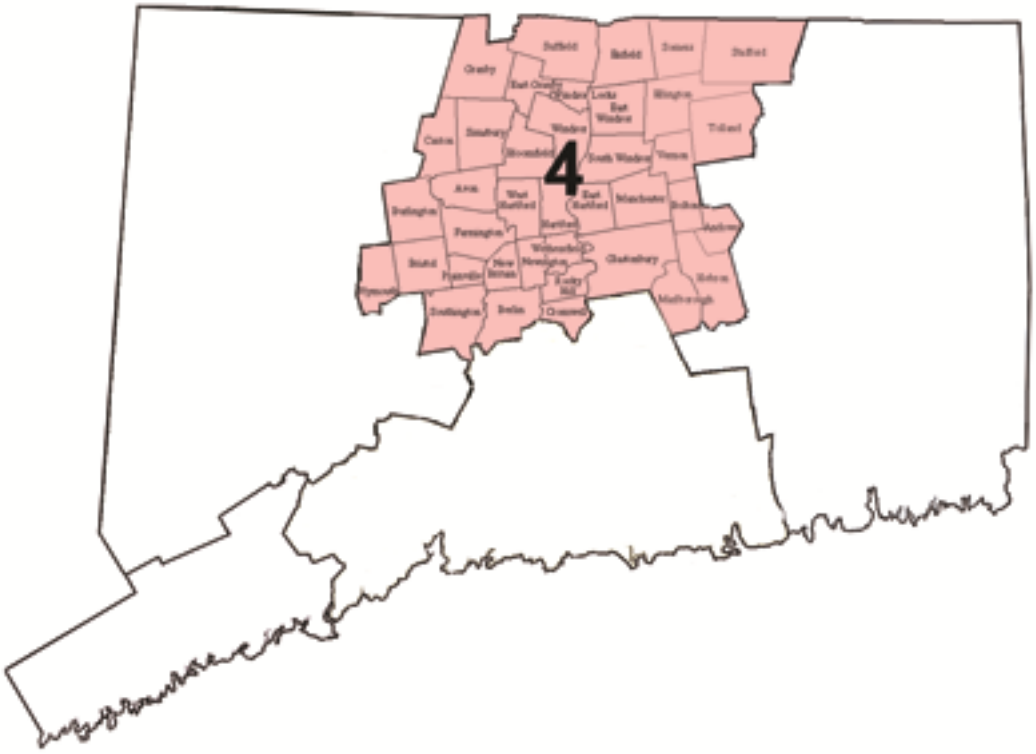
2016 REGION IV
PRIORITIES AND RECOMMENDATIONS REPORT



Submitted by the
North Central Regional Mental Health Board (NCRMHB)
East of the River Action for Substance Abuse Elimination (ERASE)
Capital Area Substance Abuse Council (CASAC)
Substance Abuse Action Council (SAAC)

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I. 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 and legislative advocacy agenda for each RMHB and RAC. This report summarizes the findings of the 2016 DMHAS Region IV biannual needs assessment and presents recommendations for improvement in mental health and addiction services for in North Central Connecticut (CT).

II. Process and Data Sources

The Priority Planning process included several forms of data collection which took place in the fall of 2015 through the summer of 2016. These are summarized below.

- Focus groups conducted by RMHBs and RACs with key stakeholder groups in each Catchment Area Council (CAC)
- Needs assessments conducted by the three Regional Action Councils (ERASE, CASAC, and SAAC) that provide services in Region IV
- Regional Profiles and utilization data provided by DMHAS describing DMHAS services provided in each region
- Surveys conducted with Region IV providers of mental health and addiction services and Municipal Social Service Directors
- Interviews conducted with providers of addiction services in Region IV
- Information solicited via RMHB provider evaluations and fidelity reviews throughout 2015-16
- Review of data available through the Behavioral Health Partnership
- Review of data available through the CT Alcohol and Drug Policy Council and Older Adult Behavioral Health Workgroup
- Information solicited from key informants from both within and outside of the DMHAS services system (NCRMHB Catchment Area Council [CAC] and Review and Evaluation Committee [R & E] members, staff from town social services, shelters, health departments, local colleges and universities, and parents and individuals in recovery who are new to the system or in the private sector.

A. Focus Groups

In May 2016, local perspectives from all the towns in Region IV were gathered by North Central Regional Mental Health Board (NCRMHB), East of the River Action for Substance Abuse Elimination (ERASE), Capital Area Substance Abuse Council (CASAC), and Substance Abuse Action Council (SAAC) through a series of focus groups.

Ten focus groups were held, one in each of NCRMHB's six Catchment Areas, and one with members of the Hartford Provider Collaborative, Manchester Continuum of Care, operators of a young adult Warm Line at

TOIVO, and the NCRMHB Regional Consumer Advisory Council. Participants included town appointees and interested community members from the towns in each of the Catchment Areas, people in recovery, family members, community referral organizations, and providers. There were a total of 88 participants – 40 people in recovery, 10 family members, 25 community referral organizations, and 14 Mental Health/Substance Abuse (MH/SA) providers.

Participants were provided with a grid and were asked to rank five core areas of Mental Health and Substance Abuse Services in order of priority along seven (7) dimensions (see table below). Please see Appendix A for a copy of the grid and a detailed explanation of each of the core areas of service.

Core Areas	**Dimensions**
Inpatient Services	Awareness
Outpatient Treatment	Capacity
Residential, Crisis, and Respite Services	Accessibility
Recovery Support Services	Services Match Needs
Education, Research, and Prevention Services	Gaps
	Workforce
	Coordination

Participants were then given 3 dots to identify their top three priorities among all of the core areas and dimensions. Discussion regarding those choices was documented on flip charts. Please see Appendix B for a full summary of comments gathered during those discussions.

B. <u>Surveys</u>

An on-line survey was developed and sent to DMHAS funded and operated mental health and addiction providers in order to capture their perspectives on service priorities and the impact of recent budget reductions on services. Surveys were sent via Survey Monkey to the chief administrators of DMHAS-funded provider organizations throughout Region IV. Surveys were completed by 11 providers.

Providers were asked to respond to the following questions (See Addendum C for a summary of their responses):

- Given the state's financial picture, what are the critical areas for the behavioral health system to protect in the next few years?
- The following are the 5 priorities in the DMHAS system. Please rank these priorities from 1 (top priority) to 5 (lowest priority of the 5), in your opinion.
    - Inpatient Services
    - Outpatient Treatment
    - Residential, Crisis, and Respite Services
    - Recovery Support Services
    - Education, Research, and Prevention Services
- Is anything missing from the list of priorities? If yes, please specify.
- What are the critical areas (including but not limited to those listed above) that most need to be strengthened in order to meet changing circumstances?
- In what parts of the behavioral health system do we need to do things differently?
- What models should we consider for each of these areas?

- Which current or new populations are most difficult to serve?
- What is the impact of the recent and latest budget cuts on your agency? Check any and all that apply:
    - Elimination of programs
    - Reduction of program hours
    - Increase in caseloads
    - Increase in waiting lists
    - Turning away people from services
    - Layoffs
    - Staff reassignments
    - Hiring Freeze
    - Other
- Please provide any additional details, including names of programs eliminated, if applicable.
- What are any emerging issues that you are seeing or hearing about?
- Are there types of data that should be collected to help identify gaps and needed resources?
- Please provide any additional feedback or comments specific to these topics or in general (including any recommendations to the state to address the financial crisis).

A similar survey was sent to the Directors of Social Services in each of the municipalities in Region IV. Eight (8) Social Services representatives participated in the focus groups described in section A. An additional 12 Social Services Directors completed the survey. (Please see Addendum D for a copy a summary of their responses):

C. Evaluations

Each year the NCRMHB Review and Evaluation (R & E) Committee conducts a comprehensive review of services by DMHAS-funded providers of mental health and addiction services in Region IV. During fiscal year (FY) 2015, the R & E review focused on the crisis response system. The report summarizing the experiences and perspectives of individuals in recovery, their families, DMHAS-funded mobile crisis and crisis intervention teams, law enforcement, and hospital staff can be found on the NCRMHB website (www.ncrmhb.org). The FY 2016 review focused on outpatient services offered by DMHAS-funded providers across Region IV. The review was conducted with a particular lens given to integrated treatment for co-occurring (mental health and addiction) concerns, cultural competence, and trauma-informed care. The report will be completed by September 2016 and will also be available on the NCRMHB website. In addition, members of the NCRMHB R & E Committee participated in 2 fidelity reviews of DMHAS-funded Community Support Programs throughout FY 2016. Comments and perspectives gleaned in all of those reviews were also considered in this reporting.

D. Other Key Informants

Feedback obtained from discussions in monthly CAC and R & E meetings was documented and considered in this report. In addition, feedback obtained from participants in several grant-funded projects were considered.

Over the summer of 2015, in a project funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the NCRMHB organized a series of 15 Community Conversations about the Affordable Care Act (ACA) in Black communities all over the state of Connecticut (CT). Over 150 people who

had lived experience with mental health or addiction issues, or who identified as Black or African American participated in the dialogues. The NCRMHB embarked upon this project because research indicates that African Americans who are vulnerable to mental health issues have the tendency to underutilize mental health services. The NCRMHB wanted to better understand how the ACA affected African Americans' ability to access mental health and addiction services as well as healthcare. In our research, we found that African Americans tend to view medical professionals with suspicion and are more are likely seek help from church leaders or pastors than physicians or mental health professionals. The results of that project are summarized in in a report, "Civil Justice in Healthcare: The Affordable Care Act and the Black Community in CT," and can be found on the NCRMHB website (www.ncrmhb.org). As a follow-up to these Community Conversations, and with funding from the CT Health Foundation, NCRMHB is now working in collaboration with leaders from several Black churches conducting follow-up conversations and training with pastors and leaders of emerging health ministries in CT Black churches.

E. Prioritization Process

Feedback from all of the sources above was summarized and shared with leadership of the 3 RACs serving Region IV, R & E Committee, and NCRMHB Regional Consumer Advisory Council (RCAC). The group was convened and asked to rank the cores areas of service using a Priority Ranking Matrix. The core service areas for both mental health and addiction services were ranked (1 = lowest, 2 = low, 3 = medium, 4 = high, 5 = highest) according to the following priority rating scale:

- Magnitude (Burden of problem): A relatively large number of people are affected. The number affected is sufficient to assess change over time, settings and sub-groups.

- Severity/Impact (Depth of problem across dimensions): The social (i.e., health, economic, criminal justice) costs are high.

- Changeability (Reversibility): The indicator is amenable to change and services are available to affect change.

- Readiness /Capacity: The system is ready and has the capacity to address this priority.

It is important to note that by using the Priority Ranking Matrix, factors other than the breadth and depth of concerns about a particular core area were factored into prioritization choices. For example, even though mental health recovery supports were seen to be the top priority in terms of magnitude and severity, the reviewers saw these areas as less amenable to change and accordingly gave them lower scores for changeability and readiness than outpatient and education/research/prevention services. Also in terms of magnitude, it was assumed that a larger number of people would be affected by a reduction in outpatient services than inpatient or residential services. It is also important to note that outpatient services include a large array of treatment and recovery supports - case management, young adult and behavioral health home services in addition to outpatient treatment. Recovery supports include social clubs, supported housing, employment, and peer supports. Reviewers also commented that education/research/prevention should actually be incorporated as key elements in each of the other four core areas as opposed to being considered separately. Please see Addendum E for a summary of results of the priority ranking and Addendum B for rankings by each of the 10 focus groups.

III. Region IV Demographics

Region IV is comprised of 37 towns surrounding Hartford: Andover, Avon, Berlin, Bloomfield, Bolton, Bristol, Burlington, Canton, East Granby, East Hartford, East Windsor, Ellington, Enfield, Farmington, Glastonbury, Granby, Hartford, Hebron, Manchester, Marlborough, New Britain, Newington, Plainville, Plymouth, Rocky Hill, Simsbury, Somers, South Windsor, Southington, Stafford, Suffield, Tolland, Vernon, West Hartford, Wethersfield, Windsor, and Windsor Locks.

Please see Addendum F for detail regarding population by town including primary racial and ethnic groups, age, poverty related indicators. Some key characteristics are as follows:

A. Racial and Economic Diversity

Among the 37 municipalities, East Hartford, Hartford, New Britain and Windsor stand out as the only communities where Caucasians are in the minority. The largest city, Hartford, has the largest population of persons of color, 38% Black or African American, 2.5% Asian Pacific American, and 43.6% Hispanic or Latino. Four of the 37 municipalities have double digit poverty rates: Hartford at 34.4%, New Britain at 23.5%, East Hartford at 14.3%, Manchester at 11.6%, and Stafford at 10.8%.

B. Aging

CT's population is aging. Currently the average number of persons over 65 in Region IV is about 15%. By 2025, that number is expected to increase to least 20% in almost every CT town.[1] In 2015, 18% of adults served by DMHAS in Region IV were age 55 or over. This is a 7% increase over 2014. In 2012, NCRMHB began working with a group of organizations concerned about the adequacy of behavioral health services for older adults. An "Aging and Disability Resource Center Older Adult Behavioral Health Asset Mapping Study" was initiated in October 2015. The study confirmed a number of factors associated with the crisis in unmet behavioral health needs of older adults both nationally and in CT. These factors contribute to decreased quality of life, increased utilization of health care services and costs, higher mortality rates, and in some situations result in unnecessary institutionalization. For an executive summary of the report, please see http://www.ct.gov/agingservices/lib/agingservices/behavioralhealthmapping/assetmappingexecutivesum.pdf.

C. Behavioral Health as a Key Factor in Overall Community Health

Mental Health and Substance Abuse were ranked as top priority issues for improving community health in both the 2014 Central CT Health District and 2015 Hartford Hospital Needs Assessments.[2] Of those surveyed by Hartford Hospital, 12.3% self-reported their mental health status as "fair" to "poor".[3] Experiences of fair to poor were most strongly associated with low income and ethnic origin (21.8% Hispanic). Of those surveyed, 17.8% of adults had been diagnosed with depression and 27.8% had experienced symptoms of chronic depression.

D. DMHAS Population in Region IV

DMHAS serves the 0-to-18 year-old population by focusing on mental health promotion, substance use prevention, and suicide prevention. This work is carried out through the three Regional Action Councils

[1] US. Census Bureau, 2014
[2] Community Health Improvement Plan, Central CT Health District, 2013
[3] 2015 PRC Community Health Needs Assessment, Hartford HealthCare

(RACs), which work with Local Prevention Councils, school and parent groups, local providers, hospital, police departments and other first responders in all 37 towns and cities.

DMHAS provides mental health and substance use treatment and supports to adults 18 and over through a combination of state operated and private non-profit providers located throughout Region IV. Region IV is divided in to six catchment areas, and each catchment area has a Local Mental Health Authority (LMHA), a provider responsible for DMHAS-funded services and supports for individuals living in that area. In 2015 DMHAS providers served 36885 adults in Region IV. Please see Addendum G for a breakdown of individuals served by age, gender, race or ethnicity, employment and living situation and comparisons to total CT population served by DMHAS in CT as well as the overall CT population. The data reflects a larger percentage of persons of color receiving DMHAS services for mental health or addiction issues than is reflected for their same demographic in the overall CT population. The exception is for persons of Asian origin whose percentages served by DMHAs are significantly lower than their presence in the overall CT population. Also of note is the difference in ratio between male to female served by DMHAS compared to the CT population. The ratios for CT are very similar, but for the DMHAS population, males outnumber females by over 17%. Also of note, not surprisingly, the rate of unemployment and homelessness is much higher for persons in the DMHAS system compared to the overall CT population.

IV. Key Priorities for Behavioral Health

A. Overarching Issues across Core Areas

- Budget and reimbursement system concerns were consistently brought up by all informants as an overarching and looming topic of concern. In spite of that, there were several providers and focus group participants who expressed appreciation for the efforts of DMHAS Commissioner and her team for managing and mitigating the impact of these issues on providers and individuals who rely on them for services and supports.
- The majority response to DMHAS's priority order for the 5 core areas was that the order should be reversed. The titles, groupings, and descriptions of the core areas were confusing to most respondents. One person said, "We are not working on solutions, we are simply reacting to situations as they come up."
- Lack of safe, affordable and supportive housing continues to be the top priority issue raised by all groups as a primary barrier to recovery. "Emergency shelter placement is near to impossible these days and even more difficult for folks with behavioral health needs." Transportation is also a major barrier, especially for people living in outlying communities. Budget cuts that have resulted in reductions to State-funded Logisticare medical transportation will further limit access to services.
- Among the 7 dimensions considered, access and capacity were ranked as top areas of concern across all of the 5 core areas. Lack of access and capacity were seen as highly related to workforce concerns, i.e., low pay and reimbursement rates, inadequate staffing levels, training and cultural competency, resulting in high caseloads, high turnover, burnout and poor outcomes for individuals served.
- Coordination between systems and across communities was also noted as a major concern. Treatment is segregated – wherever people show up for service, they tend to be screened in or out for what that organization can provide. We need a seamless system with no wrong doors and ensure people get to the right places for the services or supports they need. We need to normalize inclusion of community as an integral partner in recovery planning. Community Care Teams that

have formed around most of the Region IV hospitals were seen as a positive step for addressing the needs of people who frequently rely on emergency or inpatient treatment, however efforts to adequately fund those teams have been unsuccessful. The new Behavioral Health Homes are also a source of coordination and integration of physical and behavioral health concerns for those who qualify. Their focus on whole person wellness has been well received.

B. Core Areas

1. Outpatient Services

Overall Strengths noted for Region IV were huge strides with offerings of same day of next day access to an intake appointment and the focus on integration of behavioral health with overall health. Five out of the six LMHAs have established a medical clinic on site. The sixth has established a close working relationship with a nearby hospital for medical services. Two providers have become certified as Federally Qualified Health Centers (FQHC). One provider has clinical staff located in a neighboring outpatient clinic. Several people stated that they would be absolutely lost without the services of their provider. One jail diversion program we visited integrates clinical care with case management services. People participating in that program greatly appreciate the practical support they receive with life issues that impact their recovery significantly.

The following comments and **concerns** noted are broken up by type of service:

Overall: Inadequate services at the outpatient and/or community support level result in crises and higher demand for intensive and more expensive services. It is important to continue to show the correlation between decreased community support and increased inpatient hospitalizations.

Intensive Outpatient Mental Health/Substance Abuse (MH/SA)

- Insurance co-pay too high
- Duration of service too short, not ready for discharge, anxiety builds over that
- Hours of IOP conflict with maintaining employment (key to maintaining recovery)
- Have to stop doing life to focus on treatment – no flexibility
- Serving more people from court referrals, but model of service doesn't fit IOP well
- Need to ensure immediate and ongoing access

Mental Health (MH) Outpatient

- Understaffing (especially prescribers and bilingual staff), lack of timely access, long waiting lists, high caseloads, all resulting in fewer services and poorer outcomes for people who use them. MH services are increasingly difficult to access
- Cut back on prescriber time for outpatient results in up to 6 weeks between appointments
- Access more difficult for outlying communities – need more satellites, transportation resources
- People don't know how to communicate problems – don't understand professional jargon
- People complained about being too highly medicated instead for learning other coping strategies
- People expressed that sometimes medication makes things worse and doctors don't listen, especially about side effects

- Reasons experienced for discharge or cutting back on services – other people need the services more, or too ill for one level of care, not ill enough for another. Need appears to be determined per the provider's perspective, not the individual's
- Trend is toward clinical treatment in groups vs individual therapy, however group work is not effective for everyone. Some people have difficulty in groups or the grouping they are placed in (gender, age, language, diagnosis, etc.), some people are disruptive, sometimes people are told not to talk about certain issues because it will traumatize other members of the group
- Need to follow person into natural environments
- Need more for more use of Dialectical Behavioral Therapy (DBT)
- Need to address regulatory and reimbursement barriers that limit access to care and integration of mental health and addiction treatment

Substance Abuse (SA) Outpatient

- Need rapid access to treatment
- Ambulatory detox is underutilized
- Not enough outpatient medication assisted treatment alternatives available. Need more Suboxone prescribers and accompanying recovery support services.
- Have to be high to get in detox or have to stay clean long enough to get in rehab or outpatient– at very high risk for while waiting and trying to stay clean.
- People expressed concern about being grouped with people who are mandated to be in treatment.
- Silos still exist for co-occurring issues. Need to address regulatory and reimbursement barriers that limit access to care and integration of mental health and addiction treatment.
- Not addressing what is needed for sustained recovery. Long term, ongoing, transitional, wrap around and supports for the whole family are needed.
- People who have high deductibles or insurance plans that are not widely accepted (including Medicaid) have great difficulty accessing services.

Community Support Program (CSP) / Assertive Community Treatment (ACT) / Case Management

- The structure of CSP with its strict fidelity requirements limits flexibility for providing services on demand or for people who require intensive engagement.
- Providers cited challenges with the model for employing individuals in recovery to carry out all the requirements of their prescribed role within the CSP model.
- There is a waiting list for the Recovery University training that is required for certifying peer staff.
- Inadequate staffing results in staff being spread too thin, high caseloads, or waiting lists.
- There is not enough capacity in the ACT or BHH programs, so people spill onto waiting lists or CSP.
- One provider in particular has made great strides recently with skill building and wellness groups and activities that are appealing and engaging to people on their caseloads. By using their clubhouse as center of those activities, they have drawn in others who can also benefit.
- CSP staff express concern that most people seeking their services are coming to them for help securing housing. As long as basic needs remain unaddressed, it is difficult for people to develop other goals, gain new skills, or move forward in their recovery.

- More Case Management and supportive services are needed for relapse prevention.
- Town personnel asked for more clarity for assisting people outside the DMHAS network with "who gets what services and when."

Behavioral Health Homes (BHH)

- Eligibility is based on data from DSS for people who have high Medicaid costs. People who have Medicaid and Medicare (dual insurance) are not likely to be eligible even though they are often people with co-existing medical and behavioral health needs.
- High caseloads for BHH – the 2 hours of Case Management per month is often not enough.
- BHH can divert or reduce people's use of emergency care as source of primary care and help people obtain better care and health outcomes.
- People expressed concern that often their physicians do not talk to their behavioral health providers, but they do use diagnosis against them; people described many instances of discrimination for occasions when they were seeking medical attention. Hopefully, BHH services will help with this.

Young Adult Services (YAS)

- Of the young people (14849 people between the ages of 18-34) in the Region IV DMHAS system, less than 300 are served in Region IV YAS programs. Most referrals come from the Department of Children and Families for youths who are aging out of their services. It is very difficult for someone without DCF referral to access YAS services regardless of level of need. There is also need for other DMHAS-funded services to be more sensitive and responsive to the unique needs of young adults.
- Several young adult programs were described as wonderful – offered jail diversion, help with budgeting, housing, daily living, getting a job, building skills and confidence, etc. However, others complained that staff were disrespectful and unhelpful and expressed fears about aging out of YAS before they had the safety net and skills for greater independence.
- People described the programming and opportunities through YAS BIZ as wonderful.
- Young people getting clinical services from outside the DMHAS system are often not told about all the supports available to them. Several young adults expressed great frustration with the fact that they had to figure it all out on their own.
- Not enough help with obtaining further education.
- Not enough awareness of peer support.
- Need for more awareness at college campuses. For many years CCSU has offered a model program – Central Access and Student Development program that was described as lifesaving by some of the students we interviewed. Unfortunately, in the wake of budget cuts, the program has been discontinued. Students described experiences at many college campuses as places where there are no supports for individuals with disabilities except counseling, and "no one wants to go there."

2. Education, Research and Prevention

Overall Strengths: As can be seen in the focus group and survey summaries, "education, research, and prevention" as a separate core area was not ranked as a high priority by the groups who informed this

report. The high ranking in the Region IV Priority Ranking Matrix comes as a result of 1) giving credence to their feedback that education, research, and prevention should be incorporated as key elements in each of the other four core areas as opposed to being considered separately; and 2) a belief that this core area is ripe in terms of changeability (strategies are available to affect change) and readiness (the system is ready and willing for change). We are at a point of renewed and serious attention at the local, state, and federal levels for both mental health and addiction concerns. Federal legislation is on the horizon that offers promise for additional resources and better practice guidelines. Legislation was passed by the 2016 CT General Assembly that promotes greater access to Narcan, limits initial prescriptions for opiates to 7 days, and increases prescriber capacity for Medication Assisted Treatment. New requirements for law enforcement crisis response training were also addressed. Funding for continuing the work of the Regional Action Councils was restored in the FY 2016-17 budget. The CT Alcohol and Drug Policy Council was re-constituted and is in the process of developing a CT Strategic Plan to address the Opiate Crisis. Many forums are being held to inform and involve the public in addressing the opiate epidemic. A significant investment is ongoing for Recovery Coach and Mental Health First Aid (MHFA) Training. Cooperative agreements are imminent for the establishing recovery coaches and/or crisis workers in local hospital emergency rooms. Drop boxes for safe disposal of prescription medications are located throughout the region (many paid for via DMHAS funding). A growing number of emergency responders in Region IV towns and cities carry Narcan. These are all evidence that concern is widespread and commitment is high.

The following comments and **concerns** noted are broken up by type of service:

Prevention

- Not enough prevention
- Schools are not meeting health education curricula requirements
- Schools don't know how to talk about mental health and addiction! Many schools do not want their issues highlighted or to frighten the community, so have not participated in DMHAS funded needs assessments
- Young people are becoming addicted to substances, notably opioids, at very young ages; we need to find ways to address this much earlier and more effectively. Social media plays a large role in the distribution of drugs – it is a place where young people find out where to get drugs.
- Need for Narcan to be more readily available to the people who can use it to save lives
- Concern over the elimination of gatekeeper program for outreach to older adults with behavioral health challenges
- The "Take it to the Box" program is great, but people are reluctant to go police stations. Need to consider alternate locations, like pharmacies
- Ensure enforcement of the prescription monitoring program

Education/Awareness

- Need to change the negative stigma and discrimination toward people who are in recovery. Public needs to be educated so they can be part of the solution rather than the problem. Often people with addiction don't reach out for help because of stigma and discrimination
- Still too many people lack awareness, need help, and do not know where to turn. They can't find the resources they need

- "The term 'behavioral health' needs to change – it misleads the public about the reality of illness and conditions people face and increases stigma and discrimination. This term leads people to believe that behavior is the problem. Do we walk around saying we have 'behavioral health?'"
- Need assertive outreach, education and earlier identification with access to services
- Ongoing information to the community is essential as it is the community who will be the support for their residents who have mental health and addiction challenges
- Don't know how to refer someone who needs help
- Frustrated with Health Insurance Portability and Accountability Act (HIPAA) – unable to provide/receive information
- I feel when one has a problem, only an advocate working on your case and one who is familiar with all the services could possibly navigate the maze and put you in touch with the best course of action.
- More education for town social services needed
- Need for continued Crisis Intervention Training (CIT) for law enforcement personnel
- Need for education about safe prescribing practices for pain

Research

- Capacity-building for providers re: culturally-relevant services/practices & research-based best practices

3. Recovery Support Services

Strengths: DMHAS and DMHAS-funded providers have demonstrated a strong commitment to developing and maintaining recovery support services. The two Supportive Housing options settings recently developed in Manchester are stellar. Members of the review team were particularly complementary of the wonderful web of supports offered by CCAR including telephone support, volunteer opportunities, recovery coach training, etc. DMHAS funding was also used to develop the TurningPointCT website, led by and available for young adults throughout the state for information, resources, and on-line support. Several Region IV providers host Warm Lines staffed by individuals in recovery. DMHAS provided much of the impetus and support for the establishment of Hearing Voices Support groups throughout CT. Region IV is particularly fortunate to have Advocacy Unlimited's TOIVO program located in Hartford. TOIVO offers numerous educational programs, support groups and non-clinical approaches to healing and wellness. TOIVO offers a Warm Line specifically for young adults.

CT's efforts to end homelessness are focused on people who are assessed for vulnerability and meet the definition of chronically homeless. This is in line with new federal mandates, and CT has made progress in its efforts – having celebrated the end of chronic Veteran homelessness last year. While this effort has not been without its challenges, the two Coordinated Access Networks serving region IV, Journey Home and Central CT CAN (CCAN) both report progress toward their goals of ending chronic homelessness by the end of 2016 (at 55% and 30% respectively as of July 2016).

The following comments and **concerns** noted are broken up by type of service:

Recovery Supports - Housing

- Many people described nightmare experiences trying to access shelter through 2-1-1 and the Coordinated Access Networks

- Region IV experienced a reduction in “East of the River” emergency shelter options just before the cold weather hit last year. As temporary measures, a warming center opened in Enfield and limited funding was secured for a Vernon shelter to manage overflow
- Lack of supported housing
- Can't find housing for anyone
- Info online totally inaccurate
- Have to make a certain amount of money to live in public housing
- 15 year wait for senior housing
- Housing is top priority, everything depends on housing – folks are out there really struggling
- People living in bad places have no options until become homeless; turn to hospitals because not ‘chronic’
- Waitlist for Section 8 Vouchers – especially for very low income – not sure where to send someone who needs something now
- Where to house people coming out of prison?
- New PATH program for homeless outreach

MH Recovery Supports - Employment

- The structure of the Individual Placement and Support (IPS) model with its strict fidelity requirements limits flexibility to address the needs of people who are not successful with that model
- Cuts from the Department of Correction led to the elimination of an entire program at one agency that was able to offer alternatives to the IPS model
- Use of YAS BIZ curriculum offers creative alternatives for young adults who are just forming career goals. Led to the development of a video business for young adults served by one Region IV provider
- Several providers using offerings like “open hours” to offer more timely support when supported employment program is at capacity
- One person wanted a baking job, was encouraged to quit job to ‘try’ baking for possible hire, can’t take the risk!
- Large pool of people with ‘lived experience’ looking for positions as recovery coaches. Positions are few and hard to find. No career patch
- Transportation barriers. No money for bus passes
- One person said no one was told about vocational services; was told they had to join clubhouse first

MH Recovery Supports - Clubhouses

- People not aware of what offered
- Like the activities, groups good
- With some providers a person can only be in clubhouse if receiving treatment there
- Used to go every day when I didn’t have a life, made friends there
- Comment from a young adult – saw so many older people there, it brought me down, difficult to match the needs of all ages

- Comment from a clubhouse member who received an NCRMHB mini-grant – clubhouse staff oversight too intensive for mini grant. Doesn't give person room to do the work

SA Recovery Supports

- AA and NA are not for everyone. Need multiple pathways
- Sent from inpatient to bad sober houses. Need more sober houses. CCAR is in the process of developing certification standards and process for CT sober housing through the National Alliance for Recovery Residences (NARR). Need to ensure that residents are able to live in a drug and alcohol free environment
- Not enough halfway housing: cost/insurance, knowing where to go, how to quality
- Things that help: exercise, SMART Recovery programs, recreation
- CCAR doing amazing job – need a CCAR for adolescents
- Need 24-hour access
- Need a mandate not to turn someone away due to non-compliance

Peer Supports (see strengths above)

- Hearing Voices Network is thriving and drawing people who have been 'outsiders' to the DMHAS system
- TOIVO offers unique approaches to issues that challenge individuals with mental health challenges: Laughter yoga, Alternative to Suicide groups, etc. Alternatives to Suicide approach offers a place where people can talk about feelings of suicide without fear that someone will forcibly hospitalize them
- There is a waiting list for the Recovery University training that is required for certifying peer staff.
- Some things that several peer support staff told us that we need to do to make services more responsive were:
    - Acknowledge that people's issues and symptoms are real without defining /diagnosing them
    - People need the flexibility to meet new challenges; find ways to work outside of services instead of cramming people into the system, be unorthodox
    - Medication doesn't work for everyone
    - Trying to put a square peg into round hole hurts
- Staff who work as Recovery Assistants in the Medicaid Waiver program only get paid if they connect with the person. For people who are resistant to services, this practice discourages outreach and engagement

4. Residential, Crisis Response, and Respite

Overall Strengths: in FY 2014-5 NCRMHB conducted a review of the Region IV crisis response system and noted the following strengths: longevity and expertise of crisis team staff, integration with the local community mental health services, and in several cases, strong collaborative relationship with law enforcement, other emergency responders, and town personnel. A separate crisis response system, Emergency Mobil Psychiatric Services (EMPS) is available to children. EMPS is funded by the Department of Children and Families, can be accessed via a call to 2-1-1, and is subject to a robust evaluation system via the Child Health and Development Institute (CHDI). In addition to its provision of mobile crisis services, the state of CT has made a significant investment in specialized training in the Crisis Intervention Team (CIT) model for law enforcement and other first responders. As of this date all but 6 of the 37 towns in Region IV have CIT

trained officers. CIT promotes safety for all involved and links the person in crisis to services in the community whenever possible.

The following comments and **concerns** noted are broken up by type of service:

Crisis response

- Mobile crisis understaffed – not enough staff for territory covered. Results in long wait for a crisis or have to rely on police response
- Due to budget cuts, the hours of crisis response have been reduced
- Often people in crisis who are sent to the hospital for evaluation are discharged still in crisis and with no follow-up plan
- Mobile crisis services are not evaluated on measures involving people's experiences, nor on diversion from emergency room, from hospitalization, or from incarceration. These are measures that can indicate success but that are not currently considered.

SA Rehabilitation/Residential

- People who want treatment but can't get treatment in a timely fashion.
- Many experiences of discharge from Inpatient SA for rehab to street and then have to call every day until a bed opens up. Detox and rehab need to go hand in hand
- Many experiences of relapse while waiting
- Not admitted if no drugs in your system so people go back out and use.
- Folks just out of prison declined for services because no drugs in system. If on parole, may be discharged to Medication Assisted Recovery. If on probation, may be referred to services. But if discharged at end of sentence, there is no support; must use to get services
- Need discharge plan before accepted into treatment; no services for someone who is homeless
- Most residential programs 15-20 waitlist
- Must commit a crime to get services
- Have to show that have failed at outpatient before insurance will authorize a higher level of care
- Desire for long-term care because can't stay clean on own
- Insurance has a cap how many times you can go to rehab
- In Danbury and Willimantic - can go to sobering center while waiting for a spot in rehab, but no one was aware of a similar service in Region IV
- It is hoped, with the merger of InterCommunity and the Alcohol and Drug Recovery Center, that a stronger continuum of care has been created in portions of Region IV.
- Inadequate reimbursement rates for residential treatment services make it difficult for providers to maintain services and qualified staff.
- Loss of beds due to cuts in the Court Support Services Division budget is expected to have a very negative impact.

MH Residential

- There are no options in between group home and independent living, no middle ground w/o crash & burn
- Not enough group homes, respite, and recovery apartments

- Need transitional/crisis stabilization housing/options for interim & higher levels of care
- Concerns for people who have always lived with family when family begins to decline
- Lack of residential options results in longer wait time in hospital
- Lack of capacity for young adults at Central Valley Hospital (CVH)
- Several people described negative experiences in DMHAS funded residential settings, i.e., residential housing sucks, staff lack empathy, some are abusive, not enough staff, staff not qualified, not well trained, lack sensitivity, high turnover
- Most residential programs 15-20 waitlist
- Need group homes with greater programming flexibility than Medicaid Rehab Option (MRO) group homes
- Not aware of options and sometimes staff don't know
- People falling thru cracks. Leads to poor quality of life, decompensation, relapse, use of ER, self-medication

Respite

- Lack of respite care available
- Need for peer respite options that are not connected to the service delivery system
- Where a person can get real rest and have their stay be private
- Peer respite program is Western Massachusetts is very successful - staff have lived experience – very valuable for recovery
- Not enough respite for what intended used for long term stays because nowhere else to go
- One person stated the staff she encountered in respite were unprofessional and rude

5. Inpatient Treatment

Overall Strengths: Community Care Teams that have formed around most of the Region IV hospitals were seen as a positive step for addressing the needs of people who frequently rely on emergency or inpatient treatment, however efforts to adequately fund those teams have been unsuccessful.

The following comments and **concerns** noted are broken up by type of service:

MH Inpatient

- Can't get inpatient – long wait in ER and not getting any service.
- ER will discharge instead of referring for services
- Need help and support at the initial event to get us on the right track quickly to prevent wasted time, money and a worsening condition.
- Hospital stay is only about getting on right meds, outlet to clean up quickly, stop gap, "give them a pill and send them out." Repeat visits to ER without receiving proper treatment leads to a revolving door
- Not there long enough to see full effect, premature discharge
- Doctors don't listen, especially when trying to talk about side effects
- Sometimes meds make worse and doctor doesn't listen
- Cut back on groups – too much free time, CT Valley Hospital (CVH) groups not helpful

- Visitation very limited 7-8pm
- No coordination between hospital and housing services
- Understaffed/overworked
- Lack of connection between inpatient and outpatient - no referral, no resource info

SA Inpatient

- Lack of immediate/in time access to inpatient substance abuse treatment
- Insurance won't pay for multiple detox
- People who can't get help re: state or private insurance or lack thereof, co-pay costs
- No choice of treatment. People going home without being treated at all
- Turned away from inpatient treatment if have been there too many times
- Not enough beds. Can't get in/once in, can't get appropriate care, dumped out, only getting worse
- Employed SA patients have difficulty relating to unemployed peers when in detox programs. Unemployed people collecting funds from state are not motivated in the same way. Insurance cost dictates which facility to send you.
- Eligibility of some SA programs dependent on methadone dosage or whether taking psych meds
- Some won't take people if on certain meds i.e. benzodiazepine or methadone
- ED overnight, then released with no discharge plan.
- When ready and in need of detox there are no beds; told to call back. Leads to relapse, revolving door in hospital
- People being told 'not sick enough' need to fail detox more
- Folks using more substances to get treatment. Potential for overdose
- Have to commit a crime to get a state bed
- People are being discharged before the drugs are out of their system.
- Need for coordination. Lives saved after overdose with Narcan, then what?
- Need to offer Medication Assisted Treatment in ER. Can give Suboxone, but not methadone
- Need for aftercare post inpatient – not a strong connection made to follow up

C. <u>Gaps:</u>

The following were identified as special populations for whom additional gaps or barriers exist

- Older adults, especially those who are homebound, lack transportation, have serious medical issues or physical challenges
- Middle aged adults who have lived or maintained strong ties with their families all their lives and whose families are declining. In addition to their own mental health challenges, they are now struggling to address the care needs of their declining parents, facing the unknowns of being without family support, and finding no support in their new role as caregiver.
- People with hoarding disorders
- People with autism, traumatic or acquired brain injury (TBI/ABI), or cognitive impairments seem to fit nowhere in the service system, provider community is not trained/equipped to handle
- People with hearing impairments

- People with co-occurring MH disorders with other disabilities or complex medical conditions
- People with MH disorders who don't want to receive treatment alongside others with serious addiction.
- We need better mechanisms to check in with people who drop out or decline services and are at risk in the community.
- People who live in rural communities where access to behavioral health is limited due transportation barriers.
- Adolescents
- Parents with MH or SA challenges trying to maintain their families and/or custody
- People who face language or cultural barriers to accessing care
- Minority and LGBTQ youth and young adults
- People with high deductibles or with health insurance plans that are not widely accepted

D. Emerging/Rising Issues:

The following were noted as emerging or rising issues that require our attention

- Opioid Epidemic: Prescription opioid deaths are now outnumbering fatal heroin overdoses. Young people are becoming addicted to substances, notably opioids at very young ages. Several key pieces of CT legislation passed during the 2015-16 session that promote greater access to Narcan, limit initial prescriptions for opiates to 7 days, and increase prescriber capacity for Medication Assisted Treatment. At least one Region IV community is exploring the establishment of an "angel program," offering access to treatment in lieu of arrest as a means to carry on their war drugs. The Governor's Alcohol and Drug Policy Council has been re-constituted and, in partnership with Yale, is in the process of developing recommendations and a CT strategic plan.

- Problem Gambling: With Keno and gambling expanding across vulnerable communities, CT needs to ensure earnings are reinvested to help prevent and address problem gambling issues.

V. Recommendations

The CT Alcohol and Drug Policy Council is in the process of forming a Strategic Plan and priorities for addressing the Opiate crisis. We must ensure the public is aware of proposed strategies and takes advantage of opportunities to provide feedback. We must advocate for funding and policy changes that help move the plan forward. We need to continue and expand upon community education and prevention initiatives in a broad range of community settings. We need to continue efforts to improve access to life-saving Narcan, timely and effective treatment options, and safe limits for prescription painkillers.

Given large minority and immigrant populations in some of our communities, we must increase our efforts to ensure health equity in all health-related work. Issues of translation, interpretation, workforce diversity, and cultural sensitivity all play a role in creating healthier communities. Without dedicated resources for translation and interpretation, many people who need behavioral health services are essentially without access. Additionally, while a more diverse workforce can help with creating more culturally competent services, we should not assume that matching people of similar ethnic backgrounds is the only or even best

way to establish therapeutic relationships. It is important that all providers are trained in cultural sensitivity. Statewide efforts by Access Health CT and the State Innovation Model (SIM) initiative are also focused on health equity. Starting July 1, 2016 NCRMHB will be working with SIM's Consumer Advisory Board outreach and engagement efforts with addressing health equity and behavioral health as top priorities.

As described in above in the sections on Region IV demographics and service gaps, CT has a growing population of older adults who experience a unique set of gaps and barriers for addressing their behavioral health needs. Much work has been done by the Older Adult Behavioral Health Workgroup to understand and address the needs of this population. Much of that work was led by a DMHAS staff person who has since retired from her position. It will be critical for DMHAS to continue its leadership in the workgroup and help move its agenda forward.

In increasing numbers, individuals experiencing mental health challenges are seeking non-traditional and non-clinical approaches for finding and maintaining recovery. Our system must become flexible in its work with people as they explore and find avenues that best meet their needs. We must address licensure, regulations, and reimbursement issues that limit the use of peers and recovery coaches in that work. We need to explore more and varying types of support to help people secure and sustain employment. We must find better ways to reach out and engage our communities, including faith communities and leaders of diverse ethnic and cultural groups. We need to develop a greater presence and visibility of resources available in neighborhood centers and community sites where people live. We need alternatives to Emergency Room (ER) or Inpatient Psychiatric Care (i.e. peer run respite) for emerging behavioral health crises.

It is important to note that most of the feedback obtained for this report was obtained prior to a second round of devastating budget cuts for non-profit providers, so many of these impacts were yet to be felt. We must all be vigilant about paying attention to and reporting these impact of service reductions on vulnerable people, especially those listed above who are already facing gaps and barriers due to special circumstances or needs. Funding cuts to state agencies other than DMHAS will also affect our constituents. We need to shore up relationships between state agencies and sources of on-line navigation assistance. There should be no wrong door for people seeking services or information.

CT is the recipient of an Innovation Accelerator Program (IAP) technical assistance grant to help us align policies and funding between Medicaid, disability services and housing agencies to maximize affordable and supportive housing opportunities. As DMHAS is a partner in this effort, we are somewhat hopeful that this initiative will provide a means to address the needs of some of our constituents who are highly vulnerable (high utilizers of health care services and people with disabling conditions who need a robust set of services linked to housing in order to be successful in the community) but do not currently meet the criteria for chronic homelessness.

DMHAS is currently leading a grant-funded Policy Academy team, working to transform the adult crisis response system. The goals are for persons in distress to 1) have immediate access to a continuum of crisis response services of their choice, including clinical services, peer services, and community supports; and 2) to expand the role of peers as support providers and further develop partnerships with mobile crisis teams, community leaders, faith communities, law enforcement, and others to provide a full continuum of crisis response. NCRMHB is pleased to be working with CT Policy Academy team and is hopeful that many of the recommendations from our 2014-15 crisis response system evaluation report can be addressed within the goals of this project. We hope for DMHAS's continued support to move this initiative forward.

VI. Closing Remarks

We thank DMHAS for this opportunity to involve recipients of mental health and addiction services, family members, providers, referral organizations and concerned citizens in this priority setting process. There is a strong desire on the part of RMHBs and RACs to ensure that this process provides the needed information to DMHAS that will help set priorities and inform the budget. There was much time contributed and earnest thought among survey, focus group participants and key informants that their participation would make a difference. We look forward to working with DMHAS going forward in order to clarify and promote the recommendations contained in this report.

Appendix A: 2016 Priority Setting Grid and Definitions

Dimensions	**Mental Health Core Services**				
	Inpatient Services (psychiatric, forensic & enhanced security)	**Outpatient Treatment** (PHP, IOP, forensic community, ACT, case management, care coordination, behavioral health homes, outreach & engagement, & community support)	**Residential, Crisis & Respite Services** (group homes, transitional, sub-acute, mobile crisis, CIT, respite, and intensive residential)	**Recovery Support Services** (housing & housing supports, supportive housing, supervised apartment, peer services, advocacy, social rehab, voc rehab, supported employment & transportation)	**Education, Research & Prevention** (supported education, staff training, suicide prevention, violence prevention)
Awareness: I know these services exist.					
Capacity: I can get these services without a long delay.					
Accessibility: I can get these services without facing barriers.					
Services Match Needs: The specific service I need is offered.					
Gaps: Services for all special populations are offered.					
Workforce: Staffing (numbers and training) is adequate for these services.					
Coordination: There is communication and coordination between this and other services.					

Scoring: Place an Ø in any boxes in which the service is inadequate along the dimension indicted
Place an X in any boxes in which the services are good

Dimensions	Substance Abuse Core Services				
	Inpatient Services (medically managed & monitored detoxification)	**Outpatient Treatment** (IOP, MAT, ambulatory detox, case management, & community support)	**Residential, Crisis & Respite Services** (intensive, inter-mediate & long-term residential, & halfway houses)	**Recovery Support Services** (recovery houses, peer services, advocacy)	**Education, Research & Prevention** (staff training, tobacco retailer compliance, violence prevention, substance use prevention)
Awareness: I know these services exist.					
Capacity: I can get these services without a long delay.					
Accessibility: I can get these services without facing barriers.					
Services Match Needs: The specific service I need is offered.					
Gaps: Services for all special populations are offered.					
Workforce: Staffing (numbers and training) is adequate for these services.					
Coordination: There is communication and coordination between this and other services.					

Scoring: Place an Ø in any boxes in which the service is inadequate along the dimension indicted
Place an X in any boxes in which the services are good

PRIORITIZATION OF AGENCY ACTIVITIES
SUBMITTED BY DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
TO THE OFFICE OF POLICY AND MANAGEMENT (OPM)

JUNE 2016

Inpatient Services

Inpatient services include acute psychiatric inpatient, intermediate duration acute psychiatric inpatient, forensic maximum and enhanced security inpatient, substance abuse inpatient rehabilitation, medically managed detoxification, and medically monitored detoxification.

Outpatient treatment

Outpatient treatment includes mental health and substance abuse outpatient clinical services, partial hospitalization (PHP), intensive outpatient, medication assisted treatment (MAT), ambulatory detoxification, forensic community services, assertive community treatment, case management, care coordination, behavioral health homes, outreach and engagement, and community support

Residential, Crisis, and Respite

Residential, crisis, and respite services include group homes, transitional residential treatment, sub-acute programs, mobile crisis programs, crisis intervention teams, respite services, intensive residential treatment, intermediate or long term residential treatment, long term residential care, transitional living and halfway houses, and intensive residential enhanced co -occurring treatment.

Recovery Support Services

Recovery support services include housing and housing supports, residential support, supportive housing, supervised apartment programs, recovery houses, peer based services, advocacy programs, social rehabilitation, vocational rehabilitation, supported employment, and transportation.

Education, Research, and Prevention

Education services include supported education, staff training, and services DMHAS is required by law to provide to eligible residents between the ages of 18 and 21 in DMHAS facilities. Research investigates issues of policy relevance in the mental health and addictions fields. Prevention services promote the overall health and wellness of communities and individuals across the lifespan with areas of focus including tobacco retail compliance, violence prevention, alcohol and drug prevention, and suicide prevention.

Appendix B: 2016 Priority Setting Process Grid - Summaries

Dimensions	Mental Health Core Services				
	Inpatient Services **60**	**Outpatient Treatment** **63**	**Residential, Crisis & Respite Services** **79**	**Recovery Support Supports** **87**	**Education, Research & Prevention** **19**
Awareness: 16 2,2,3,5,4	*16-1 R-1	16-1 R-1	18-1 19-1 R-1	15-1 16-1 T-2 R-1	18-1 19-1 HC-1 T-1
Capacity: 99 23,17,29,29,1	15-3 16-2 19-6 23-6 M-2 T-3 R-1	16-3 17-2 19-4 23-2 M-4 T-1 R-1	15-2 M-4 16-2 T-3 17-3 R-1 19-3 23-8 HC-3	15-1 M-4 16-4 T-2 17-2 R-1 18-4 23-8 HC-3	19-1
Accessibility: 80 18,19,19,19,5	15-2 16-3 17-5 23-5 T-3	15-4 16-2 17-6 19-1 23-2 T-4	15-3 M-2 16-3 T-1 18-4 R-1 19-1 HC-4	15-4 T-3 17-2 18-3 19-1 23-2 HC-4	17-1 18-1 19-1 T-2
Services Match Needs: 12 1,4,2,3,2	19-1	15-1 17-2 18-1	15-2	15-1 17-1 R-1	15-1 19-1
Gaps: 58 12,11,18,12,5	16-6 18-5 R-1	15-3 HC-1 16-1 M-1 18-2 R-1 19-1 23-1	15-1 HC-2 16-6 M-3 17-1 R-1 18-2 19-1 23-1	15-3 16-2 19-3 23-2 HC-1 M-1	15-3 R-2
Workforce: 45 **4,10,8,19,4**	16-1 19-1 T-1 R-1	16-1 17-1 18-2 19-1 T-2 R-3	16-3 HC-2 T-2 R-1	15-2 16-2 17-2 18-2 19-7 HC-2 T-1 R-1	15-1 19-2 R-1
Coordination: 20 5,5,2,5,3	15-2 23-2 R-1	15-3 M-1 R-1	15-1 R-1	15-1 16-1 17-1 18-2	18-2 23-1

Dimensions	Substance Abuse Core Services				
	Inpatient Services **29**	**Outpatient Treatment** **24**	**Residential, Crisis & Respite Services** **46**	**Recovery Support Supports** **13**	**Education, Research & Prevention** **11**
Awareness: 6 0,1,3,0,2		18-1	M-1 T-1 R-1		17-1 18-1
Capacity: 50 17,6,21,6,0	16-5 19-6 23-1 M-4 T-1	15-3 16-1 19-1 M-1	17-4 18-2 19-4 23-5 M-3 T-2 R-1	18-2 M-3 R-1	
Accessibility: 30 6,11,12,0,1	15-2 16-1 17-2 23-1	15-2 16-1 18-6 19-2	15-3 16-2 17-2 19-3 T-1 R-1		17-1
Services Match Needs: 6 1,1,3,0,1	R-1	19-1	15-1 17-1 18-1		R-1
Gaps: 8 2,2,3,1,0	16-1 HC-1	15-1 M-1	15-1 16-1 R-1	15-1	
Workforce: 8 0,0,3,2,3			16-1 T-1 R-1	15-1 23-1	17-3
Coordination: 15 3,3,1,4,4	15-1 19-2	15-3	15-1	15-1 16-1 18-2	17-1 18-3

*Numbers 15, 16, 17, 18, 19, 23 Refer to CAC numbers
HC = Hartford Collaborative
M = Manchester Continuum of Care Workgroup
T = TOIVO Warm Line Staff
R = NCRMHB Regional Consumer Advisory Council

Appendix C: Region IV Provider Survey

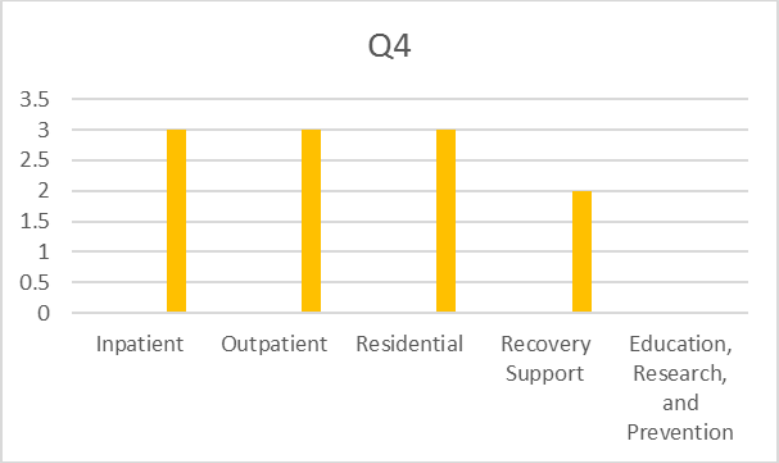
Q2: Organization

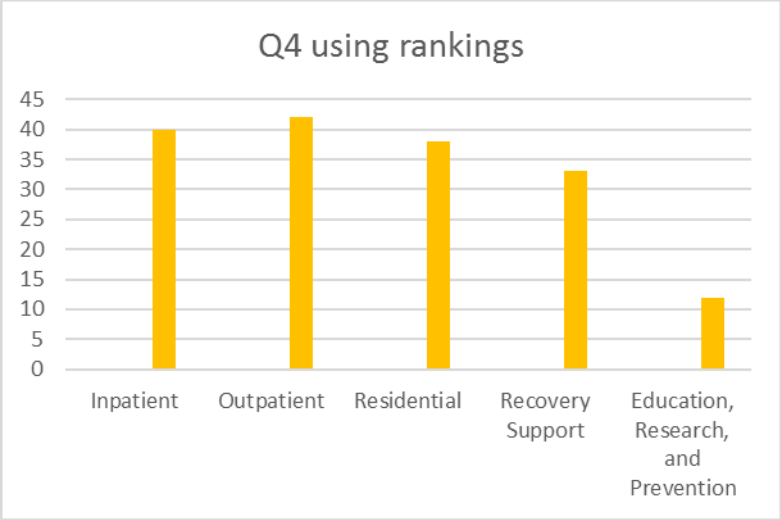
Catholic Charities
InterCommunity
Chrysalis
Farrell Treatment Center
Hartford Dispensary
Wheeler Clinic
Stafford Family Services
Mercy Housing
CT Community for Addiction Recovery (CCAR)
Hartford Hospital/Rushford/Institute of Living
Youth Challenge of CT

Q3: Critical areas to protect

Community Services – outpatient, residential and vocational supports
access, case management, employment, recovery services, health and wellness
Evidence Based Practices; Medication Assisted Recovery Programs; Peer Support Services
Ensuring clients have immediate and ongoing access to community clinical services, including psychiatric, in addition to the recovery supports needed for sustained recovery.
Access to all levels of treatment for mental health and addiction (includes programming and transportation); housing for transient people; funding for insurance and medication
I am very concerned with the amount of services that are being cut and with the looming budget concern it only points out that more are coming. Mobile Crisis is 9-5 Monday through Friday, Housing services have been cut. Employment services cut and the list goes on.
access to addiction treatment and community based recovery support
Tx. beds for individuals with substance abuse disorders Community Support Programs /Vocational programming
Due to the rise in substance use and the opiate addiction and treatment needs, further cuts to substance abuse and mental health services are critically impacting our ability to provide services to those most in need. Our population of clients are no or low-income clients who are not able to seek treatment on a fee-for-service or able to afford co-pays so it is critical that DMHAS continues to provide reimbursements to these clients.

Q4: Rank Priorities

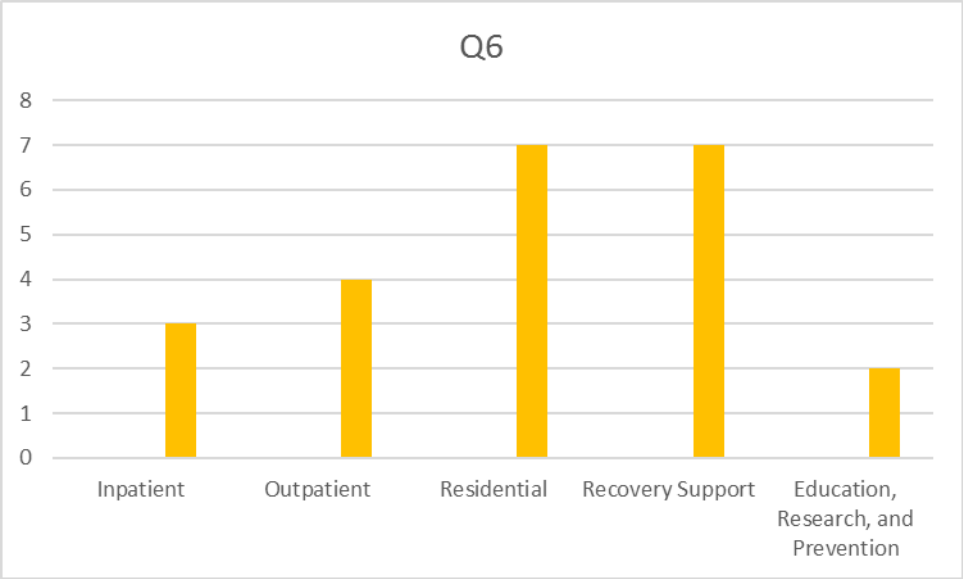




Q5: Is anything missing?

Employment Support, Health and Wellness and other prevention initiatives
Encourage physicians in becoming certified in Suboxone and have them join non-profits. Not everyone will go to a methadone maintenance program.
Medication Assisted Treatment Evidence Based Practices
Prevention activities need to be targeted at the younger than DMHAS served population - no description of coordination with DCF and SDE regarding health curricula and early education.
Job services, more outpatient addiction services
1) support for young people and families struggling with alcohol and drug addiction 2) MAT is only a partial 'response' to the overdose problems and it is only that for SOME people. We must improve access to counseling and peer recovery support, while budget cuts already threaten what exists.

Q6: Critical areas that most need to be strengthened in order to meet changing circumstances



Develop Actual systems/continuums of care.
Job services, more outpatient addiction services

Q7: In what parts of the behavioral health system do we need to do things differently?

Increase support for care coordination in grant funded agencies
better support and initiatives around community integration and wellness
Transitions of care from higher to lower levels of care; further integration of primary and behavioral health care
Better coordination with inpatient, IOP and outpatient (continuum of care); access and transportation for rural clients; increase in psychiatrists serving the indigent population
We have services that are located outside the areas that need the services. We don't need huge building away from the neighborhoods in need smaller outpatient units located where the most need is working with local providers in collaboration to enhance services. Creating a team approach to a services enriched area.
The term 'behavioral health' needs to change - it misleads the public about the reality of the illnesses and conditions people face and increases stigma and discrimination. This term leads people to believe that behavior is the problem. Do we walk around saying we have 'behavioral HEALTH'?
Since the change in policy about catchment areas allowing individuals to go to whatever service system they choose, there is a competitive atmosphere that is not conducive to the financial times we are in. It would be great if DMHAS could take the lead on pulling providers together to discuss how we can work more collaboratively.
Reimbursement rates for residential treatment services have not received any increases in years, therefore it makes it very hard to providers such as Youth Challenge of CT to maintain services and qualified staff.

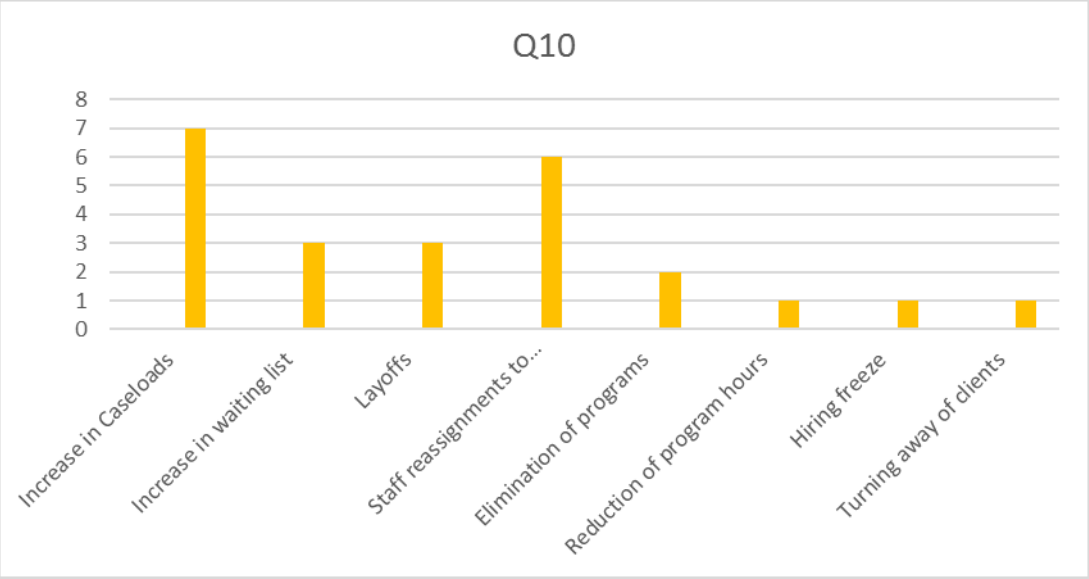
Q8: What models should we consider?

enhancement of DMHAS recovery model, SAMSHA wellness model, supportive employment with robust job development activity
We needed to have an honest conversation between DSS, DMHAS and DPH to look at barriers to treatment (including low reimbursements for care).
Seamless Systems of "NO Wrong Doors"; Continuums rather than silos;
Care coordination/management, integrated primary/behavioral health
I like the model of Pathways in NY city minus the Master leasing this can be obtained in Ct. by the state and local providers working together. A great example is the Hope team in Hartford. With Clinical Case Managers working in the local Shelters being supervised by local providers while having a clinical supervisor at Capitol Region. We now have a way to find clients and to assess the need at the local area. Because they now speak the same language

Q9: Current or new populations most difficult to serve

aging, medically compromised, young adults
Politicians
Individuals with co-occurring mental health and substance use disorders + complex medical conditions
Marijuana users ages 14 - 18; single people in their late teens/early 20s; elderly population with combined mental health, addiction and physical challenges
Elderly and Children aging out of DCF
young people who are becoming addicted to substances, notably opioids, at very young ages: we need to find ways to address this much earlier and more effectively
Clients with co-occurring treatment needs.

Q10: Impact of recent budget cuts



Q11: Additional details

Just wat to say the work load on the state providers with less and less resources is very difficult
DOC cut led to elimination of an entire program
Lost about 125 beds in our local area this will have a huge this is a huge impact on the people seeking shelter
WE had 5 total beds that we had contracted for through CSSD. # were intermediate LOS and 2 were detox. While we will easily be able to refill those beds, it may not always be with CSSD clients. It is a step backward in terms of giving people who have been in adjudicated from having a "preferred" access to very limited beds.

Q12: Emerging Issues

Reduction in eligibility for Medicaid means that clients are going to be uninsured or insured with high deductibles. And they will not engage in treatment until they are in an acute state
Medicaid billing for supportive housing, young adult employment, health issues and wellness
There is a strong emphasis on MAT (rightfully so); however, not all addicts need MAT's. Physicians need to become certified in Suboxone and the state needs to adequately reimburse providers.
Increase in heroin/opiate addiction -Increase in individuals presenting with co-occurring mental health and substance use disorders + complex medical conditions
Increase in housing issues, lack of access to psychiatrist; increase in marijuana use (and quantity) in teenagers
We now have a population getting older and if you add living with Mental Illness I would say that we are not prepared for this emerging impact of this population.
The worry at this point is that further cuts will be to core programs and that will impact the whole system.
Lack of detox services and beds, which does not allow clients to be eligible to receive residential services

Q13: Data

There is a plethora of data already; the real issue is funding. Doing more with less is now impacting good clinical care. Unfunded mandates are straining providers.
Access to real-time hospitalization/ER utilization data is needed.
ER visits that result in hospitalization or other referrals; EMPS data (child and adult); school-based health centers; survey of senior center staff recommendations for their clients
More DATA collected the DATA we now have needs to be studied and the information given to providers for future planning.
Data should measure effectiveness of services.
Track how many clients are in need of detox, but are turned away because of lack of detox beds. Length of stay in detox has been reduced which does not allow detox and long-term substance abuse treatment success.

Q14: Additional Comments

We want to thank the Commissioner, and her team, for how hard they have worked to minimize the impact on grant funded programs. We are grateful for the acknowledgement of the value of the services that we provide.
Wellness is at the center of all recovery. DMHAS should adopt and fund initiatives that support the SAMSHA model which is outlined in detail on their website
State needs to do a better job of accessing Federal Dollars.
Seek opportunities to privatize state-operated community and outpatient services.
I appreciate the support from DMHAS, as they struggle to manage budget cuts that were handed to them to accomplish.

Appendix D: Region IV Social Services Directors Survey

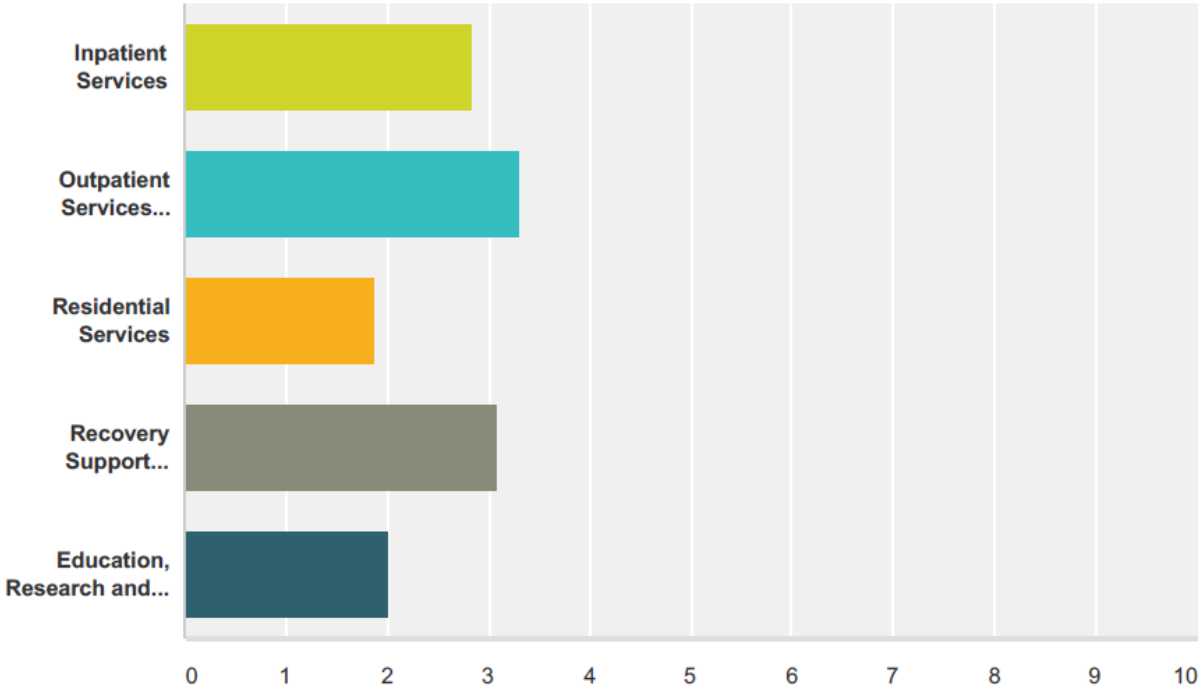
Q1: Town

Simsbury
Somers
Newington
Enfield
Bristol
Rocky Hill
East Hartford
Glastonbury
Suffield
Tolland
Ellington
Windsor

Q2: Critical areas to protect

Outpatient support and residential services are crucial. Upon discharge from inpatient settings, clients require assistance to reintegrate to the community and significant support to remain connected to treatment and outpatient services.
Assertive outreach, education, earlier identification and access to services. Long term wrap around ongoing support/services needed. Follow up especially with those vulnerable in often stopping their stabilizing medications
residential & support programs addiction & recovery services employment assistance programs
inpatient services, outpatient, residential, crisis response and respite, and recovery support services including supportive housing.
Home based services, outpatient providers, addiction services for all ages
Outpatient treatment
24-hour mobile crisis service and access to child/adolescent psychiatric care
Access to transportation and housing -Supportive housing services
access to timely behavioral health resources, which even now is a struggle, especially for low-income residents and those who may have serious but non-life-threatening issues.
Mental health services for youth Regional site locations that provide services are not closed
Substance abuse treatment, ensuring there are adequate community supports, housing, sober houses, in home counseling for older adults with mental health diagnoses and substance abuse issues

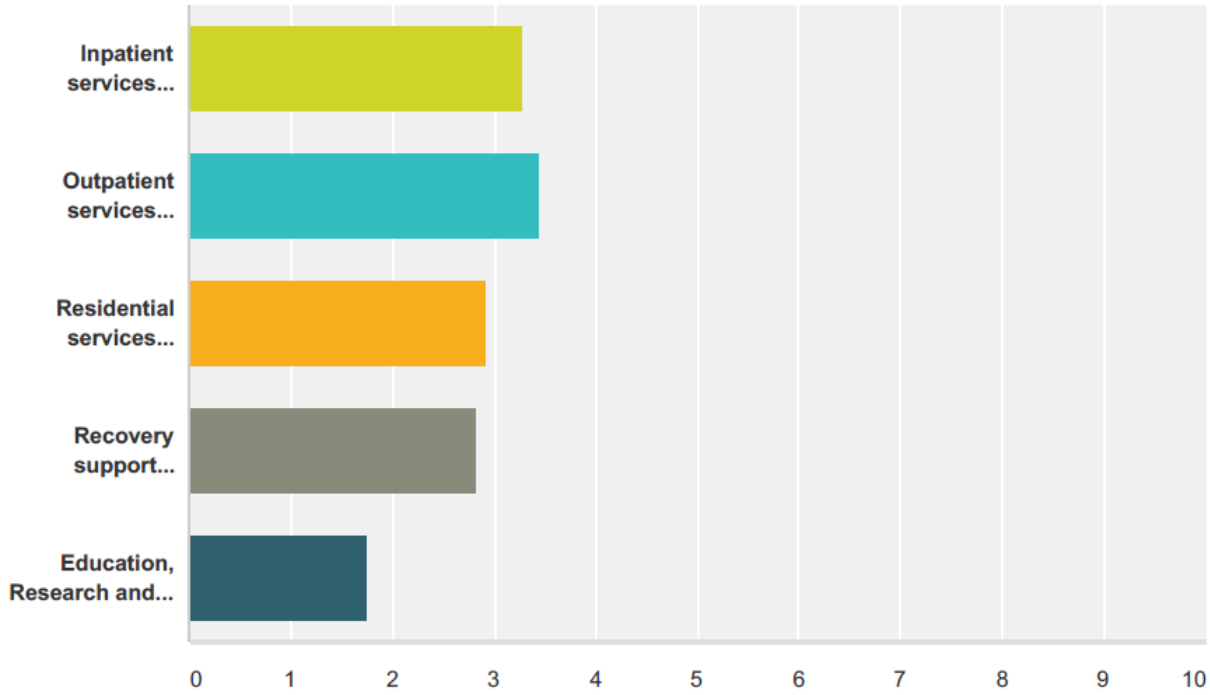
Q3: Rank Priorities – Mental Health



Please comment on your choices above

We need enhanced long term follow up so folks maintain stability longer 7/15
Housing and stabilization first.
survey would not allow me to rate other categories?
To have supportive services to assist in relapse prevention either in the community or residentially is very important. The work of recovery seems half done at D?C from acute hospital stay or detoxification stay.
Inpatient services and follow up support services along with education and prevention are needed and required. Supportive housing is too high in demand and not enough of to be a major factor, other options must be considered.

Q4: Rank Priorities - Addiction



Please comment on your choices above

All of these services are crucial. Cuts to outpatient/residential/recovery support services will only result in an increase in inpatient services.
Again, long term, ongoing wrap around services/support needed
Constant community information is essential as it is the community who will be the support for these residents who have MH & addiction challenges

Q5: Is anything missing?

capacity-building for providers re: culturally-relevant services/practices & research-based best practice
Outreach
home based services for children, adults and families given the lack of beds and services from those affected by mental health and addiction issues
Better coordination of services for consumers who are in different points in their recovery. Better communication of behavioral case managers and community resources. Clear guidelines for those assisting consumers from outside the DMHAS network. "who gets what services and when"
Consistent, long term counseling programs with more emphasis on individual counseling.
In home counseling

Q6: Critical areas most need to be strengthened in order to meet changing circumstances

Low cost treatment or treatment covered by Title 19
Housing options need to increase for those who are returning to the community from inpatient settings.
Reduction of stigma and discrimination. Reduced out of pocket costs
recovery & transition services related to the Opioid crisis
Stabilization, a bed; more coordination and a smooth transition from detox facilities to inpatient treatment and recovery. Then, residential sober houses with professional support.
They are all equally important however if we cannot access a bed for a client who needs detox or hospitalization it is challenging to focus on longer term needs
wrap around services longer term intensive outpatient (including family treatment)
More emphasis on recovery should be married with community responsibilities for residents with mental health and addiction challenges.
More timely and accessible outpatient and supportive services
Counseling services, both in-patient and out -patient.
more detox & rehab together. I know some people who go through detox then have to wait to get into rehab... not good.

Q7: In what parts of the behavioral health system do we need to do things differently?

Community support
aftercare follow up and assertive outreach
FUNDING!
Immediate response teams, outreach and transition to services.
communication throughout processes with referring providers and follow up care
Normalize inclusion of community service providers in care planning for recovery.
Better assessment at entry into in-patient
more in home services, and ongoing in home community supports

Q8: What models should we consider?

Return to case management models
More organized advocacy
Supportive housing seen as a community supportive model. Provide housing subsidies with wrap around services...

Q9: Current or new populations most difficult to serve

Low income population
Services for individuals with behavioral health issues ONLY without co-occurring substance seems to be lacking.
Those with language and/or transportation barriers, lack of family support, homeless/moving often, those lacking insight into their illness/es
immigrant populations & minority youth
Dually diagnosis - or undiagnosed - refusing medical attention. No diagnosis, no housing services!
having enough providers, specifically that take Husky Insurance

Homeless
Adolescents and their families in immediate crisis and families with limited financial resources
Chronic addiction coupled with MH needs. Treatment communities such as 90 days plus (serenity Glen) are very difficult to access yet can be the option that is best suited for the clients in unbroken cycle of detox and using.
those with high deductibles or with health insurance plans that are not widely accepted
Youth and the elderly who are more often misdiagnosed. 6/28
Older adults

Q10: Impact of recent budget cuts

none yet, but anticipate impact 7/22
Decreased community supports/case management services.
Same folks continue to rob from Peter to pay Paul. People feel even less supported and more discriminated against.
increased homelessness & related social impacts addiction relapses & related heroin ODs
Little access to inpatient service - give them a pill and send them out. Repeat visits to Emergency Rooms without receiving proper treatment; thus, the revolving door. Need for a respite center for people under the influence seeking treatment.
loss of basic needs, increased anxiety and depression and willingness to ignore self-care. Self-medicating and addiction trends are up with my clientele
Availability of services
longer wait times to access services
If seems like there is less follow up by MH and addiction clinics of patients after acute treatment.
We're not seeing the impacts yet, but we know they're coming
Have not noticed any changes yet
Aren't able to access treatment for detox & rehab

Q10: Data

It is important to continue to show the correlation between decreased community support and increased inpatient hospitalizations.
CCEH homelessness data heroin-related deaths
Hospital Critical Care Team data on mental health and substance abusing patients.
statistics on Heroin use, reported Hoarding cases and overall referrals to mental health providers
turn around visits to Detox- time in between and what f/u services have been mandated by courts

Q11: New or emerging issues impacting people with behavioral health needs

Opioid addictions
Not really new or emerging, but emergency shelter placement is near to impossible these days and even more difficult for folks with behavioral health needs.
hostility in the community increasing, perhaps because of the current political rhetoric?
Opioid/heroin addiction; erotica websites that are a source of income for the "unemployable" and prey on their vulnerability; marijuana overdose by children/teens

co-pay costs, lack of available providers that accept state insurance, heroin use, hoarding (not new issues just continuing to rise)
social media addiction
Not enough supportive housing for those transitioning from youth to adulthood. Once youth reaches 18, parents /guardians want them out of home. Often they end up on the street.

Q12: Additional Comments

We need SROs with supportive services. Convert the closed nursing homes!!!
Explore additional federal revenue generation options with the Congressional delegation
Part of tax on cigarettes and alcohol needs to go directly to YSB and mental health agencies.

Appendix E: Priority Ranking Matrix

Priority Rating Scale: 1=Lowest 2=Low 3=Medium 4=High 5=Highest

Priority Issue	Magnitude (Burden of problem) A relatively large number of people are affected	Severity/Impact (Depth of problem across dimensions) The social (i.e., health, economic, criminal justice) costs are high	Changeability (Reversibility) The indicator is amenable to change and services are available to affect change	Readiness /Capacity The community is ready and has the capacity to address this priority	Total	Individual Ranking	Magnitude/Severity Ranking	Average
MH Outpatient	24	25	23	20	92	2	2	92
SA Outpatient	24	25	23	20	92	2	2	
SA Education, Research, & Prevention	24	24	24	21	93	1	3	89
MH Education, Research, & Prevention	23	23	22	17	85	3	4	
MH Recovery Support	25	25	20	15	85	3	1	77
SA Recovery Support	22	13	17	16	68	6	7	
SA Residential	20	20	20	15	75	4	5	75
MH Residential	19	17	23	15	74	5	7	
SA Inpatient	21	21	15	10	67	7	6	57
MH Inpatient	16	11	11	8	46	8	8	

Top 3 priority areas for Region IV: 1) Outpatient Services 2) Education, Research & Prevention 3) Recovery Support Services

Appendix F: Demographics by Municipality

Town/County	Population	% White	% Black or African - American	% Asian Pacific	% Hispanic or Latino	% Other/ Multi-race	% 65 and over	% Below Poverty rate	% Un-employed	% In subsidized housing
Connecticut[4]	3582053	68.2	11.6	4.6	15.4	7.9	15	10.5	6.6	4.7
Hartford County	987374	58.7	12.1	4.2	14.7	8.1	15	12	6.9	5.4
Avon	18298	87.5	.4	8.3	2.6	2.1	17	4.4	4.4	1.5
Berlin	20352	92.4	1.0	3.2	2.8	1.2	18	4.1	5.2	3.4
Bloomfield	20626	34.1	55.2	1.9	5.2	6.3	25	7.9	7.3	5.1
Bristol	60556	82.2	3.2	2.0	10.7	6.0	16	9.6	7.3	5.8
Burlington	9443	94.3	1.0	3.0	2.0	.9	11	4.5	4.8	1.1
Canton	10334	91.6	.5	.9	6.0	3.1	16	3.1	4.7	3.2
East Granby	5098	85.0	6.2	3.4	3.6	2.0	16	2.7	4.9	2.1
East Hartford	51211	30.5	25.1	5.7	29.1	15.8	13	14.3	8.5	7.2
East Windsor	11353	75.1	8.0	6.8	6.3	7.6	14	6.0	6.6	6.5
Enfield	44713	79.5	5.8	2.4	8.3	5.3	16	8.0	6.3	4.8
Farmington	25515	83.0	2.2	9.5	3.0	3.0	17	5.8	4.6	3.5
Glastonbury	34661	83.2	2.4	11.5	3.9	2.6	15	3.7	4.5	2.2
Granby	11,310	92.2	1.1	1.0	3.2	2.5	16	2.5	4.6	1.2
Hartford	125,211	15.9	38.0	2.5	43.6	23.3	10	34.4	12.2	15.7
Manchester	58270	62.5	12.7	8.5	15.1	7.2	13	11.6	6.5	6.5
Marlborough	6428	93.8	1.3	.5	4.1	2.1	15	.8	5.1	.8
New Britain	73095	46.5	10.8	3.1	10.8	19.9	12	23.5	9.5	9.0
Newington	30652	78.5	5.6	6.1	8.4	5.4	19	4.9	5.4	3.6
Plainville	17791	87.2	3.4	1.9	7.3	2.5	17	8.8	6.3	3.4
Rocky Hill	19838	77.1	2.7	10.7	6.8	4.3	16	7.8	5.0	2.2
Simsbury	23681	88.0	2.4	4.5	5.0	2.5	15	3.1	4.4	1.4
South Windsor	25795	77.9	5.1	10.3	5.6	3.0	16	4.0	5.2	2.8
Southington	43509	92.5	1.2	2.1	3.4	1.5	19	4.4	5.5	2.3
Suffield	15764	79.6	10.0	1.7	6.2	5.8	14	5.8	5.4	1.9
West Hartford	63396	74.4	7.1	6.6	9.9	5.6	17	7.9	4.7	3.2
Wethersfield	26579	80.4	4.4	3.9	10.6	5.0	21	5.3	5.7	3.7
Windsor	29130	48.0	37.7	3.8	8.1	6.5	16	5.7	6.4	3.0
Windsor Locks	12554	81.5	4.5	7.7	4.3	2.4	17	6.5	6.3	3.8
Litchfield County	187542	90.5	1.6	1.8	5.0	3.0	17	6.8	5.9	2.9
Plymouth	12085	93.1	1.1	.3	4.4	3.7	13	6.9	7.8	3.5
Tolland	152251	86.7	3.0	3.5	4.7	3.8	13	6.6	5.6	3.2

[4] US Census Quick Facts Connecticut

County										
Andover	3181	91.4	2.8	1.2	1.5	3.6	13	3.7	5.6	1.8
Bolton	4963	90.0	1.2	2.0	4.5	3.1	15	3.5	4.5	.5
Ellington	15725	94.4	.7	2.2	1.6	1.1	12	2.6	5.1	2.4
Hebron	9627	94.2	.8	.6	2.0	2.5	11	1.4	4.8	1.1
Somers	11,431	82.2	7.8	2.6	6.3	4.9	14	4.5	5.6	1.7
Stafford	12013	94.3	.3	1.7	2.3	2.2	12	10.8	6.8	3.5
Tolland	14971	91.7	.3	1.7	4.6	1.8	14	1.9	4.5	1.3
Vernon	29162	81.9	5.8	3.5	7.4	5.7	17	9.3	6.4	7.4

Appendix G: Unduplicated DMHAS Active Clients Fiscal Year 2015[1]

	Region IV Persons served By DMHAS	Person Served by DMHAS % in Region IV Total	Person Served by DMHAS % in CT Statewide	CT population[5]
Substance Abuse only	17930	48.6	47.9	
Mental Health only	16181	43.9	43.1	
MH and SA	2774	7.5	9.1	
Male	21538	58.3	59.2	48.8
Female	15340	41.6	40.3	51.2
Caucasian	22645	61.4	65.1	68.2
Black/African American	6171	16.7	15.5	10.2
Asian	351	1	.7	4.1
Other/Multi-race	478	20.2	21.0	7.9
Hispanic or Latino	8478	23.0	26.3	15.4
Employed Competitively	8324	26	25.1	
Unemployed	7966	24.9	29.9	6.6
Independent Living	25059	78.4	79.7	
Dependent Living	1195	3.7	7.4	
Homeless	1079	3.4	3.5	.3[6]

[5] US Census Quick Facts Connecticut
[6] Reaching Home, Ending Ramily Homelessness, Connecticut's Landscape April 2016