# 2016

# BEHAVIORAL HEALTH PRIORITY SERVICES REPORT FOR SOUTHWESTERN CT

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# I. Introduction

## A. Purpose

Every two years, the Department of Mental Health and Addiction Services (DMHAS) planning division undergoes a Priority Planning Process to facilitate planning for mental health and addiction services at the local, regional, and state levels and to inform the DMHAS Behavioral Health Block Grant. The process is based on a needs assessment conducted in each of Connecticut's five regions by the Regional Mental Health Board (RMHB) and Regional Action Councils (RACs). The results of the needs assessment are used, together with data collected by DMHAS, local hospitals, and other sources, to generate recommendations and priorities at the regional level. These are reported out both regionally and to DMHAS, where they are presented to the Adult Behavioral Health Planning Committee in order to identify initiatives and funding priorities for the federal block grant.

The present report is the result of the 2015-2016 process in southwestern Connecticut—DMHAS's "Region 1." It is a collaborative effort among the Region 1 RACs—Communities 4 Action and Mid-Fairfield Substance Abuse Coalition (MFSAC), a program of the Human Services Council—and the Southwest Regional Mental Health Board (SWRMHB). The third RAC in Region 1, RYASAP, did not participate this year due to a staffing vacancy.

## B. Goals

For the 2016 biannual report, DMHAS in conjunction with the Adult Behavioral Health Planning Committee members (including the RMHBs and RACs) decided to streamline the needs assessment in response to the State's financial crisis, which has involved years of cutbacks and rescissions with more to come. The focus of the needs assessment was therefore to identify the top three priorities in each region, describing the elements that most need to be protected or are most critical to invest in strengthening/fixing, and including recommendations for policy and/or program changes.

An additional goal was to inventory the impact of the budget cuts to date across each region, in order to provide information to legislators, policy makers, program managers and/or funders about needs in the region.

# II. Methods

The main questions for data collection were identified through discussion at the Adult Behavioral Health Planning Council and follow-up meetings of the RMHBs and RACs along with Susan Wolfe of DMHAS. A grid was created on which various functions (access, awareness, workforce, etc.) could be identified for each of the five core elements of DMHAS services. This grid was used during focus groups to gather stakeholder views on which areas were working or not working.

A small set of open-ended questions was developed and tested at Catchment Area Council (CAC) meetings, then used in focus groups with different groups of stakeholders, including consumers, providers, and municipal social

services. (See list of respondents in the Appendix.) The same questions were also turned into a 10-question provider survey that was sent out through Survey Monkey.

Additional data used included information from the Census 5-year updates, DMHAS-generated Regional Profiles for 2015, state reports including the DMHAS 2016 Triennial State Substance Abuse Plan, and Access Mental Health CT quarterly reports. Beyond these data collection techniques, SWRMHB's Executive and Deputy Director and the RAC Directors convene meetings of key stakeholders in the region throughout each year as well as participating actively in a large number of local and regional committees and coalitions. This "ear to the ground" allows constant identification of needs on an ongoing basis.

# III. Regional Background

## A. Profile of Region 1: Southwestern Connecticut

Region 1 is comprised of the 14 towns and cities in Southwestern Connecticut: **Bridgeport, Darien, Easton, Fairfield, Greenwich, Monroe, New Canaan, Norwalk, Stamford, Stratford, Trumbull, Weston, Wilton, and Westport**. Table 1 (below) reports the population and basic demographic statistics for each town (or city), based on the U.S. Census Bureau's 2014 (the most recent statistics available) American Community Survey 5-Year Estimates. Also reported are statistics for Fairfield County, since Region 1 represents 73.3% of Fairfield County's population, for a total population in Region 1 of 695,143.

### Table 1: Demographic Profile

| Town | Population | % Caucasian | % Black or African-American | % Asian | % Hispanic or Latino | % Two or More Races | % 65 Years & Over | % < Poverty Level | % Homes Other Than English |
|---|---|---|---|---|---|---|---|---|---|
| Bridgeport | 146,680 | 41.7 | 36.3 | 3.7 | 38.9 | 1.3 | 9.8 | 20.4 | 46.1 |
| Darien | 21,190 | 93.0 | 0.4 | 4.0 | 2.4 | 2.1 | 11.7 | 4.5 | 10.8 |
| Easton | 7,593 | 94.9 | 0.5 | 3.0 | 5.5 | 1.6 | 16.6 | 3.0 | 17.2 |
| Fairfield | 60,678 | 90.0 | 1.8 | 4.7 | 5.2 | 2.4 | 15.0 | 4.7 | 16.2 |
| Greenwich | 62,141 | 86.7 | 2.0 | 6.7 | 11.4 | 2.1 | 15.3 | 5.0 | 27.7 |
| Monroe | 19,744 | 93.9 | 0.7 | 3.2 | 4.8 | 1.6 | 14.3 | 4.7 | 10.2 |
| New Canaan | 20,073 | 93.6 | 1.0 | 3.4 | 2.9 | 1.4 | 14.1 | 2.8 | 13.1 |
| Norwalk | 87,214 | 72.8 | 15.3 | 5.3 | 21.9 | 2.3 | 14.3 | 8.1 | 33.1 |
| Stamford | 125,401 | 60.1 | 13.6 | 8.5 | 27.0 | 2.5 | 12.6 | 9.9 | 44.1 |
| Stratford | 52,092 | 76.3 | 15.2 | 2.9 | 14.1 | 2.2 | 18.1 | 7.4 | 18.9 |
| Trumbull | 36,444 | 89.9 | 2.1 | 4.4 | 8.1 | 1.9 | 18.7 | 2.5 | 16.4 |
| Weston | 10,319 | 92.4 | 1.3 | 3.4 | 3.7 | 2.6 | 11.4 | 2.2 | 11.7 |
| Westport | 27,055 | 90.0 | 0.8 | 6.0 | 4.6 | 2.2 | 16.4 | 4.3 | 14.7 |
| Wilton | 18,519 | 90.3 | 0.9 | 6.4 | 2.4 | 1.9 | 13.5 | 3.6 | 11.3 |
| ***Region 1*** | **695,143** | | | | | | | | |
| ***County*** | **948,053** | **74.3** | **11.1** | **4.9** | **17.9** | **2.4** | **13.9** | **9.1** | **28.4** |

As shown above, Region 1 includes both "Gold Coast" towns (the towns running from Greenwich to Fairfield, along Long Island Sound) which are notable for their high per-capita income levels and lack of ethnic diversity, as well as three of the largest urban areas of the state (Bridgeport, Stamford, and Norwalk) where the demographic and economic diversity is much greater than in the "Gold Coast" suburbs.

### *Racial Diversity*

Region 1 continues to be predominately Caucasian. Among the 14 municipalities, Bridgeport stands out as the only place where Caucasians are a minority ethnic group, at 41.7 percent, although the city's Caucasian population has increased by 2.1 percent since 2012. Of note:

- Cities with a significant African-American population include, in descending order, Bridgeport, Norwalk, Stratford, and Stamford. At 36%, Bridgeport's African-American population is more than twice as high as Norwalk's (15%), which is the second-largest in the region.
- Municipalities with significant Latino populations include, in descending order, Bridgeport (39%), Stamford (27%), Norwalk (22%), Stratford (14%), and Greenwich (11%).
- While Asians make up only 5% of Fairfield County's population overall, five municipalities in Region 1 have Asian populations greater than this average: Stamford (8.5%), Greenwich, Wilton, Westport, and Norwalk (in descending order). In Stamford and Norwalk, the majority of the Asian population in Norwalk is Asian Indian, while in the other towns the Asian populations are represented by a majority of ethnic Chinese.

Changes identified in the Census data since 2012 include:

- Bridgeport's Caucasian and African-American populations have both increased by approximately two percent. Meanwhile, the percentage of Bridgeport residents reporting being two or more races dropped from 4.3 percent to 1.3 percent.
- Stamford and Easton stand out as having the largest increase of Hispanics/Latinos of all communities—3.2 percent for each. Trumbull has also had an increase in its Latino population of 2.4 percent.
- The rate of increase in the Latino population in Stamford over the past two years was 4.6 times greater than the gain in this population in Bridgeport.
- Two other municipalities with significant Latino populations—Norwalk and Fairfield—both recorded decreases in their Latino populations since the last report. In fact, the decrease in Fairfield's Latino population was significant over this two-year period—with a change from 18.2 percent in 2012, down to 5.2 percent in 2014. It may be that Fairfield's Hispanic population is moving to other towns in the region, since 10 out of 14 municipalities showed an increase in their Hispanic/Latino population from 2012 to 2014.

### *Linguistic Diversity*

Across Fairfield County, more than one quarter of households do not speak English as the primary language at home:

- As was the case in the report of two years ago, approximately 45 percent of households in Bridgeport and Stamford continue to speak a language other than English in the home. In Bridgeport, of that number, 30 percent speaks Spanish at home. In Stamford, 23 percent of the population speaks Spanish at home.
- In Norwalk, one third of households do not speak English as the primary language. The predominant language is again Spanish.
- In Greenwich, where 27.7 percent of residents speak a language other than English in the home, only 10 percent of the total is speaking Spanish at home.

### *Aging*

Across Fairfield County, 14% of the population is aged 65 and up. Within Region 1, nine of the 14 towns have higher-than-county-average percentages of older adults, with the highest being Trumbull (18.7%), followed by Stratford, Easton, Westport, Greenwich, Fairfield, Monroe & Norwalk, and New Canaan. The 65 years and older population in Fairfield County is estimated to have increased 11.1 percent between 2010 and 2013,[1] and, from 2013 to 2025, the share of Connecticut resident older than 60 is expected to grow 44 percent.[2]

### *Economic Profile*

The visible wealth of the suburban areas of Region 1 often masks the existence of poverty. If you were to take a drive through backcountry Greenwich, it would be difficult to believe that Greenwich or for that matter any of Fairfield County had any poverty at all. According to Zillow, the median home value in Greenwich is currently 1.4 million dollars. In actuality, however, five percent of the Greenwich population lives below poverty level.[3]

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[1] Batt, Steve. July 14, 2016. University of Connecticut, University Libraries: *Outside the Neatline* (Online).
[2] Pandey, Erica. July 29, 2015. *TrenD ct*. Commentary: How livable is Connecticut for the aging population?

As a comparison, the median home value in Bridgeport is $146,000—one tenth the median home price in Greenwich.

- The cities of Bridgeport, Stamford, and Norwalk remain the municipalities within Region 1 with the greatest amount of poverty. Notably, the percentage of the population living below poverty level in Bridgeport (20%) is twice as high as the populations in Stamford (10%) and Norwalk (8%).
- Although Bridgeport has the highest level of poverty in Region 1, its poverty level dropped 3.2 percent from the last survey.
- Fairfield's poverty level also dropped—down 4.1 percent from the previous survey.

The minimum wage in Connecticut currently stands at $9.60/hour and is slated to go up to $10.10/hour in 2017. This wage doesn't go far in Fairfield County, as the median cost of housing in the county in 2014 was $1,826/Month.[4]

According to Sperling, the Cost of Living Index (COLI) in Stamford in 2014 was 167 overall (where 100 is the median for the U.S. as a whole). Stamford has the highest COLI of any city in the state and Norwalk has the second-highest COLI (148.7); the third-highest is Danbury at 129.3.

Further, when it comes to housing, Stamford's index is a whopping 259, where again, 100 is the average for the country. Compare Stamford's numbers to Torrington, which has a housing COLI of 80. In other words, housing is 3.2 times less expensive in Torrington than in Stamford.

## B. Behavioral Health Profile of Region 1

Behavioral health prevalence rates for Connecticut are available at the state but not regional level. The 2014 National Survey on Drug Use and Health reports that nationally, 18.1% of adults 18 and over experience a mental illness in any given year, with the highest risk group being ages 25-49 (20.4%), then 18-25 (20.1%), and the lower risk group being those 50 and over (15.4%). According to the Connecticut 2015 Behavioral Health Barometer from SAMHSA, Connecticut's mental illness indicators are similar to national figures for Severe Mental Illness and Substance Use Disorders:

- 3.5 percent of adults 18 and over had a Serious Mental Illness (SMI) in the year prior to the survey. This was lower than the national rate of 4.2 percent.
- 9.7 percent of adolescents aged 12 -17 had at least one major depressive episode in the year prior to the survey.
- 3.3 percent of all adults had serious thoughts of suicide prior to the year of the survey. This number was down 0.4% from the prior study year.

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[3] U.S. Census Bureau, American Community Survey, 2010-2014 American Community Survey 5-Year Estimates. S1701 – Poverty Status in the Past 12 Months

[4] U.S. Census Bureau, American Community Survey, 2010-2014 – American Community Survey 5-Year Estimates S2503 - Financial Characteristics.

- More than half (52.5%) of adults 18 or older with any mental illness did not receive mental health treatment/counseling.
- Data from the state's office of the Chief Medical Examiner (CME) indicates that suicide is a problem of growing intensity in the state of Connecticut:
    - In 2015, suicide was twice as likely to cause the death of a resident than firearms (not used in suicide). Between 2014 and 2015 the suicide rate in Connecticut increased by 2.9 percent up to 386 suicides—the highest suicide rate recorded since 1990. (2014 was the second highest, with 375 suicides.)
    - While suicide figures for Region 1 are not published, the most recent CT Suicide Advisory Board data indicate that Fairfield County had the lowest suicide prevalence rate in the state (7.8 per 100,000) during 2014, although the rate had increased slightly from 7.5 in 2012.

The Connecticut 2015 Barometer also reports substance use disorder figures that are comparable to national statistics:

- 2.9 percent of individuals aged 12 or older reported illicit drug dependence or abuse (slightly higher than the national average)
- 6.0 percent of CT residents 21 years of age and older reported heavy alcohol use, slightly less than the national figure of 6.7 percent
- Four-fifths (79.9%) of CT residents with illicit drug use were not receiving treatment.
- Over nine out of 10 (92.9%) of CT residents 12 and older with alcohol dependence or abuse did not receive treatment.
- In 2015, there were 729 deaths due to drug overdoses in the State. (Source: CME)

The opioid epidemic, which has spread rapidly and is receiving tremendous attention in the region, has affected Southwestern CT. Statistics from the Chief Medical Examiner's Office show 41 deaths due to drug toxicity in Region 1 during 2015. 85% of these were attributable to heroin, fentanyl, or a combination of either or both of these with other substances:

- Fentanyl + other substances was the cause of death in nine cases
- Heroin alone was the cause of death in eight cases
- Heroin + other substances was the cause of death in eight cases
- Fentanyl alone was the cause of death in five cases
- Heroin + Fentanyl were the cause of death in five cases

### *Municipal Programs & Services*

The behavioral health system in Region 1 is composed predominantly of private and nonprofit services. The majority of the estimated 125,820 regional residents in need of behavioral health care have private insurance.

There are five medical hospitals and one private psychiatric hospital serving the region; two federally qualified community health centers (Optimus and Southwest) and the private Community Health Centers, Inc.; state-operated services in Stamford and Bridgeport; and state-funded providers throughout the region. School-based

health centers provide mental health services to students in Bridgeport, Norwalk, and Stamford and soon Trumbull.

During 2015-2016, all hospitals in Southwestern Connecticut (Bridgeport and Greenwich Hospitals—part of the Yale New Haven Hospital group, St. Vincent's Medical Center, Norwalk Hospital—part of the Western CT Hospital Network, and Stamford Hospital) conducted Community Health Needs Assessments (CHNA) in their surrounding towns:

- In every case, when the results were presented back to key stakeholders for a prioritization exercise, **mental health and substance use were identified among the top priority needs for each hospital's catchment area,** as was also the case in the prior hospital CHNA process.
- The hospitals in the three major urban areas (Greenwich, Norwalk, Stamford-Greenwich) have all developed **Community Care Teams** (CCTs) since the last CHNA process. These have been very successful in serving some of the most vulnerable high utilizers in the system and have led to cost savings, improved quality of care, and increased communication among hospitals, behavioral health providers, and housing providers.

Most municipalities have a social services or human services department that provides information and referrals, benefits enrollment, case management, support for basic needs, and in some (but not all) cases behavioral health counseling. Municipalities also conduct awareness and prevention programs through their Local Prevention Councils and Youth Services Bureaus, as well as providing education, advocacy, and overall wellness programs through their social services, teen centers, senior centers, and libraries and various commissions.

The municipalities in Region 1 are proactive in developing programming to meet identified needs, in collaboration with many stakeholders including the RACs and RMHBs. To cite a few examples:

- Many towns and cities have task forces that enable collaboration among human services, emergency staff, and other agencies around various issues such as Domestic Violence, Hoarding, and Emergency Operations.
    - In Bridgeport, representatives from law enforcement, code enforcement, health, utility, etc. meet weekly to discuss cases and take a team approach to problem solving.
    - Stratford is developing a similar model, based on the success of the CCTs. Rather than meet around a specific issue, the weekly meeting will enable all participating agencies to develop relationships and bring forward cases at any time to a larger group capable of making decisions.
- Municipal Juvenile Review Boards (JRBs) work to divert and connect youth to services.
    - Stratford has been a leader in re-envisioning the juvenile justice program. Its Juvenile Review Board uses a restorative justice model. All referred youth as well as their families undergo a mental health assessment. They are offered program options such as yoga and meditation as part of their program in order to develop healthier coping skills.
    - In Greenwich, an Interagency Team (IAT) is a part of a restorative justice initiative but diversionary, connecting youth with case management and services. The IAT hopes to move down to the elementary level.

- Many towns and cities focus on increasing mental health awareness and services in schools.
    - School districts are increasingly using social-emotional learning curricula from elementary on (e.g., Bridgeport) and incorporating meditation or DBT skills in high schools. In Stamford, DBT skills are being taught by trained teachers rather than outside consultants, in order to make a grant-funded initiative more sustainable in the long term.
    - Some municipalities have mental health counselors at the high school and, in some places, at the middle school level as well. In Greenwich, the "Teen Talk" program represents a collaboration between the Greenwich Department of Social Services and a local provider agency; the town now hopes to bring the program down to the elementary school level.
    - Several towns have very active youth leadership groups who work diligently on reducing the stigma and providing easy access to mental health resources. In mid-Fairfield, the Teen Awareness Group (TAG) coordinates an annual Youth Leadership Conference on mental health for teens from three towns.
- In some areas, the town human services department coordinates closely each month with schools and other providers at case and family support meetings.
- United Way of Greenwich runs the "Community Answers" project, which is similar to 211 but specific to Greenwich, providing information, connections to services, and events via phone and website. They hope to improve it to the point where callers will be able to get up-to-the-day info on bed openings, housing, etc.
- St. Vincent's Medical Center is piloting a telepsychiatry project to increase access to psychiatrists, working with their urgent care clinic in Stratford.
- The majority of regional pediatricians are participating in Access Mental Health CT, a DCF program launched in June 2014, which offers free telephone consultation to Private Care Providers (PCPs) seeking assistance in treating youth with behavioral health concerns under the age of 19 years. Consultation includes education on assessment, treatment and access to community resources. To-date the program has been very well received by PCPs as indicated by an average satisfaction score of 4.99 out of 5. (Source: Access Mental Health CT Quarterly Progress Report 3/31/16)

### *DMHAS Services*

The Connecticut Department of Mental Health and Addiction Services (DMHAS) provides both prevention and treatment services to state residents. DMHAS's prevention services focus on mental health promotion, substance use prevention, and suicide prevention across the lifespan. The Prevention Unit consists of the CT Clearinghouse, the Governor's Prevention Partnership, the CT Suicide Advisory Board, and the CT Prevention Network (CPN), which consists of 13 Regional Action Councils (RACs). At the sub-regional level, the RACs work with Local Prevention Councils, school and parent groups, local providers, hospitals, police departments, and other first responders. In terms of direct care, DMHAS both provides and oversees mental health and substance use treatment to adults ages 18 and over who have Serious Mental Illness (SMI) and are Medicaid-eligible. DMHAS also supports "wrap-around" services, such as supported employment, supportive housing, and supported education, for this population.

**According to the 2015 CT Barometer from SAMHSA, a majority--84.3 percent—of mental health consumers in Connecticut reported improved functioning from treatment received in the public mental health system, a slight decrease of a decrease of 0.8 percent since 2014.** For comparison purposes, 69.5% of youth aged 17 and younger reported improved functioning from treatment received from the CT public sector (through DCF). This was up 0.2 percent from the previous year.

In Region 1, DMHAS served some 17,000 clients[5] in 2015—13.8% of the estimated population in need, or approximately 2.4% of the region's total population. Of note:

- Clients served by DMHAS dropped 11.3 percent compared with 19,562 clients in 2013.
- DMHAS clients were predominantly African-American (21.7%) and Latino (26.0%) and male (61.7% - all ethnicities), compared with the region's population, which is predominantly Caucasian.
- Half were served for substance use disorders (49.1 %), 41.8 percent for mental health, and 9.1 percent for co-occurring disorders (substance abuse and mental illness, combined).

DMHAS statistics in Region 1 differ from those in other regions in the following ways:

- The proportion of SWCMHS clients being treated for substance abuse was highest of all regions, with opioids as the most-used primary drug and alcohol second. Relatedly:
    - Region 1 had the highest percentage of clients reporting use of heroin, non-prescription methadone, and other opiate use as primary drug at admission: 45.3 percent, compared with 34%-39% in other regions.
    - Region 1 had the lowest percentage of clients reporting alcohol as the primary drug at admission: 26.4%, compared with 34%-45% in other regions.

- Primary drug at admission for young adults (ages 18 – 25) showed a different picture than the drug use profile of DMHAS clients in this region as a whole. Marijuana was the number one drug of choice—37.3% of young adults—with heroin & non-prescription methadone in second place. However, all opioids together accounted for 40.4% of young adults.

- 57.4% of active clients with alcohol and drug use report being abstinent, the highest proportion of any region.

- Region 1 displayed the lowest percentage of clients served within their own region (81.1%) when looking at statistics for clinical outpatient care. On the other hand, clients in Region 1 had a relatively high percentage of Case management services being delivered within the region, at 88.7%.

[5] The number of unduplicated active clients by program type was 17,363 and by diagnosis type, 16,782. The discrepancy of 581 clients represents 3.3% of the total.

- Region 1 had the highest percentage of unduplicated active clients who were competitively employed, at 4,168 clients, or 28.4% of all unduplicated active clients. Clients in Region 1 also had the lowest number of DMHAS unduplicated active clients not in the labor force, at 2,289 or 15.6%.

- Region 1 stands out in two areas related to the living situation of clients: The region has the highest percentage of clients residing in independent living (84.7%) but also the highest percentage of clients reporting being homeless (4.5%). This representation of homelessness in Region 1 may very well be correlated to the very high costs of housing in Region 1.

During focus groups at the state-operated facilities, consumers noted that the state-operated services were "good when you get in" and an area to protect, citing the fact that they provide a range of levels of care, types of service, and groups, and that they can allow consumers to have a voice and feel empowered. At the same time, SWCMHS consumers identified areas for improvement, listed in the Recommendations section.

## IV. Priorities

With Connecticut in a financial crisis, this year's needs assessment focused on identifying a short list of areas that require protection or strengthening in the coming two years. The behavioral health community was canvassed to determine the top priorities for the region, under the assumption that the system is shrinking and priority must be given to critical elements rather than new areas.

The prioritization effort was difficult, because all five areas suggested (inpatient, outpatient, residential/crisis/respite, recovery support services, and education/prevention/research) were felt by respondents to be essential. **One key informant noted that the primary priority is "Basic needs! In a budget crisis, the primary area to protect is to ensure that people have a roof over their head, food & clothing, some health care. In behavioral health, that translates to protecting *case management* as a primary concern."**

Overall, the top three priorities that emerged across the region—including responses from consumers, providers, and municipal social services—were:

1. Outpatient Services
2. Workforce/capacity
3. Inpatient Services

It is worth noting that Inpatient Services, ranked as top priority by DMHAS as a state agency, emerged in third place both across the region and among DMHAS providers within the region:

- Among DMHAS-funded providers responding to the statewide online survey, the priorities from first to last were: (1) Outpatient, (2) Residential/Crisis/Respite, (3) Inpatient, (4) Recovery Support, and (5) Research/Prevention/Education.

- More than one respondent commented that DMHAS's rank-ordered priorities "should be the reverse! These areas are important for DMHAS – but in terms of resources, [you need to] maintain the clients in the communities as much as you can."

Each of the three overall regional priorities is summarized below, with recommendations in the final section of this report.

## A. Overarching Issues

Although the behavioral health community recognizes that the state is in a financial crisis and difficult funding decisions have had to be and will continue to be made, **there are tremendous concerns about:**

- **Quality of services**, which is decreasing as more is expected with less. Already caseloads are increasing and staff members (especially in the public sector) are demoralized. (See "Impact of Budget Cuts" in Section V.) Clients will feel the impact more and more. Respondents observed that policies, procedures, and review and evaluation will be important to monitor this issue.
- **The impact of the budget on access to services**, which was already a concern in particular with regards to prescribers, bilingual providers, and wait times to get an appointment. Providers questioned "the viability of nonprofits keeping their doors open."
- **Ability to maintain a balance of community-based services, including recovery supports and case management**, when direct care—especially inpatient services—is also critical but very costly.
- **Housing**, which is essential to recovery yet in short supply, especially in Region 1. Affordable housing, supportive housing, transitional residential programs, and shelter beds are all lacking.

Over the past two years, the new Coordinated Access Network (CAN) for accessing shelter and housing has made inroads into housing the most vulnerable populations, while the Community Care Teams (CCTs) have helped bring wraparound services, including housing, to extremely high users of emergency rooms in the region, decreasing their ED usage and improving their quality of living. As the state continues to chip away at individuals' benefits, housing, and at the many organizations that provide supportive services of all types, the fear is that new populations will fall into homelessness and extreme need, replacing those who have been successfully cared for through these successful initiatives.

**Many respondents identified structural and policy barriers to effective delivery of behavioral health care** in CT. Issues raised included:

- The lack of a continuum of services across the lifespan within the public sector, due to the long-standing split between DCF (overseeing services to the 0-18 population) and DMHAS (providing services to the Medicaid-eligible population 18+).
- The question of having DMHAS provide direct services as compared to providing oversight and policy setting and contracting services out to nonprofit providers, who many felt are better able to provide

effective services at lower costs. A number of stakeholders note that the nonprofits can operate outside state labor contracts, which provides greater flexibility with hiring & firing, implementing change, and encouraging innovations.

- The ongoing fragmentation of services: DMHAS vs DCF vs DSS; Medicaid-eligible vs privately insured; mental health vs substance use disorders. Respondents highlighted the need to "protect coordination and information" services such as those provided by the RMHBs and RACs, among other agencies.
- Insurance concerns including an ongoing trend to decrease coverage for behavioral health services. This contradicts evidence-based practices which consistently indicate the need for longer treatment sessions than provided by insurance. Insurance also came up as a concern for those who can no longer afford medications under "Obamacare".

An additional concern specific to Southwestern CT is the **much higher relative cost of living in Region 1 compared with other parts of the state**. Stamford is the most expensive city to live in and Norwalk the second most expensive in CT. It costs 58% more to live in Stamford than in Hartford, and 36% more to live in Norwalk than in New Haven. With the cost of living so much higher in Fairfield County, daily life for residents can be stressful, and the costs of seeking help for mental health or substance use can be unaffordable. In addition, the cost to Region 1 providers of operating behavioral health services, providing housing, and paying a fair wage becomes a much greater challenge.

## B. Priority #1: Outpatient Services

Outpatient services were identified as the top priority across all respondents in the region, as well as among DMHAS providers specifically, though some observed there have been some improvements. Issues include:

### *Cost of care*

The cost is a barrier both due to many providers not accepting public insurance and to the cost of co-pays for the majority of area residents who have private insurance.

- Among 44 psychiatrists in Region 1 responding to a recent SWRMHB CAC survey, 23 don't accept any insurance, >1/2 accept private insurance, <1/2 accept Medicare and/or Medicaid, and just 19 provide a sliding-fee scale. 1/2 of private-practice prescribers responding neither accept insurance nor offer a sliding-fee scale. The table below shows the fees charged by Region 1 prescribers:

| Type of Visit | Charges Noted by Responding Prescribers |
|---|---|
| Evaluation | $150-$750 |
| Maintenance Visit | $75-$420 |
| Medication Management | $75-$325 |

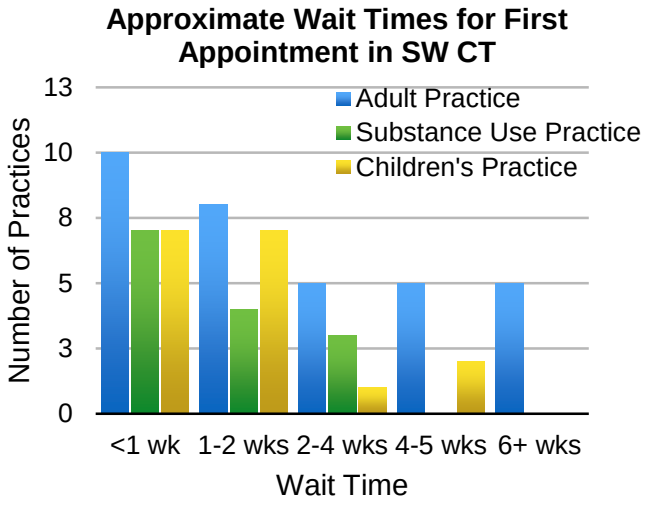
### *Access to medication:*

The main barrier to accessing medications is the difficult access to prescribers, both for consumers and provider programs. (See Priority 2: Workforce.) Some respondents recommended an emergency medication refill program.

### *Timely access:*

**Wait time** for appointments continues to be reported as long. Consumers report the need for **after-hours appointments** as well as for **urgent care appointments**.

- In Region 1, LifeBridge Community Services operates under the Open Access model, structuring services in order to offer walk-in hours.
- During the summer of 2015, agencies in Region 1 were surveyed by phone to determine wait times. The approximate wait times found at that time are shown in the graphic below. Since then, however, recent budget cuts have led provider agencies to report increased caseloads, increased waitlists, turning away clients, reducing program hours, and laying off staff, which have most likely worsened the wait times. Focus group participants reported 3-4 week waits for an urgent care appointment. This survey will be repeated during 2016 to determine current wait times, as suggested by various respondents.




### *Need for specialized and/or targeted services:*

Areas identified as needing more resources include:

- Increased EDT or IOP for children
- Youth mental health, particularly for those who have been victimized
- Mental health services for crisis care needs (domestic violence victims, homeless individuals) and for those with co-occurring disorders
- In-home services / outpatient residential

### *Access to addiction recovery services:*

Treatment for substance use disorders is an important priority, especially given the current opioid crisis:

- There is a lack of services for people under age 16 and very limited services for ages 16-18.
- There is strong evidence that programs longer than 30 days are more effective.

Consumer and social services had mixed reports about the new Substance Use Assessment Hotline, including:

- Being told that it was only for detox; call 211 instead.
- Needing to be on benzos as well as an opioid or cocaine in order to access treatment.

In a number of conversations throughout the community, consumers and some social workers expressed concerns that:

- Treatment centers "forced" young adults onto HUSKY even if they had private insurance.
- Treatment centers pushed methadone as the only option.
- There was no "detox" program to get off methadone.

### *Transitional and intermediate care programs:*

- This level of care was cited in the 2014 biannual report as a need, yet since then, with the recent budget cuts, the two Transitional Residential Programs in the region have closed.
- Respondents cited a lack of Intensive Outpatient Programs (IOPs) and Partial Hospitalization Programs (PHPs).
- Consumers pointed to a need for better connections from hospitals to outpatient care.
    - In a couple of consumer focus groups, respondents identified a need for follow-up home visits, noting that Recovery Support Specialists would be excellent supports in this situation—similar to the Peer Bridger model. An alternative also suggested was 10-minute daily phone calls from a peer.

## C. Priority #2: Workforce/Capacity

Workforce emerged as the second priority across all core service areas (inpatient, outpatient, mental health, addiction services, etc.). Workforce is so important for a number of reasons including:

### *Availability of Providers:*

Overall, there were an estimated 1631 behavioral health providers (including psychiatrists and psych nurses, psychologists, and social workers, but excluding counselors) in Southwestern CT in 2014-15 (SWRMHB study).

- The ratio of 62 clients per social worker in Region 1 identified in 2015 is significantly **higher** than the caseload range of 40:1 – 50:1 for community mental health services identified by the National Association of Social Workers.
- Due to recent rescissions and budget cuts, the capacity of the public and nonprofit sector to serve those in need is worsening. In the provider survey conducted for this report, **11 out of 17 responding agencies reported an increase in workload, and 6 agencies reported an increase in waiting lists.** FS Dubois reported during a provider discussion that its staff is half the size it was two years ago. There are several layers of impact:
    - Consumers noted that it is harder for providers to return calls the same day.
    - Some consumers had experienced several staff turnovers during a short period of time, as their doctors and/or case managers were reassigned, which is likely to affect quality of care.
    - Respondents noted the need to provide staff self-care in this environment of increasing stress, workloads, and uncertain job prospects.
    - As layoffs took place and bumping occurred, public sector employees were transferred, in some cases leaving gaps in key skills. For example, the only Creole-speaking case manager at FS Dubois

in Stamford was transferred to Bridgeport, despite the large Haitian population in Stamford and the fact that Bridgeport already had a Creole-speaking case manager.
    - A provider commented on "trends that continue or worsen: waiting lists for clinics, IOPs, IICAPS, etc."
- More bilingual providers (all types) are needed. In a phone survey of 59 large behavioral health programs and clinics, SWRMHB found that 42% of adult and 59% of child mental health agencies and programs reported Spanish-language capability. 11% of adult and 29% of child practices had Haitian Creole capability. 50% of substance use practices contacted had Spanish-language capability and two reported competence in Haitian Creole. 9% overall had access to a phone translation service.
- "We need more clinicians who can be available to our homeless people without waiting for weeks at a time for an appointment."
- In the private sector, access to providers is limited by the high cost of care. Consumers report that many providers are unaffordable and do not accept insurance.
    - Relatedly, the nonprofit sector has difficulty attracting and retaining staff due to the low funding available for salaries. Many respondents noted the need to adequately pay staff.
- Consumers report a need for more case managers.
- There is a felt need for outreach workers for people in crisis and/or with addiction, and for in-home services (which are often available in the youth mental health system).
    - Respondents mentioned the example of an ACT team psychiatrist being able to go to someone's home when there is a crisis and the person cannot or will not leave.
    - ACT teams are needed outside Bridgeport. Some respondents noted, "we have ACT clients but no ACT team." They specified the need for 10 clients max per ACT team.
    - Others recommended bringing back / expanding the Peer Bridger program.
    - Several focus groups supported providing mental health follow-up at home post-hospitalization, or at least daily check-in phone calls. Peers could provide this service.
    - Need for "in home treatment that is covered by all insurance."
- On a positive note, the DMHAS Training and Technical Assistance Service Center has spearheaded opportunities for more individuals working in prevention to get their Prevention Specialist Certification. This is timely as DMHAS and other state departments are increasing their focus on prevention.

### *Access to Prescribers:*

Prescribers are perhaps the most-cited gap. One provider observed that there are "very little psychiatric medication management services in lower Fairfield County." There are approximately 32 prescribers (including psychiatrists and APRNs) per 100,000 population in Southwest CT, which falls within HRSA guidelines. However:

- They are unevenly distributed across the private and nonprofit sectors. In 2015, several area hospitals were competing with each other for psychiatrists. Within SWCMHS, potential hires were able to turn down offers of $200,000 and new hires during the last year left within a short period of time.
- A shortage of 46,000-90,000 psychiatrists is expected nationally by 2025, due to demographic trends. Between 1995 and 2013, the US population increased by 37%, while the number of psychiatrists rose by

only 12%. A focus group member noted, "only 4% of doctors go into psychiatry; what is the state doing about it?" (See recommendations.)

- 59% of US psychiatrists are age ≥55 and retiring or reducing their workload. Psychiatrists responding to SWRMHB's recent survey reported working an average of 29.6 hours per week, with 8 out of 44 respondents (representing 17% of prescribers in the region) reporting working fewer than 10 hours per week.
- Apparent gaps include expertise in child/adolescent psychiatry, geriatrics, and addictions. Hoarding is an area of concern. 27% of prescribers responding to the recent SWRMHB survey reported that they were trauma informed.
- While it is important to work toward increasing the numbers of prescribers through various means (see Recommendations), the primary barrier for consumers in accessing a psychiatrist is financial, as mentioned in Priority #1: Outpatient Services, above.

### *Low Utilization of Peers:*

Peer support is an evidence-based model with a proven record of success. CT has invested in training certified Recovery Support Specialists (RSS) through Advocacy Unlimited and Recovery Coaches through CCAR. Many of these trained and certified peers are working in the system, providing support for socialization, recovery, self-advocacy, employment, and community living skills through one-on-one and/or group support.

Peers are currently an underutilized resource. There are 900 trained RSS's in the state not employed. Many focus groups emphasized the need to increase the workforce through increased use and pay of RSS's—a more cost effective strategy to increase the workforce.

- The Peer Bridger program, which was shown effective in Massachusetts, came to Region 1 last year but lost its funding. It is going to be revamped through FOR-U.
- The CCTs all support having trained Recovery Coaches working in emergency departments to engage and support those struggling with substance use.
- Consumer groups that suggested having mental health follow-up visits and/or phone calls at home noted that peers could provide this service.

## D. Priority #3: Inpatient Services

The third priority identified by Region 1 respondents was Inpatient Services. Consumers and providers shared concern regarding:

### *Inadequate Number of Inpatient Psychiatric and Substance Abuse Beds*

The state currently operates 786 substance-abuse treatment or psychiatric beds, and funds private nonprofit providers that operate 1,333 substance-abuse treatment beds and 353 mental health beds. DMHAS's written comments to the Appropriations Committee said that, on average, 90 percent or more of the beds are filled each night. According to the CT Mirror, there were 33 people on a waiting list for state-operated psychiatric beds in March 2016, most of whom were waiting in general hospital inpatient units.

According to the "Statewide Health Care Facilities and Services Plan, 2014 Supplement," mental disorders were the leading cause of hospitalization for males and females ages 5 to 14, 15 to 24, and 25 to 44 in Connecticut. For men ages 45 to 64, mental disorders were again the leading cause of hospitalization. The same report shows that the number of days that patients with behavioral health problems in the state were hospitalized surged 5.3 percent between 2011 and 2013, to nearly 260,000 patient days. Despite this rise, the state has lost 126 psychiatric beds in the past six years.

| STATE | 2016 TOTAL STATE HOSPITAL BEDS | 2010 TOTAL STATE HOSPITAL BEDS | NUMBER OF BEDS LOST OR GAINED | 2016 BEDS PER 100,000 POPULATION | RELATION TO TARGET BEDS PER CAPITA |
|---|---|---|---|---|---|
| Connecticut | 615 | 741 | -126 | 17.1 | 34.3% |

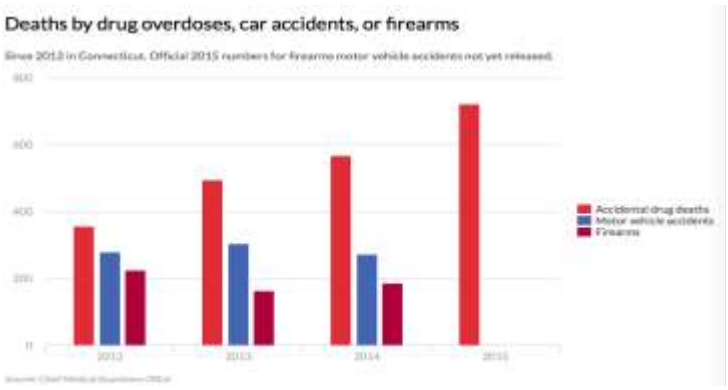
The Connecticut Hospital Association reports that in 2014, more than 25 percent of all inpatient and emergency department visits to hospitals were to treat patients with a primary or secondary behavioral health disorder, including those related to substance abuse. Between 2010 and 2014, hospitals saw a 31 percent increase in patients with a behavioral health diagnosis.

- **Adult Beds:** The 2014 Supplement shows that of about eight million visits made to Connecticut emergency departments from 2009 to 2013, one million were for psychiatric or drug- or alcohol-related mental disorders. Almost one-third of patients who came to emergency rooms with psychiatric problems needed to be admitted for inpatient treatment, the report says.

  An insufficient number of beds result in people in crisis waiting longer for inpatient care. In 2015, nearly 90% of surveyed emergency physicians reported in 2015 that mentally ill patients were being "held" in ERs for lack of hospital beds to admit them to, a practice known as "boarding."[i]

- **Adolescent Beds:** Mental disorders were the leading cause of hospitalization in Connecticut in 2012 for children ages 5 to 14. Despite this demonstrated need, the ability to provide temporary emergency shelter and services for Fairfield County children was seriously compromised when the state's Department of Children and Families (DCF) cut all state funding for Kids in Crisis. Last year, the Greenwich-based Kids in Crisis provided over 3,000 bed-nights, a 16 percent increase from last year, and responded to 400 urgent crisis calls followed by in-person counseling meetings, a 20 percent year-over-year increase. Almost two-thirds of all children in the shelter program and individuals served by the Kids in Crisis hotline are from Greenwich, Stamford and Norwalk. Today, there are no state-funded adolescent crisis beds south of New Haven.

- **Substance Abuse Beds:** On average, two people die of a drug overdose every day in Connecticut. There were about 2,000 drug overdose deaths in Connecticut between 2012 and 2015. Many centers have waitlists for inpatient treatment beds. At a time when Connecticut is seeing record levels of heroin use—723 people died from drug overdoses in Connecticut last year (see figure below demonstrating the increase in drug deaths)—the need for those services are greater than ever.




In focus groups, consumers described their difficulties in accessing inpatient care:

- One noted the "*severe shortage of residential hospital and crisis beds,"* while another described her experiences facing *"waiting lists for beds and [the fact that] PATIENTS need to call the hospitals."* Other consumers agreed that there is *"not enough long-term treatment,"* and one person observed that it is *"hard to get a bed unless you say "suicide."*
- In terms of substance use treatment, respondents noted that when a person is ready, there can be a 2-3 month wait. Respondents also pointed to the need for Husky C coverage for substance abuse.

Several providers shared similar concerns about the need for long-term and intermediate care psychiatric inpatient treatment:

- One provider stated that *"inpatient stays need to be longer with actual therapy provided, not just about medication evaluation and management; a more comprehensive team approach,"* while another noted that *"we will not be able to turn over the long-term psych beds until there are adequate community supports."*
- Other concerns expressed included *"Longer wait times for inpatient care - instead of a month or more wait times, it's now over 2 months"* and *"there are fewer and fewer hospital beds, so those of us with chronic homeless beds are working with the most vulnerable street homeless people."*
- Providers highlighted the need for inpatient substance use treatment and 30-90 day rehabilitation programs.
- One recommended *"For those who are end stage and do not have an interest in sobriety, we should develop safe spaces to sober up (modeled on the wet houses in St. Paul, MN)."*

## E. Other Priorities

While not among the top three priorities for the region, the other core areas were also deemed essential by respondents, some of whom observed "they are all important & difficult to rank." Below we summarize areas highlighted in focus groups, interviews, and meetings throughout the region.

### *Residential, Crisis, and Respite Supports*

The most-cited services to protect and/or improve were:

- **Housing**, which has been a top priority in Region 1 for many years due to the exceedingly high housing COLI noted in III. Regional Background.
    - Supportive housing (all levels, from group homes to scattered site apartments) and community-based residential living were felt needs.
    - There were multiple mentions of the need for transitional housing dollars and security deposits and rental subsidies for those who have been chronically homeless and could return to homelessness.
- **Mobile crisis** received many mentions from consumers and providers.

Other services identified included:

- Intermediate levels of care (the closing of the TRPs was seen as very problematic), including:
    - Long-term and intermediate care psychiatric inpatient treatment
    - 30-90 day substance rehabilitation programs
    - "We will not be able to turn over the long-term psych beds until there are adequate community supports."
    - "We need to spend more on direct patient contact in the areas of early recovery support, residential treatment, group homes and substance abuse treatment."
- Community Support Program/Recovery Pathways (CSP/RP) services
- Need for emergency medical refill services

### *Recovery Support Services*

**Case management** was the most-often cited recovery support service mentioned in focus groups and key informant interviews. Access to case management was seen as vital:

- More case managers are needed across the system.
- One respondent recommended that DMHAS consider closing their direct outpatient services and holding on to case management, then letting the case managers purchase the services the client needs from local providers.
- Financial assistance for case management.

The role of **Recovery Support Specialists** was also mentioned very frequently as an underutilized resource that is already available. (See discussion under Workforce, above.)

Other areas mentioned included:

- The **Community Care Teams** (CCTs), which are effective problem-solving groups that work to help the most vulnerable, yet which are under- or in some cases unfunded. The cost savings to the hospitals alone should be able to support the cost of a navigator for each CCT.
- "**Transportation** to appointments that is reliable would be good…" especially for homeless and low-income populations.

- **Vocational services**, with some specifying a need for therapeutic vocational services for young adults.

### *Prevention, Education & Research*

Feedback from participants in Region 1 focus groups for this report and from conversations in numerous meetings indicate an increasing need to focus on **prevention and early intervention** as it relates to health and wellness. This approach increases individual and community participation in prevention efforts as it a strength-based and positive approach. Focus on prevention is also an effective cost-saving measure. A report titled the Power of Prevention noted that "Every $1 spent on substance abuse prevention results in an average of $10 in long term saving including health care costs. (www.carsrp.org/publications/PowerOfPrevention/POP_0101.pdf)

- Given the existence of the DMHAS infrastructure and the deep community relationships fostered by the RACs, the expressed need to focus more on prevention, and the cost effectiveness of this approach, it would be only reasonable to build upon what is already in place and continue to build a coordinated effort across departments and across the lifespan.

- Prevention efforts have been primarily concentrated on youth as both addiction and mental health issues usually start in adolescence. (Source: CASA Report "Adolescent Substance Use: America's #1 Public Health Problem" 2011). However, two factors have expanded prevention efforts over the past few years to include adults and older adults. First, the opioid epidemic is an addiction that has also started with adults and older adults. Secondly, Connecticut demographics are changing. The baby boomers are coming of age and we have a growing older adult population that has different behavioral health needs than our youth.

- One respondent commented that there is a need to "Create a new model for prevention beyond the Strategic Prevention Framework (SPF), addressing mental illness in conjunction with prevention programs." However, as a result of using the SPF, some communities, have identified and are addressing ATOD priorities and mental health issues.

Many respondents commented on the need for **review and evaluation**, checks and balances, and a system of procedures all aimed at monitoring changes in the system—especially as the funding climate continues to evolve.

- The Regional Mental Health Boards provide a venue for the community to have a voice in the system through the Reviews & Evaluations (R&Es) carried out by CAC members with the support of RMHB staff. The R&E process is a participatory process enabling both consumers and providers to provide constructive feedback on aspects of the state-funded system.

- Focus group respondents noted that the funding changes to date (with more forthcoming) will have an impact on quality of services, staff morale, waitlists, and more. These changes have already begun to occur (see "Impacts" in Section V.A.). Evaluation processes will be important to help monitor impacts.

In terms of **research**, the behavioral health providers surveyed were asked whether there was any additional data that should be collected. Their suggestions included gathering information on:

- Wait list data for outpatient clinics (multiple mentions). Identify who is not being served, what are the wait lists, what individuals are falling through the cracks because of gaps in services. (SWRMHB's Review & Evaluation Committee will repeat the wait list study from summer 2015.)

- The value added by providing mental health supports, from prevention to crisis services: How does it save communities/businesses/health systems money?
- Other respondents did not feel any additional data collection was needed because it does not lead to changes due to lack of funding. A respondent working with the homeless pointed out that "we are already trying to [gather more data]. It's just that there is less money to do the programming for our statewide homeless database to customize reports that we could use to improve what we do based on our collected data."

# IV. Impacts & Gaps

A key element of the biannual needs assessment is to identify gaps and emerging issues. At present, the most notable emerging issue is ongoing fear and uncertainty about the financial situation of the state and its downstream impact on communities and providers. Below we list the reported impacts of budget cuts and rescissions to date, followed by identified gaps and emerging issues.

## A. Impact of Budget Cuts to Date

Out of 17 responding DMHAS-funded behavioral health providers in Region 1:

- 11 agencies reported an increase in caseload
- 6 agencies reported an increase in waitlisted clients
- 4 agencies reported an elimination of programs
- 4 agencies reported turning away clients
- 4 agencies reported staff reassignments
- 3 agencies described realigning programs and positions
- 3 agencies reported a reduction in program hours
- 3 agencies reported staff layoffs
- 3 agencies reported a staff hiring freeze

Within SWCMHS, the closing of the two Transitional Residential Programs in Norwalk and Bridgeport led to staff layoffs and reassignments, demoralized many staff and managers, and upset clients. SWCMHS is to be commended, however, on successfully relocating all former TRP clients.

Consumers and Municipal Social Services revealed several consistent concerns in response to state budget cuts, including:

- Overall lack of resources: Across communities, virtually all programs that provide behavioral health-related services have been reduced (YSBs, SBHCs, providers, hospitals, town budgets), for a greater overall impact since there is nowhere left to turn. Funding sources such as the United Way have also reduced their available funds.
    - Within the region, Kids in Crisis—the only emergency shelter beds south of New Haven—lost all its state-funded beds.
    - Greenwich Hospital stopped providing pediatric behavioral health services

    - Municipalities have had to make cuts to positive youth programming (for example, Stratford had to cut its summer theater)
- Consumers feel insecure and unstable because of the ongoing loss of community supports—including, in some cases, cuts to health insurance
- Need for cultural competency (for example, Dubois no longer has a Creole-speaking Case Manager, despite an established client need)
- Repeated staff turnover is disruptive and confusing to staff (who are demoralized and overworked) and clients (who must emotionally reconnect to providers and repeatedly tell their stories) – these factors make continuity of care challenging, if not impossible
- Significant cuts impact trips and training, including WRAP training
- Housing supports have been severely impacted:
    - Rental subsidies have been reduced
    - Security deposits are no longer available
    - The HOME Program is no longer accepting new applicants
- Stamford has had to move Juvenile court to Bridgeport
- At FS Dubois, the staff is half the size it was 2 years ago, impacting both provider workload and client service delivery

## B. Gaps & Emerging Issues

Consumers, Catchment Area Council members, and municipal social services identified the following as gaps that are not being met:

Population gaps:

- The undocumented
- HUSKY C for residential substance use disorder treatment
- Elderly with substance abuse and complex medical issues
    - No residential options

Service gaps:

- Cultural awareness of mental health, mental wellness, prevalent mental health disorders – depression, anxiety, ADD…
- Limitation of services needed by college students (high risk population). UConn-Stamford reported:
    - no one to refer to for med management unless student has private pay
    - No availability of appointments unless critical
    - No one to refer to for substance abuse
- Beds:
    - Severe shortage of residential hospital and crisis beds
    - No respite beds
    - Peer respite alternatives (not hospital, like Afiya)

- Hoarding issues: mental health issues that interfere with code compliance
    - Can't afford specialized care – must choose between care/rent
    - Hoarding – gap in care provision
    - Health community and municipal services must get involved
- Adult mental health remains a fragmented of a siloed system; there is not a well-coordinated system of care for adults
    - Hospitals need better outpatient programming support for substance abuse, including substance use intensive outpatient services; hospital are not strong in this needed service provision
    - Providers that offer mental health services only offer part-time psychiatrists
    - Child Guidance is overwhelmed with service requests, and currently maintains long waitlists – Child First and similar programs are crucial
    - Organizations that understand child development must expand programming to meet client need
- Youth mental health
    - Early detection programs (from 0-5 yo) are needed
    - Differentiate children's mental health from adult mental health. Use expert agencies such as Child Guidance to develop programming
    - Primary gap for children's behavioral health is the need for specialized Intensive Outpatient Programs and Partial Hospitalization Programs. In Greenwich, Kids in Crisis may be a model as they explore creating an IOP/PHP program.
- A need to humanize service delivery, making it more people-centered; too many DMHAS clients feel that agency "sees us as numbers, as beds, not people"
- Establishing a greater sense of empowerment for clients; explore bring back programs like CT Self-Advocates for Mental Health

Emerging issues cited repeatedly include:

- Substance abuse - No availability of beds when someone is ready (2-3 month wait)
    - 800 hotline has to be for **ALL** substance use and needs monitoring & evaluation
    - More transient people are very difficult to reach
    - Assessment Centers can only assist active users – benzos/coke must be in system to go to detox 9and be put on methadone); no rehab options if withdrawal has been initiated Gap: when calling 800 substance use hotline not needing detox, you are directed to call 211, an unnecessary responsibility that should not be placed on those seeking help –
    - A lack of education, and a great deal of misinformation amongst young adults (for example "marijuana is a good alternative to quitting cigarettes")
- Opioid use and abuse in the community –need to review Medical Examiner records and note who is most likely to die of an overdose (in 2015, males between 35 and sixty made up the majority of overdoses); target prevention efforts towards those communities most impacted.
- Increase in untreated mental health issues among community residents

- Increasing number of young teens (13-16 years old, often girls) with anxiety and unregulated moods with minimal family support
- Families still affected by stigma, reject possibility that it is a mental health issue → Generation Gap affects response, perceptions and ability to seek help
- Supportive services for family members dealing with a loved one with substance use or mental health disorders

- Suicide prevention remains a pressing issue (in 2015, CT saw the highest number of suicide deaths EVER)

# VI. Recommendations & Considerations

A large number of recommendations and considerations were suggested and discussed throughout our focus groups, key informant interviews, and provider surveys, as well as at meetings throughout the year. In this section we present (a) models of care that were recommended to be expanded or replicated as effective and efficient ways to better serve client health; (b) recommendations related to each priority and core area, indicating which levels of the system could be involved in implementing them, followed by (c) recommendations specific to SWCMHS. We conclude with (d) a set of alternative models proposed for discussion, to encourage possible paradigm shifts as the state's financial picture continues to evolve.

## A. Models of Care to Build Upon

As respondents discussed the need to protect key services in an environment of shrinking budgets, they highlighted the need to maximize resources and focus on outcomes by building on or adapting integrated and coordinated care models and making use of innovations such as telepsychiatry. "Agencies need to operate more like a business and much more thoughtfully rethink how they engage people seeking services – both of these are aimed at achieving better outcomes and gaining efficiencies."

Models of care recommended to be strengthened or expanded include:

- Integrated medical & behavioral health care (cf community health centers, which provide onsite medical, psychiatric, and oral health; DMHAS's Behavioral Health Homes initiative, which coordinates medical care for identified high-need behavioral health patients). Another option mentioned was Choices, which is a Medicare model providing both palliative and rehabilitative care.
  - Include integration of case management into services for all those in need to ensure a wraparound approach.

- Coordination & team models among providers and agencies, from the CCTs to the CAN. In our region, the CCT model is being applied at the municipal level as a way to bring various services together regularly to coordinate around cases regardless of the specific program or issue they fit into. "No wrong door!"
  - Where integrated care is not available, develop coordination mechanisms to improve connections among Primary Care Providers and behavioral health providers. In the Greater

Bridgeport area a committee of the Primary Care Action Group will be piloting a screening and referral model in urgent care clinics.
    - As a provider wrote, "Deepen collaboration beyond mental health agency walls. Work on collective impact, cross training and collaboration training for staff, advocacy to fill service gaps. Cultural competency."

- Programs that offer skill building, case management, and other supports such as the CSP/RP program, WISE waiver, and MH Concierge. Currently these programs are only available to specific individuals, based on diagnosis + ability to pay (insurance), rather than the overall population.

- Peer-based programs. As described above, Certified Recovery Support Specialists and Recovery Coaches are available to provide a range of supports but are underutilized in the system, with many currently unemployed.

- Telepsychiatry, such as the Access Mental Health CT model which provides consultation to pediatricians or other models, such as the St. Vincent's model being piloted, which provides clients with direct access to a psychiatrist and social worker. A variety of telemedicine models are in effect for medical health that may be able to be adopted.

- Increase use of technology for coordination and networking.
    - Improve centralized registries such as the CAN, bed registries, etc.
    - Promote awareness of various social media for online networking (including finding therapists):
        - "wellness professionals of CT" facebook page was recommended by several providers
        - Meetup.com – in Region 1 a "Wellness Is Where We're At" page was set up to provide social/recreational opportunities for consumers and supporters
        - Angie's List
        - Resources to Recover (rtor.org) is Laurel House's website providing vetted information and referrals to "family-endorsed providers"

## B. Recommendations by Priority Area

| Recommendation | Legisla-ture | DMHAS / State | Providers | Regional Team |
|---|---|---|---|---|
| **ACCESS TO OUTPATIENT SERVICES** | | | | |
| 1. Protect existing mental health & addiction services—which are bare bones—from further cuts. Seek to restore transitional / intermediate care programs (including IOPs, PHPs) to divert those in need from homelessness and/or hospitalization. | ✔ | | | |
| 2. Expand implementation of Open Access model for urgent /immediate care; make intake "seamless" | | ✔ | ✔ | |

| Recommendation | Legisla-ture | DMHAS / State | Providers | Regional Team |
|---|---|---|---|---|
| 3. Monitor client wait times, waitlists | | | ✔ | ✔ (review & evaluation) |
| 4. Offer after-hours and/or in-home services to make services available when and where needed, such as following a hospitalization.<br>▪ Consider having RSS's provide in-home follow-up visits and/or daily phone calls. | | ✔ | ✔ | |
| 5. Improve discharge planning and connections to community services from hospitals. | | ✔ | ✔ | ✔ (provider resource forum being planned) |
| 6. Provide appropriate salaries to attract and retain qualified behavioral health professionals and avoid the revolving door in the public sector | | ✔ | ✔ | |
| 7. Address cost of behavioral health care through insurance reform:<br>▪ Streamline systems and reduce / create uniform paperwork. Place all insurance formularies on a single website.<br>▪ Better promote the benefits of participating with insurance companies.<br>▪ Investigate other system reforms, such as tort reform or requiring providers to either participate in insurance and/or provide a sliding fee scale.<br>▪ Increase the number of sessions covered by insurance, following best practice guidelines (i.e., 30 day programs are not enough) | ✔ | ✔ | | |
| 8. Provide emergency access to medication refills | | ✔ | ✔ | |
| 9. Monitor and improve new opioid hotline – expand it into a statewide addiction hotline - no wrong doors approach | ✔ | ✔ | | |
| 10. Make SUD treatment available to those under 16 (currently only limited programs exist for 16-18) | | ✔ DCF+ DMHAS | ✔ | |
| 11. Consider treatment telephone emergency line similar to Quitline or Hopeline where someone can talk to a doctor | | ✔ | | |
| **WORKFORCE / CAPACITY** | | | | |
| 1. Expand the successful and low-cost "Access Mental | ✔ | ✔ | | |

| Recommendation | Legisla-ture | DMHAS / State | Providers | Regional Team |
|---|---|---|---|---|
| Health CT" telepsychiatry program to other providers besides pediatricians. | | | | |
| 2. Monitor the St. Vincent's telepsychiatry model and research other models. | | ✔ | | ✔ |
| 3. Develop task force to explore expanding the scope of work of other providers to supplement psychiatrists. | ✔ | | | |
| 4. Create incentive systems to expand the pool of doctors entering psychiatry. | ✔ | | | |
| 5. Develop incentives for providers to learn Spanish. | | ✔ | ✔ | |
| 6. Research models such as the "Welcome Back Center" at Laguardia Community College which retrains/updates skilled immigrants so that they can be recertified in this country. | | ✔ CT Board of Regents | | |
| 7. Research cost-effectiveness of peer support services as a primary staffing model | ✔ (OLR) | | | |
| 8. Expand use of peers (RSS's, Recovery Coaches, Peer Bridgers) in provider agencies, hospitals, EDs | | ✔ | ✔ | |
| 9. Support Medicaid reimbursement for services provided by certified peers | ✔ | | | |
| 10. Protect case management services | ✔ | ✔ | | |
| 11. Provide ACT team services | | ✔ | ✔ | |
| 12. Seek to create a "hardship clause" where staff cannot be reallocated due to layoffs if they have a unique skill or language that is required in their current program. | ✔ | ✔ | | |
| 13. Consider developing niche behavioral health services as a way to treat conditions in-state, provide employment, and build the revenue base. For example, instead of last year's proposal to build a new casino, seek to attract/develop a premier treatment facility for gambling addiction in Eastern CT near the CT and Mass casinos. Similarly, many CT residents seek private addiction treatment out of state. | ✔ | | ✔ | |
| **INPATIENT SERVICES** | | | | |
| 1. Increase the number of inpatient beds, which has been reduced even as needs and waitlists have increased. Develop alternatives to the ED for those waitlisted. | ✔ | ✔ | | |
| 2. Create online up-to-the-minute statewide registry of all available beds in public & private sectors and use IT | | ✔ | | |

| Recommendation | Legisla-ture | DMHAS / State | Providers | Regional Team |
|---|---|---|---|---|
| tools to facilitate trading or sharing funded beds as needed. (Seek private funding or relationship with hospital systems.) | | | | |
| **RESIDENTIAL/CRISIS/RECOVERY SUPPORTS** | | | | |
| 1. Protect housing supports such as security deposits, rental subsidies, and emergency funds to keep people at risk housed. | | ✔ | | |
| 2. Protect Permanent Supportive Housing. | | ✔ | | |
| 3. Protect mobile crisis. | | ✔ | | ✔ (R&E) |
| 4. Improve bed registry to include all beds and keep up to the moment (seek funding) - E.g. Expanding detox daily notifications | | ✔ | | |
| 5. Investigate creation of Sobering Centers, as in the Houston Recovery Center model, to divert people from jails and/or the emergency department and provide access to recovery coaches. | | ✔ | | |
| 6. Protect and fund CCT model. | ✔ | | | |
| 7. Support and improve the CAN shelter access system, including collaborating with first responders to identify people earlier. | | ✔ | | |
| 8. Monitor the application of the CCT model to other areas that is taking place in Bridgeport and Stratford, for possible replication in other communities. | | | | ✔ |
| **PREVENTION, EDUCATION & RESEARCH** | | | | |
| 1. Gather data on wait lists and who is being affected by the budget cuts. (How many people are waiting >2 weeks?) | | | | ✔ (R&E) |
| 2. Reach out to all police departments in region to determine % of officers who have CIT training or MHFA public safety training. Work with them to increase training. | | | | ✔ |
| 3. Develop template for municipal suicide response plan, following model of municipal crisis response plan and implementing suicide postvention best practices. | | ✔ CT SAB | | |
| 4. Work locally to develop postvention suicide response plans with each community. | | | | ✔ |
| 5. Work with SDE to ensure consistent SA Prevention and MH promotion education in curriculum (via ADPC) | | ✔ | | |

| Recommendation | Legisla-ture | DMHAS / State | Providers | Regional Team |
|---|---|---|---|---|
| 6. Update DMHAS website to include more information on best prevention practices in CT and in other states | | ✔ | | |
| 7. Continue to provide multiple opportunities to train parents and individuals on addiction | | | | ✔ RACs |
| 8. Provide, post and notify of annual updates on DMHAS 6 strategies and related Action Steps described in the 2016 Triennial State Substance Abuse Plan(Pgs 15-29). | | ✔ | | |
| 9. Continue to advocate with Legislature for funding. | | ✔ | | ✔ |
| 10. Advocate for decrease in Narcan costs | | ✔ ADPC | | |
| 11. Educate medical providers around alternative pain management, wellness techniques. | | | | |
| 12. Educate and destigmatize on M-A-T- esp. methadone. | | ✔ | ✔ | ✔ |
| 13. Support treatment providers to offer more than one MAT | | ✔ | ✔ | ✔ |
| 12.Create short video on methadone recovery success stories | | ✔ | | |
| 14. Develop opioid prevention messages for all groups eg. people in 40-50's are not getting this info. | | ✔ DPH | | |
| 15. Expand SUD hotline to be full service i.e. help people connect to services ie. one-call service & advertise widely | | ✔ | | |
| 16. Ensure young adults have info on recovery options | | ✔ | ✔ | ✔ |
| 17. Address transportation challenges to get patient from hospital to SUD treatment or detox | | ✔ | | ✔ |
| 18. Protect funding for prevention, education, and research | ✔ | ✔ | | |
| **MANAGEMENT / FINANCING – provider recommendations** | | | | |
| 1. Streamline provider requirements and oversight process to ensure that it does not use up significant provider time without adding value to client outcomes. | | ✔ | | |
| 2. Create financial reform mechanism that allows and encourages providers to generate and retain "excess" revenue for future investment | | ✔ | | |
| 3. Increase reimbursement rates | ✔ | | | |
| 4. Develop a cohesive public policy and strategic plan around behavioral health | | ✔ | | |

DMHAS recently presented an overview of their 2016 Triennial State Substance Abuse Plan at the ADPC and Adult Behavioral Health Committee meetings. The 6 Key Strategic areas and corresponding goals (noted below) and action steps (noted in report) identified for a Comprehensive and Coordinated State Substance Abuse Plan include:

- Prevention and Education (Pgs 15-17 in report)
  - Achieve quantifiable decreases in substance abuse and abuse, and suicide and suicide attempt rates statewide through the skilled delivery of timely, efficient, effective, developmentally appropriate, and culturally sensitive evidence-based prevention strategies, practices and programs.
- Treatment (Pgs 18-20)
  - Expand access to broad spectrum of substance abuse services
  - Increase the use of evidence-based treatments (EPBs)
- Recovery (Pgs 21-22)
  - Increase the use of peers and natural supports.
  - Maintain recovery supports
- Criminal Justice (Pgs 23-24)
  - Implement criminal justice reforms that will increase diversionary options and the availability of substance abuse treatment in jails and prisons
  - Reduce barriers and adverse consequences faced by prisoners when they are released from prison or jail.
- Collaboration and Cost Effectiveness (Pgs 25-26)
  - Increase inter-agency coordination and collaboration in order to more effectively prevent and treat substance use disorders.
- Accountability and Quality Care (Pgs 27-29)
  - Ensure that providers deliver high quality services
  - Use data to improve care throughout the system

A number of the related Action Items from this plan are also recommendations from Region 1. Posted updates from this plan on the DMHAS website and advising of such will help coordinate efforts and increase efficacy of resources.

## C. Recommendations Specific to Region 1 State-Operated Facilities

Among other suggestions, consumers at the state-operated facilities in Bridgeport and Stamford made a number of recommendations specific to programs and services within SWCMHS. The recommendations are very feasible and low-cost:

1. Review grievance procedures, including sexual harassment, with staff and clients through training and posting information:
   - A respondent who had reported a sexual harassment complaint did not feel heard or well responded to and had no sense of whether the concern had been handled months to a year later.
   - A grievances poster in the GBCMHC elevator had a blank space for the Grievance Officer's name and contact info to be listed.

- Staff who had been trained as Clients Rights Officers were not sure what their role should be nor how clients would identify them as such.

2. Improve discharge planning & connections to care:
   - Provide follow-up home visits post-hospitalization, perhaps using RSS's—similar to the Peer Bridger model—or 10-minute daily phone calls from a peer.
   - Consider a **g**roup for people who missed med appointments: they drop in, psychiatrist there, talk→ social support.

3. Rebuild a common body of knowledge and a common philosophy such as existed during the transformation movement when everyone was trained together back in 2006-07
   - Provide refresher training
   - More trained facilitators so that people don't get locked into repeating the same training over and over
   - More groups related to stages of change

4. Bring back funding for trainings

5. Promote the NetLab / CogLab program or similar that used to exist in Bridgeport, or a similar program such as Laurel House's "Thinking Well" program

6. Bring back the chaplain and expand spirituality groups

7. Provide more exercise on the inpatient floor

8. Increase access to the social worker; one consumer who is also an employee noted that after becoming an employee there were no longer visits with the social worker or call backs, but rather "stop by when you need to."

9. Integrate health care and wellness into offerings. For example, the mammography van used to come to Dubois. Similarly, inform consumers about available healthcare options. Consumers at FS Dubois were not aware of the very extensive free health, dental and mental health programs offered every October in Stamford at the Hispanic Health Fair, despite the fact that SWCMHS staff participate at the fair and it is not limited to the Latino community.

10. A particular area of concern was the need to improve handling of staffing changes, especially with more funding cuts coming which may lead to additional layoffs. Consumers felt they were not given advance notice about doctors or other staff leaving and that they were not given opportunities to support them through multiple transitions. They recommended:

    - Provide opportunities to process and provide mutual support around departures of long-time staff members
    - Allow consumers to participate in exit interviews

- Be more flexible about switching and transitioning case managers, therapists, and other staff
- Respect the client's voice (examples of consumers being transferred to services despite saying the services did not meet their needs)
- Honor decisions made with clients (example of client being told they would stay in a program for a fairly long period of time yet then being transferred within a couple of weeks instead)

## D. Alternative Models for Discussion

As legislators and state agencies consider ways to address overarching structural & policy barriers, different paradigms for discussion could include:

1. ConsIder eventually consolidating youth & adult behavioral health programs (currently within DCF and at DMHAS), in order to provide a continuum of services across the lifespan and to be able to address growing problems proactively. A unified agency would improve coordination and quality of care, remove barriers, and save costs. Most states follow this model.

2. Relatedly, consider altering the balance of funding along the continuum from prevention to hospitalization and residential services. Invest in a comprehensive, cross-sectoral community wellness initiative in collaboration with public & private partners, including the Department of Children and Families and the State Department of Education, with the goal of creating healthier families and communities and reducing stress, trauma, mental illness and substance use. A heavier downstream investment will produce better outcomes and lower long-term costs.

**3.** Consider making key DMHAS services available to all populations in need and charging for services.
   - DMHAS's recovery support programs, such as CSP/RP, supportive employment, supported education, and Young Adult Services; ACT teams; and the level of expertise in caring for those with co-occurring Severe Mental Illness and Substance Use Disorders, are generally not available in the private sector.
   - Recently Mental Health CT developed the fee-for-service "Mental Health Concierge" program to provide recovery-oriented services, including case management, to individuals in need who are not covered by the state.
   - If DMHAS were able to bill private insurance and/or accept fee-for-service, these services could be available to the many middle-class people seeking these services while DMHAS would also have another source of income.

**4.** Consider decreasing the direct care therapeutic and residential services provided by DMHAS and increasing contracts with outside providers. This option would allow DMHAS—with its reduced staff and budget—to focus on policy, program oversight and coordination, case management, and recovery support services. Private providers generally have more flexibility with staffing and program changes.
   - Some providers noted that DMHAS "spends too much on layers of management and Administrative Services Organizations," rather than direct patient contact.

5. Investigate the possibility of reorienting the delivery of behavioral health care so that certified peer specialists serve as primary rather than supplementary staff. Recovery Support Specialists, including Recovery Coaches, can provide a variety of supports, often at lower cost, while providing critical peer-to-peer connections. The success of peer-based models such as the Hearing Voices Network and the Afiya respite house point to the effectiveness and cost-effectiveness of these services.

**Throughout the needs-assessment process, many respondents pointed to the critical need for the state to develop a long-term plan to bolster the sagging economy. It was observed that in the current environment, providers are battling each other "over crumbs" and essential functions such as prevention, education, coordination, and research are "crowded out" in favor of treatment.**

# Appendix I: Questions for Focus Groups & Provider Survey

1. Given the state's financial picture, what are the *critical* areas for the behavioral health system to *protect* in the next few years?

2. The following are the 5 priorities in the DMHAS system: Inpatient Services; Outpatient Treatment; Residential, Crisis & Respite Services; Recovery Support Services; Education, Research & Prevention

    a. Please rank these priorities from 1 (top priority) to 5 (lowest priority of the 5), in your opinion.
    b. Is anything missing?

3. 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?

4. In what parts of the behavioral health system do we need to do things *differently*?

    a. What models should we consider for each of these areas?

5. Which current or new populations are most difficult to serve?

6. What is the impact of the recent and latest budget cuts on your agency? Check any and all that apply:

    a. Elimination of programs  Please name (optional):
    b. Reduction of program hours
    c. Increase in caseloads
    d. Increase in client waitlists
    e. Turning away of (more) clients
    f. Layoffs
    g. Staff reassignments to avoid layoffs
    h. Hiring freeze

7. Please provide any additional details:

8. What are any emerging issues that you are seeing or hearing about?

9. Are there types of data that should be collected to help identify gaps and needed resources?

10. 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).

# Appendix II: List of Focus groups & Key Informant Interviews

- Catchment Area Council 1&2
- Catchment Area Council 3&4
- Community Care Team (CCT) of Stamford/Greenwich
- Liberation Programs Inc. : Clinician, Substance Abuse Treatment
- F.S. Dubois Center - mental health consumers
- Greater Bridgeport Community Mental Health Center - mental health consumers
- Municipal social services
- Greenwich
- Monroe
- Stamford
- Stratford
- Weston
- Westport
- Recovery Network of Programs: Staff of Methadone Clinic
- Recovery Support Specialists in Mental Health system

# Appendix III: Summary of Region 1 Provider Survey Responses

#1 Priority - Outpatient Services
#2 Priority - Residential/Crisis/Respite
#3 Priority - Inpatient Services
#4 Priority - Recovery Support Services
#5 Priority - Education/Research/Prevention

COMMON THEMES IN COMMENTS SECTIONS

- The need for housing
    - Low Income Residential (5 mentions)
    - Supportive (5 mentions)
    - Group Homes (2 mentions)
    - Rental Subsidies (2 mentions)
    - Crisis/Respite, Transitional and Security Deposit (4 mentions)

- The need for increased funding/concerns about current and future funding cuts (16 mentions)
- The need for accessible in-patient mental health treatment (11 mentions)
- The need for easier access to and increased community mental health services (11 mentions)
- The need for easier access to and increased substance abuse services (treatment, support and recovery) (9 mentions)
- The need for Mobile Crisis Services (8 mentions)
- The need for increased youth services (IICAPS, FST, EDT, IOP, vocational) (8 mentions)
- The need for more prevention/awareness services (mental health, substance abuse and co-occurring disorders) (8 mentions)
- The need for Intermediate Care Services (7 mentions)
- The need to collect more data regarding behavioral health through surveys, research, etc. to accurately identify trends, recognize emerging issues and crises, expand on what is working (6 mentions)
- The need to collect more data regarding behavioral health through surveys, research, etc. to accurately identify trends, recognize emerging issues and crises, expand on what is working (6 mentions)
- The need for more Case Management services (5 mentions)
- The need to abbreviate/eliminate long wait times to access/enroll in services (5 mentions)
- The need for prescription refill/management services (4 mentions)
- The need to expand availability of and Improve access to MAT services (3 mentions)
- The need to implement outcome-oriented performance measures to maximize agency performance (3 mentions)
- The need for cultural competency training (2 mentions)
- The need to improve transportation services (2 mentions)
- The need to identify clientele that are “falling through the cracks” (1 mention)

POPULATIONS IN NEED THAT PRESENT UNIQUE SERVICE CHALLENGES

- People who are young (teens and young adults) (8 mentions)

- People who are young (teens and young adults) (8 mentions)
- People who have a substance use disorder (5 mentions)
- People who are undocumented (4 mentions)
- People with mental health disorders (4 mentions)
- People who are elderly (3 mentions)
- People who are low-income (2 mentions)
- People who are ambivalent about treatment, have transportation issues, co-occuring, homeless, LGBTQ, monolingual in uncommon languages, unmedicated, untreated or new to treatment (1 mention)
- People with co-occurring disorders, adults on the spectrum (1 mention)

RESULTS OF BUDGET CUTS

- 11 agencies reported an increase in caseload
- 6 agencies reported an increase in waitlisted clients
- 4 agencies reported an elimination of programs
- 4 agencies reported turning away clients
- 4 agencies reported staff reassignments
- 3 agencies described realigning programs and positions
- 3 agencies reported a reduction in program hours
- 3 agencies reported staff layoffs
- 3 agencies reported a staff hiring freeze

# Appendix IV: Summary of Consumer & CAC Responses

**STRENGTHS & AREAS TO PROTECT**

- **State operated** services!
  - Provide a range of level of care (LOC) and type of services, groups.
  - Sense of consumer empowerment, voice
  - Good services when you get in!!!
- Protect **quality** of services: a $ cut in one place affects everything else. Clients end up with 10 minute med checks every few months but that doc who hardly sees you is the one who is responsible for your referrals!
  - Need for system of R&E
  - Review policies and procedures
  - Ensure checks & balances
- Protect **staffing**:
  - Ability to see case managers, therapists, psychiatrists
  - Ability to retain doctor
  - At Dubois, 2 psych's have transitioned since December (are exit interviews conducted?); Dubois, Norwalk, Greenwich, Optimus have all lost psychiatrists – FSDC now has HALF the staff of two years ago
  - Don't cut therapists or case managers
  - "When I call, she picks up" "I call, I'm called back by end of day"
  - Staff self-care
- **Medications** – some can't afford, some copays
- Accessibility of services / access to care
  - Protect **coordination** and information – people call looking for answers
- Efforts to build **awareness**
- Basic needs! In a budget crisis, the primary area to protect is to ensure that people have a roof over their head, food & clothing, some health care. In BH, that translates to protecting **case management** as a primary concern.
- **Health** – more support, calls to check in (OBS - just like Dubois!)
- **Recovery** supports:
  - **Peer** Support: helps with groups, skills in employment, self-esteem, independence
  - **Employment** Support
  - **Housing**:
    - Intermediate and long term residential housing shortage
    - Supportive housing: shelter + care
    - Affordable housing (FMR in Fairfield County!!!)
- **prevention funding:** insufficient prevent funding makes it difficult to be proactive in the research and prevention of substance use/abuse initiatives which frequently stem from mental health issues
- **YSB** funding
- **health insurance:** cuts will be very problematic for our clients
- **Crisis intervention** services
- **Transition** services: we lose too many between levels
- **Peer** services: underutilized/strengthen
  - Integrated, monitored system: quality control
- **Community care teams**: integrated care, lowered health care costs- share approaches, build support
  - Opportunity to create something by overcoming siloes
- **Town social services**
- **School-based health centers**
- **Youth services**- Prevention and education for youth and families
- **Treatment services**- earlier access

    - E.g. Billable services that can address risk factors and warning signs
- **Sustainable recovery supports**- no barriers to access
    - E.g. Sober housing, transportation
- **After hours support** → Have a script
    - Would 211- after hours support
    - Warm line
- "If focus was on recovery, there would be less people going into inpatient"
- Lack of professional clinicians to take appointment - 3-4 weeks to get an appointment
- Low pay to saff
- Going through ER because no psychiatrists
- **CCT teams**- no $ for paid Navigator
- Need more urgent care appointments – takes 3-4 weeks
- Protect the continuity of the CCT team - Need dollars for a part time navigator
- **Weekly**- All who attend are there because of the mission
- Strategy with decreased resources
    - "Left hand knows what the right hand knows"
    - This is what the CCT does
- Bring down the cost of opioids treatment and narcan
- Narcan nasal would be best (breaking them because they're fragile)
- Making treatment more available
- 1-800 number is good but we need to follow through
- **Methadone**
    - Proof of one year addiction can be a challenge
    - If < 1 year ambulatory- good
    - Increase from 3 months to 6 months for detox
    - Increase dose past 60 mL
- **Suboxone**
    - Very expensive
    - Not enough regulations, structure

**STRENGTHEN/FIX**

- More RSSs
- Need to increase pay to Recovery Support Specialists (RSS)
    - Relatively New Positions
    - May not see our value
- More $, more staff
- Need to increase workforce; maintain and develop personnel; appropriate salaries (Child Guidance salaries are so low that people leave for private sector)
- Need unified model for people/families to navigate system –
    - LaGuardia example!
    - Wraparound models
    - Care coordinator
- Better integration
    - Connections to primary care providers
    - Walk-in clinics → referrals from medical side
- Clergy: info

- Go younger – need to focus on kids – but can't legislatively b/c of state agency design - ridiculous system – why graduate from DCF and go into YAS ?! to be effective keep going younger with prevention and early intervention – pay now for oil filter or pay later for new car!
    - Consolidate adult and child MH – take child BH out of DCF and put it in DMHAS
- Another suggestion for DMHAS with diminished budget: DMHAS needs to seriously consider closing some of their direct outpatient services and contracting with local providers. DMHAS holds on to case management of the clients but case manager purchases services the client needs from local providers. Get DMHAS out of direct services that they do not do well and purchase from local not-for-profits that have better quality services. It would be cheaper and better outcomes in the long-run.
- More staff: outpatient CM, therapists, psychiatrists
- Create trauma informed environment: 90% have trauma history
- Accessibility to housing – long waiting times and waiting lists
- Lack of adequate, timely information and customer service/responsiveness with DSS to assist client's in accessing services
- Increase in affordable, accessible mental health treatment locally,
- lack of transportation to treatment is problematic to low income clients
- Methadone clinics: use some of money for non-MAT services
- Bridge subsidies Dx with MH, DMHAS client, housing issue → get bridge money
- Braiding MAT and SA
- Housing is a tremendous need/stability critical to treatment
- Schools unprepared to offer MH assistance, passing clients to SS departments – "passing the buck"
- Clients referred to 211, no one qualifies - client must make phone call personally, often unsuccessful
- Shelters:
    - Increased volume at local shelters
    - People (not professionals) assume shelter is the safety net, it's not
- Collaborate with first responders - identify "hot spots" (hotels); can earlier identification happen? Ethical questions challenge response: who are "first" responders? There are issues with judgment re drug use, drug users
- Realistic Communication
- High expectations – "just fix it" mentality towards social services
- MHFA: for public safety officials (add in protocols/social services pieces)
- Do our trainings meet police CEUs – logistics preplanning
- Protect access to hospitals, ambulances
- Fix ER overcrowding
- Transition from hospital to outpatient care:
    - Help with meds, connections
    - Home health circle, 15 minute visit
    - Peer support
    - Daily phone call: Mixed opinion, some say it might help, others think personal presence even for a short time will help
- Misperception of Fairfield County as wealthy: we have needs, exacerbated by high cost of living
- Long waits because of state insurance
    - Psychiatrists and regular electors: waiting for hours at Optimus (141 Franklin)
- Mammo van used to come to Dubois, why not have dental hygienists come by? Dubois could coordinate care in this way, bring the services here – also ensure that FSD is informing clients about community-based medical options like the annual Hispanic Health Fair in Stamford which provides all kinds of free medical and dental care
- Bring Peer-Bridgers to Region 1
- When there were patients at Fairfield Hills, they were brought to Dubois twice per week to help prepare for transition
- 900 recovery support specialists not being utilized
- Prevention (#1) because we need to teach people earlier
- Recovery (#2) When a person is ready for recovery → small window of opportunity

    - Peron needs residential or just needs 12 step or just needs outpatient
    - Many people complete the 60 day program but there's a gap in access to recovery planning
- All: relating to education issues (stigma)
- In Medical field need more education on:
    - Kids with mental health problems
    - Methadone education
    - Decrease mg so people are gradually on/off- taper!
    - Alternative pain management (i.e. Yoga, physio)
    - Educate patient on pain medications
    - Behavioral techniques
    - Doctors need more addiction training
- In schools:
    - Teach alternatives to kids on pain management
    - Prevention in schools
- Addressing stigma:
    - Normalizing disease- not a moral falling
    - Ending discrimination
    - Students- mandated education to decrease stigma
- Parents need to be educated
- Methadone comes with counseling- make lifestyle changes
- Suboxone- needs more structure. Ensure counseling accompanies this.
- Generational training
- MH/SA Priority focus group did not answer what needs to be strengthened.
- Crisis is always number 1
- Local hospitals are acute but need long-term
- Need support services
    - E.g. Changing but no discussion on retention
    - Linking supports in the community
- Focus: House the chronic but can't leave them- showing up, collaboration
- Level of service inventory
    - How much is pulled into criminal justice?
    - Law much pulls into criminal vs. social?
    - Know: High risk influences
        - Low-risk as well
- Positives of CCT (Face & story)
    - Knowledge
    - Level of commitment
    - Navigate the system- this info is shared at Tue
    - Opportunity to build relationships with the most challenges

**ISSUES & GAPS**

- The undocumented!!!
- HUSKY C for residential SA
- Elderly with SA and complex medical
    - No residential
- Cultural awareness of MH – what's health, what's ADD…
- Staff training

    - License x mental health professionals – education (long term)
- UConn:
    - no one to refer to for med management unless student has private pay
    - No availability of appointments unless critical
    - No one to refer to for SA
- Beds:
    - Severe shortage of residential hospital and crisis beds
    - No respite beds!
    - Peer respite (not hospital, like Afiya)
- Fragmentation of system – still after 35 years working in the field! Adult MH side – not a coordinated system of care for adults – hodge podge –
    - Hospital: better OP programming on SUD side than psych, including SU IOP – hospital not a very solid partner –
    - Fam Centers provide MH services but only have p-t psych –
    - Child Guidance doing its best but long waitlists – Elliot Brenner working on it, trying to push Child First –
    - At Fam Centers trying to push Bob Arnold to expand child devt as much as possible
- Early detection programs needed from 0-5yo
    - Differentiate child MH from adult MH – KiC, Child Guidance, Family Centers –– GDSS tried to bring them together to see what could
    - Primary gap for children's BH is need for IOP and PHP – KiC looking into developing combined IOP/PHP program
- Stamford-Greenwich MH provider group: struggling
- Opioid use and abuse,
- suicide prevention
- Increase in untreated mental health issues among residents.
- Lack of accessible/affordable providers who accept state insurance.
- 13-16 year old girls w/anxiety: needing counseling, seeking help on own – moods unregulated → families still buy into stigma, don't agree it's a mental health issue – Generation Gap
- Substance Abuse: Impact on family
- Hoarding issues: mental health issues that interfere with code compliance
    - Can't afford specialized care – must choose between care/rent
    - Hoarding – gap in care provision
    - Health community must get involved
- Substance abuse - No availability of beds when someone is ready (2-3 month wait)
    - More transient people are harder to reach
    - Assessment Centers: only help if person is detoxing -Need benzo's in system, maybe coke, to get into detox; then they put you on methadone
    - Gap: told (by hotline) to call 211 if you don't need detox
- Upper echelons of DMHAS "see us as numbers, as beds, not people"
- CT Self-Advocates for Mental Health should be brought back
- Overall lack of resources
- Kids in Crisis lost beds
- Both state funding and United Way have cut back on grants to everybody
- Greenwich Hospital lost child psychiatrist and is referring everyone to Fam Centers – They say they're going to replace but are they putting the effort in?! are they going to put resources in when don't make money off the services…?
- We need an active and centralized data base that is updated regularly
- Need a resource list CDCS via CSSD)-- CSSD gatekeeper

- E.g. Expanding detox daily notifications
    - IP , OP- Cost high, minimal outcome / Can't afford

**Difficult to serve populations**

- Students and schools (13-17 year olds)
    - Hard to access
- Older Adults- Physical issues are more pronounced
- Younger = because they feel they are invincible
- Young adults (18-26)
- LGBTQ – High need and underserved

**REACTION TO PRIORITIES**

- DMHAS's rank-ordered priorities: Should be the reverse! These areas are important for DMHAS – but in terms of resources, maintain the clients **in the communities** as much as you can.

**Emerging issues**

- Opioid epidemic
- Increased medications with youth and lower age groups
- Connections with sports injuries and addiction
- Narcan is not effective with fentanyl and W18
- Seeing more young kids starting on pills
- Teens participating in Pharming aka bowling parties
- Youth: increase in higher risk behavior
- Seeing all ages but what they all have in common is prescription drugs
- Seeing more inhalation
- Not enough long-term treatment
- LGBTQ- high needs – esp. Hispanic families

**WORKFORCE CAPACITY:**

- Bilingual
- Well trained and well paid so mature & stay in public sector
- Issue affects access
- Lack of outreach workers for people in crisis and/or with addiction
    - People cycle in & out of ER
    - Hospital discharge plan including MH f/u at home
    - ACT team psychiatrist going to apartment – need ACT outside just Bridgeport
    - **Model**: Group for people who missed med appointments: they drop in, psychiatrist there, talk→ social support
        - Increase peer support
        - Facilitating services & supports so higher LOCs
    - Home visits!! (in private sector any home visits are out of pocket)
- Attitude adjustment for psychiatrists!
- Need for more psychiatrists: Only 4% of docs go into psychiatry – what is state doing?
- Recovery Supports work with people on recovery. Should be foundation of the health system and this can sustain our system longer than anything.

**INPATIENT:**

- Gotten harder to get a bed unless you say "suicide"
    - YNHH won't take people out of region
    - Waiting lists for beds and PATIENT needs to call the hospitals

- Could psych consults happen at night? Could APRN do it? Could mobile? Would you go home?
- Are people at ER because people aren't discharged to PHP or IOP but just to community?
    - Need for interim LOC, respite, etc.

**MODELS THAT WORK:**

- CSP/RP → focus on skill building
- WISE waiver / MH Concierge
- BHH
- Community Health Centers
- Coordination of care, TEAM approach
- Child first: grant funded and DCF funded
- Look at models from Europe
- Peers: peer bridgers, RSS,
- Social media for online networking (including finding therapists)
    - "wellness professionals of CT" Facebook page
    - Meetup.com
    - Angie's List
    - Resources to Recover rtor.org
- Centralized system like CAN
    - Bed registry
- Tele-psychiatry / telehealth
- Socialized medicine!!! / single provider system
- CHOICES
- We need an active and centralized data base that is updated regularly - Need a resource list CDCS via CSSD)-- CSSD gatekeeper - E.g. Expanding detox daily notifications

**Insurance**

- Husky C- No mental health treatment options (CVH, St. Vincent's)
- Private insurance- 8 sessions
- Obama care → now some can't afford medications. There is good medication but not affordable
- Reviewers → Addiction and mental health
- Increase to 6 month detox
- TRS (CCAR)- Weekly- Too much on too little
- Tx Telephone emergency line similar to Quitline or Hopeline where someone can talk to a doctor

**Recommendations to State-Operated Facilities & Impacts of Budget Cuts are identified in the full report**