Survey for future data collection efforts

COMMUNITY CONVERSATIONS

- Held **1st** Community Conversation for Older Adult Behavioral Health in Sprague
- **27** providers and community members participated
- **2** legislators participated in planning committee meetings
- Senator Cathy Osten & Dept. of Aging Commissioner Betsy Ritter joined the event
- Received overwhelmingly positive feedback in post-event evaluations
- Future plans: follow-up event in SE CT, and 2nd event in NE CT during summer or fall

Community Outreach

MEDIA ACTIVITIES

- *"After 40 years, Eastern Region Mental Health Board still has one challenge left," Norwich Bulletin, 6/24/2015*
- *"Murphy's mental health bill helpful, but won't prevent mass shootings," Op-Ed by Jennifer Gross, Connecticut Mirror, 8/11/2015*
- *"Bill closing deficit, cutting business taxes heads to Malloy," Connecticut Mirror, 12/8/2015*
- *"Mental health service cuts go along with layoffs," Connecticut Mirror, 4/19/2016*
- *Appearance on Rep. Susan Johnson's "Town Talk" Cable TV show, 12/16/2015*

COMMUNITY COLLABORATIONS & COMMITTEES

- *Keep the Promise Coalition Coordinating Council (also a participant in Strategic Planning Process 2015-16)*
- *DMHAS State Board of Mental Health & Addiction Services*
- *DMHAS Adult Behavioral Health Planning Council*
- *Mental Health CT Public Policy Committee*
- *Southeastern Mental Health Authority (SMHA) Network Management Council*
- *SMHA Faith Steering Committee*
- *SMHA Employment Steering Committee*
- *NAMI-CT Public Policy Committee*
- *Ledyard Safe Teens Coalition*

"Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."
~Margaret Mead

For more information, contact the Eastern Regional Mental Health Board at
401 W Thames St, Norwich, CT 06360 ★ (860)886-0030 ★ www.changingmindsct.org

2015 Recognitions & Awards

Michael Kerr Scholarships:

Melanie Nagode
Michael Marshall
Jessica Goodman
Jennifer Brownlee
Shemekia Garcia
Leslie Calkins
Marie "Beth" Donohue

Robert Davidson Advocacy Award: Bonnie Eldridge

"Extra Mile" Volunteer Award: Jo Ann Richards

"Extra Mile" Volunteer Award: Bruce Bayne

Leadership Award Commissioner Betsy Ritter

Five Ways You can lend a helping hand

- Attend one of our meetings
- Join a Catchment Area Council**
- Volunteer to help with a Program Review
- Advocate for us with your legislators
- Donate: We are a 501(c)(3) nonprofit, and your gift may be tax deductible!

**What is a Catchment Area Council?

The Catchment Area Council (CAC) is a citizen body and is the grassroots level for citizen involvement in planning for needed services. No expertise is need to join! Visit www.changingmindsct.org to learn more.

Even the smallest puzzle pieces help make the biggest picture

- Hosted performance by Second Step Players, whose comedy and music educates the public and changes attitudes about mental health issues.
- Served as Consumer Rights Officer for **2** local agencies.
- Met personally with **8** Town CEOs to learn about local needs; presented to Council of Governments
- Conducted **3** focus groups with local young adults to discover how they think, talk, and inform themselves about mental health issues and how they engage with services.
- Held 40th Anniversary celebration with **63** guests, including **4** legislators and **1** Town CEO.
- Participated in a Round Table Forum held by U.S. Senator Chris Murphy.
- Built a NEW & IMPROVED website!
- Nominated (and presented award to) Norwich Bulletin reporter Adam Benson for the Keep the Promise Coalition Media Award for excellence in covering mental health issues.
- Served as a panelist in **2** Mental Health Forums convened by State Rep. Kathleen McCarty.
- Awarded a total of **$1100** to **7** individuals in recovery through our Michael Kerr Scholarship program.
- Conducted **2** advocacy trainings for local agency clients and staff.
- Held first annual "Own Your Story" creative challenge, featuring written and visual arts, with nearly **40** entries and **6** awards given.
- Partnered with UConn School of Social Work to bring first-ever MSW intern to ERMHB for 2015-16 school year.

The ERMHB & Social Media

408 Likes
Average Post Reach: 104
Top Post Reach: 788

109 Followers
1.2K Impressions last month
Top Tweet: 60 Impressions

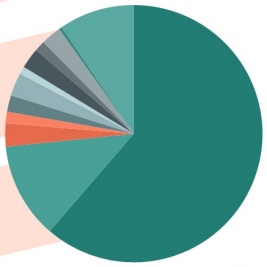
Avg. Monthly Viewers: 613
Top Pin Impression: 378
Top Board Impressions: 383

44 Followers

How we get it all done...

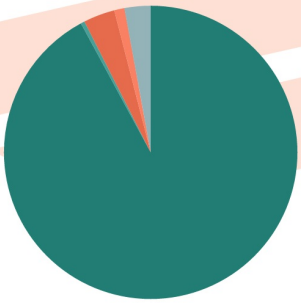
...making every dollar count

The Regional Mental Health Boards have often been called the "best bargain in the system," and our reputation for giving value to our state and its communities is well-deserved. With just one full-time and two part-time employees, and on a shoestring budget, the ERMHB coordinates dozens of volunteers and a vast array of planning and evaluation, community education, and advocacy activities.



Total FY16 Expenses: $113,687*
*Figures provided are for projected revenue & expenses

Salary (61%) Payroll Expense (12%)
Contract Services (3%) Communications (1%)
Insurance (2%) Special Projects (3%)
MKerr Awards (1%)
Supplies, Postage, & Printing (3%)
Meetings, Memberships &.. (1%) Mileage (3%)
Education & Training (0%)
Administrative & General (9%)



Total FY16 Revenue: $113,687*
*Figures provided are for projected revenue & expenses

State Grant (92%) Donations (0%)
CRO Payments (3%) Rebates & Refunds (1%)
Interest Earned (0%) Robert E. Davidson Fund.. (3%)

The Robert E. Davidson Fund was founded in 2014, in memory of our previous Executive Director, who believed passionately in recovery and a full life in the community for those living with mental health issues. Thanks to the generosity of so many who admired him, donations to the Fund have reached nearly **$10K**, allowing us to pursue exciting projects like our "People Interrupted" documentary. If you'd like to donate to other projects like this, please contact us to learn how.

Appendix H

Eastern Regional Mental Health Board
401 W. Thames Street • Norwich, CT 06360 • 860-886-0030 • www.changingmindsct.org

November 19, 2015

Governor Dannel P. Malloy
Office of the Governor, State of Connecticut
State Capitol
210 Capitol Avenue
Hartford, CT 06106

Dear Governor Malloy:

Together with the Board of Directors of the Eastern Regional Mental Health Board (ERMHB), I write in support of the efforts of United Services, Inc., Northeastern Connecticut's nonprofit Local Mental Health Authority, to secure state bonding assistance for the shovel-ready construction of a long-needed consolidated and expanded Windham Regional Clinical Center.

United Services has sought state support for this initiative since 2011. In addition to providing a long overdue facility expansion to allow the agency to meet the rising demand for services, this project will also allow United Services to co-locate children's behavioral health programs with services for their parents and other adults, improving the quality and cost-effectiveness of the region's mental health system.

Since 2007, the agency has experienced 248% growth in their volume of outpatient mental health services alone. United Services also provides vital supports as the regional Domestic Violence Program as well as other important human services including a new Center for Autism, not yet available to residents of the Windham region due to the agency's current inadequate facilities.

As members of the Eastern Regional Mental Health Board, we have a statutory mandate to advocate for behavioral health services that are appropriate and accessible for residents of the 39 towns in our region, and to ensure that those services promote overall health and wellness and a meaningful life in the community for people living with mental health challenges. Those with severe and persistent mental illnesses have a life span that is, on average, 25 years less than the average American's, largely due to treatable medical conditions. With the proper investment in integrated community mental health and primary healthcare, these individuals could lead full and productive lives.

In a recent evaluation of United Services' Outpatient Clinic, the ERMHB found that:

> [The] Windham facility is dated, cramped, and lacks accessibility for those with physical disabilities. United Services appears to have made every possible effort to maximize space, despite the huge limitations presented by the building…
>
> Ensuring privacy during clients' sessions is challenging. It is clear that the agency outgrew this building years ago, and until a pending bond request is approved, United Services is powerless to improve the situation…

Appendix H

> Sadly, this situation exemplifies the very real stigma attached to mental health issues. United Services' inability to gain bond approval for its new building sends a distressing message that our communities don't value mental health services and the people who need them, increasing feelings of shame and isolation. This disconnect is quite apparent just down the hill, where a brand-new, state-of-the-art building occupied by Generations Family Health Care is located.

Furthermore, a recent Community Needs Assessment conducted by Hartford Healthcare determined that "Mental Health is the number one health priority in Eastern Connecticut."

The residents of Northeastern Connecticut are long overdue for a significant investment in community mental health services. As you noted in your charge to the Sandy Hook Advisory Commission: "We need to make sure that our mental health professionals have access to the resources and information they need to get treatment to those who need it." Throughout their final report, the Commission repeatedly describes the state's behavioral health system as "fragmented and underfunded" and consistently calls for the state to "find ways to fund integrated models of care for both children and adults."

The Board of Directors and membership of the ERMHB wholeheartedly echo that assessment, and support United Services in their efforts to address these deficiencies. By supporting United Services' request you can take immediate steps to improve, expand and consolidate services for children, adults and families in a region that is particularly lacking in resources for people with mental health needs.

We respectfully ask you to seriously consider and fully endorse United Services' eminently reasonable and appropriate request for the support necessary to serve the behavioral health needs of the residents of Northeastern Connecticut. Thank you for your prompt and thoughtful attention to this request.

Sincerely,

Jennifer J. Gross
Executive Director