2018 UPDATE ON REGION 1 PRIORITIES IN BEHAVIORAL HEALTH

Summary of Community Feedback & Recommendations

Region 1: Southwest CT

Regional Behavioral Health Action Organization (RBHAO)

Handout at CAC Meetings, September 2018

Prepared by the partners in the new Regional Behavioral Health Action Organization:

COMMUNITIES 4 ACTION
REGIONAL ACTION COUNCIL
WORKING TOGETHER FOR HEALTHY CHANGE

RYASAP
catalyst for community change

Southwest Regional Mental Health Board

2018 Priority Services Planning Report for Southwest CT
Summary of feedback from focus groups, interviews, provider surveys

I. PREVENTION

A. New Resources/ Getting Better:

- More screenings in more locations (SBIRT / A-SBIRT / Wellness Screen)
- School systems continue to increase their focus on social-emotional programming (in recognition of the constant increase in anxiety / depression / suicidality)
    - Schools are using programs like GoZen (for childhood anxiety), GoHackify (childhood OCD), Wingman curriculum, 2nd Steps
    - Wellness Days and weeks in schools
    - Norwalk launched a city-wide social-emotional and mental health initiative (Stamford and Bridgeport have previously done this)
- DCF is planning to train 900 people (statewide) in Circle of Security Parenting
- Avielle Foundation's work
- Americares interns "PreventionCorps" providing prevention education throughout the communities
- Widespread trainings on Narcan
- Stigma surrounding mental illness and seeking treatment seems to have lessened
- Discussions and transparency minimizing stigma
- Availability of groups and forums is getting better

B. Gaps / Emerging Issues / Getting Worse:

1. Prevention: **What are the most common mental health and substance use disorders in your community**?
    - #1 most common answer: anxiety and depression – esp. kids & young people – also in parents
        - "Everybody's teens are on anti-anxiety meds: the docs are promoting it and kids are being labeled. Also ADHD meds."
        - "Everyone's looking for immediate gratification. Magic bullet thinking. People aren't getting the toolkit of meditating or breathing techniques." A panic attack lasts 10 minutes, and the Xanax is going to take 20 minutes to work; clonopin takes 30.
        - NB: School stress will get worse in coming years with new high school requirements (no free periods, requirement to identify a "pathway," requirement to do a capstone project).
    - Marijuana, vaping, alcohol
        - marijuana is normalized
            - Parents / teens have no idea about the linkage between heavy usage and 8-point IQ loss, increased risk of schizophrenia, 10% addiction rate.
        - vaping by itself and as vector for other drugs
    - Other drugs:
        - Opioids are getting all the attention but marijuana is more common.
        - PCP is reported to be increasing in Norwalk, according to the CCT. Stamford and Bridgeport CCTs report stable levels, but Bridgeport notes that PCP is more prevalent than opioids.
        - Cocaine is increasing.
        - "Spice is coming up. Easy access."

- Role of social media: isolation, bullying, sexting, glorifying drugs, amplifying anxieties and fears
- Competition for resources
- Lack of resources for single women with children and youth
- Insurance issues

2. **Given those issues, are we reaching the right people with the right messages**?
    - VAST majority of respondents said No.
        - Some said if you know where to find it.
    - "We're trying through all types of media but it is difficult."
    - "We're doing a pretty good job of intervention, but not prevention, of anxiety/depression."
    - Police & EMS could be a better vector for information, especially during crisis
    - Shatterproof has a better drug education model than DARE, which should be adopted.
    - More focus on MH recovery !
    - CAC members noted that the Change the Script campaign for the general population was not visible and people did not know what it was about.
    - There are virtually no messages in Spanish. Need radio messaging for Latino population.

3. **Recommendations**:
    - When funding is available for one substance (opioids), grants should be written broadly so that projects can use that topic to open the door to discuss broader mental health and substance use issues. Don't miss the opportunity! (e.g., Change the Script campaign, SBIRT activities when they focus only on SUD)
    - Need to focus on social-emotional wellness in schools and communities.
    - Increase focus on mass media and social media strategies. Presentations to community groups do not raise enough awareness or reach enough people. The same PTO parents always go to everything.
        - Comment that it will be extremely difficult for the prevention messages on social media to outweigh the pro-drug messages on social media
    - Start prevention / wellness work earlier: elementary school.
    - Strengthen general education on MH and SUD
        - Teachers, nurses, admin aren't equipped to deal with MH issues.
        - Parents aren't aware of what their children might be exposed to. "*Elementary* school kids are putting alcohol on tampons and inserting them. Parents wouldn't think to educate them about that!"
    - Suicide:
        - Focus prevention efforts downstream, on wellness or general mental health training
        - Integrate regional suicide network with RBHAO
        - Renew ASIST training to clinicians
        - Provide QPR trainers with refresher training & update list of QPR trainers
        - Develop brief, engaging, culturally specific Spanish-language behavioral health training and disseminate statewide
    - "A lot of the prevention is geared toward youth – would benefit the community to merge with the adult side. When people are 18 they just drop off the cliff."

II. TREATMENT

A. New Resources/ Getting Better:

- Supportive Housing Works just got a grant to purchase and outfit a mobile van to engage and provide services to homeless youth
- C2 was developed in Stratford after our discussions during last year's Priorities Planning process about adapting the Community Care Team model at a municipal level.
- CT Counseling Centers has opened a mental health and substance use center in Stamford.
- CHC and CT Ren are going to start providing suboxone
- Optimus in Stamford has reopened doors for behavioral health – no longer just for internal patients.
- Optimus has added child and adolescent services in Stamford and increased their behavioral health programs in Bridgeport.
- Americares has made a difference
- Provider training on Culturally & Linguistically Appropriate Services has taken place in the region through our efforts and through DCF. We've established a learning collaborative.
- Some report that police training has improved
- Teen Talk and similar programs in more schools
- DMHAS's bed registry was recognized as a step in the right direction although the beds are usually gone when you call. One respondent noted that you have to call right after the list gets updated each afternoon (4pm).
- Unique program to outreach to homeless at train stations: collaboration between shelters and transportation
- Telehealth programs at the hospitals, e-consults through CHC (for many different speciality programs), Access Mental Health CT. *However, question about whether these services are reimbursable. YNHH and St V's said their programs are not; WCHN said theirs is. We will connect them to discuss. Could be legislative issue.*
- Child & Adolescent ED in Stamford
- More providers (e.g., WCHN) are embedding social workers in their medical groups to integrate BH so doctors can do a warm handoff
- Community collaboration (like CCT) – working together to "do the same with less and less."
- Creativity of emerging agencies to reach people who won't come in, e.g., CareMore have primary care docs going to people's houses
- STR grant. Vouchers for those who needed opioid treatment and didn't have insurance: was really easy to get people into 30-day treatment on the same day
- Sensory rooms at hospitals

B. Gaps / Emerging Issues / Getting Worse:

1. **Disorders that are underserved**:
    - First episode psychosis (often in young adults who are heavy marijuana users)
        - In Easton, 4 recent grads out of a class of 180 have psychosis. 2 were heavy marijuana users, 2 have had Lyme. Research shows Lyme-mental illness link.
    - Co-occurring disorders (MH/SUD, or BH+medical)
        - In acute cases, MH providers say client is "too much substance" and SUD providers say client is "too MH" so nowhere to go. Substance users with high medical needs also get kicked out.
    - Hoarding

- Autism cited repeatedly as a huge need, esp. over 18 yo "Maybe one psychologist in New Haven who will even test adults."
- ADHD
- young adult mental health : failure to launch, trauma-based illnesses
- child mental health
- "It can be frustrating for those of us who work in the field to see all the effort (and resources) going to the younger population when funding is being stripped from those in current need." This was cited in our last priority report as well: The majority of the population and of DMHAS clients is middle aged, yet they get no attention. Suicide and opioid abuse are rampant in this age group.
- videogame addiction
- eating disorders, especially for men

2. Profile of the **hardest people to serve given current resources**:
    - Those with multiple challenges:
        - Those with SMI + homeless or COD and homeless, especially when they need a long-term bed
        - CVH has refused patients with COD (primary Dx SUD) because they're "too mentally ill" – where are they supposed to go if that's the safety net?
        - the reentry population who also have SUD + personality disorder;
        - older adults with significant medical comorbidities and cognitive and medication changes who aren't safe in the community but aren't yet eligible for nursing home care.
    - People with developmental disabilities fall through the cracks; nowhere to go for someone on HUSKY to be diagnosed. Schools lack capacity to deal with the needs of kids with IEPs (example, autism).
    - Adults who need to be tested for ADHD (need neuropsych)
    - The undocumented
    - Non English speakers (Spanish, Creole, French, Arabic, Portuguese cited)
        - Language Line is very impersonal – also get different translator each time
    - Deaf and hearing impaired: LifeBridge and DORS services are hard to schedule
    - Individuals who are disconnected from supports, including those who have had previous negative experiences and refuse treatment and those who are "not taken seriously" by providers for being "frequent visitors."
        - CCT teams would prefer mechanisms to mandate treatment (for MH and SUD), especially for those in supported housing. However, consumers are strongly against that.
    - Individuals who need pain management:
        - Harder to prescriptions from their Primary Care Physician; if homebound can't get to a pain mgmt. specialist and if they don't need surgery they may not qualify for a specialist. Need more options.
    - Long-term benzo users are being told to taper over a 30 day period but can't.
    - Gender dysphoria:
        - Getting psych evals for transgender surgery. Debate among providers over whether people need psych clearance any more.
        - Training for personnel to ask about identity / pronouns/ transitioning. Problem for taking urines (what organs do people have).
        - Value Care Alliance does "organ inventory"
    - Getting bariatric evals.
    - Hoarders

- The near-elderly: under 65 yet not eligible for SWCAA.
    - Related barrier: different age limits to access different programs' services

3. **Access to psychiatrists** continues to worsen. Most mentioned issue.
    - Support legislative recommendations to address the workforce shortage, including options such as expanding telepsychiatry, providing incentives to doctors to enter the field, incentivizing doctors to accept insurance, increasing the APRN workforce, changing scope of practice and training to allow psychologists to prescribe, etc.
    - Pay is insufficient to hold onto psychiatrists. One hospital keeps interviewing docs but they don't come back. It's been 8 months or more and they still can't take new referrals.

4. **Inadequate levels of care**:
    - Provider shortage generally.
        - More school social workers.
        - Recommendation: Create incentive system for those who stay 3 years
    - First episode psychosis programs are not available in Southwest CT. Need to bring STEP to Fairfield County
    - Need ACT level of care for Stamford area: intensive case management for people with chronic mental illness. Needs to be available 24 hrs/day
        - Recommendation to turn the Dubois CSP into an ACT team, since there are so many other CSP's in the area and the highest-need patients are being turfed to Dubois.
    - Need Community Support Program (CSP) level of care for those whose primary Dx is SUD rather than MH. Can we simply change the eligibility requirement?
    - Stamford and Norwalk areas report need for an IOP for mental health. Currently people come out of a hospital inpatient stay and have to go to the community health center because there isn't a higher level of care available.
    - "We don't need more detox beds, we need ANY detox beds." (Stamford) Only Greenwich and Norwalk have a few freestanding detox beds.
    - Need for MH jail diversion.
    - Inpatient psych for children and teens
        - Months-long waits for long-term / state beds. Solnit is closed for admissions until September (3 months out)
        - IOP for kids under age 12
        - Foster care population has to go up to Bridgeport because Norwalk only has Child Guidance
    - Longer-term treatment beds: 60 day, 90 day and beyond
        - Recommendation regarding homeless who have a long-term treatment bed: On day 91 they lose their status as chronically homeless which restarts the clock on the housing waitlist. Shouldn't be penalized for housing because they needed longer-term treatment! Look at the Money Follows the Person program
    - Long waitlist for Child Guidance
    - Wait times continue to get worse. One consumer recently waited more than 12 hours in the ED, during which she wasn't allowed to get off the gurney even though she wasn't being seen or treated.
    - Mobile crisis services aren't available 24/7, so people can't count on them. Makes the service less relevant. Bilingual clinicians and psychiatrists continue to be a major gap.

- Outreach and engagement is needed for a variety of populations: the homeless, untreated psychosis, hoarders, young adults with "failure to launch" who are isolating at home, older adults.
  - Need a HOT team that focuses on mental health
  - Recommendation: Create a mobile outreach program consisting of peers
- Care coordination such as CCTs.
- SUD treatment:
  - If you taper people from opioids, 95% relapse, but we taper them to get them onto maintenance. Hospitals are tapering/ detoxing people while getting them into rehab. Rehabs *will* take people on MAT
  - One month wait for substance inpatient beds – so people get discharged from detox knowing they're probably going to end up there again
- Need more Double Trouble in Recovery support groups
- More work to address trauma across the board
  - In Bpt especially, addressing root causes and also impacts of violence
- Need for mid-level supported group homes for adolescents / YA / adults
- Mobile bus in Norwalk is understaffed, needs APRN
- Need services that are mobile – e.g., med mgmt. in the community
- Need more peer counseling

5. **Anxiety and suicide are increasing. Need quicker access to care in acute cases**. Consumers in crisis have to be suicidal to get a bed and then are discharged within 48 hours; the hospital stay doesn't solve anything (but costs a lot!) Recommendations:
   - Create drop-in mental health centers.
   - Set up a room for APRN at the homeless drop-in.
   - Create mobile mental health clinics.
   - Create respite programs to divert from hospitals.
   - Raise awareness of alternatives to drugs for anxiety / depression.
   - Introduce legislation to ban direct-to-consumer marketing of pharmaceuticals. This will generate a nationwide conversation.

6. **Insurance** is not covering as much as in the past: discharging people before they're ready. Providers who don't take insurance, especially Medicaid. Deductibles growing. Prior authorization for 28 days and IOP
   - Commercial plans don't cover needs for SMI. Young adults with schizophrenia are better off going on Medicaid.
   - Very hard to get admitted to a hospital for psych. One consumer jumped in front of a moving vehicle and was sent to the hospital but since she was fortunately not hurt and "I don't look like I'm depressed" was released the next day.
   - Clinicians who take HUSKY, esp in suburbs.
   - Recommendation to support the mental health parity bill when we reintroduce it
   - Private insurance doesn't cover case management. St Vincent's referred one consumer to an external case management program which charges $300/hour.

7. **Need a family approach**.
   - Grandparents putting grandkids through school, whose biggest stressor is their adult child with COD.

- Child Guidance treats kids as patients and helps parents, but family members are sometimes the underlying cause for the child's problems. But HUSKY will cover the child but maybe not the parents.
- If a child with mental illness ages out of their school system or DCF, their only options are DMHAS or their parents. If their family doesn't put them on state insurance they can get stuck with trying to help their kid with no resources. "The only way for them to get help then is if they're homeless."
- Blend funding streams for kids, parents, etc. to bring all resources together to support family.
- CAC recommends merging DCF and DMHAS.
- CAC recommends identifying other states where the transition from DCF to DMHAS is better.

8. **As cited in past reports, wraparound services and case mgmt. are not available outside the state-funded providers – this is especially a gap with young adults**
   - Recommendation: DMHAS programs such as YAS should be targeted to people with severe need that cannot be met in the community, regardless of income – safety net based on illness, not insurance
   - In Maryland, the state agency has 100 slots for case management from the General Funds for individuals with high need regardless of income eligibility. Block grants can allow this. (Statement by SAMHSA auditor at ABHPC focus group)
   - Revisit our proposed legislation from 2 sessions ago to have insurance cover case management for behavioral health

9. **Discharge planning** is an area that needs attention. One consumer was discharged from IOP with no appointments and no meds. Was suicidal within a week. Another got out after a year inpatient with no follow-ups. A third was hospitalized three times within a month. She got sent to IOP despite not responding well to group therapy. Recommendations:
   - Change provider policies to ensure a warm handoff, with appointments made together with the client before discharge.
   - Train providers to question clients to determine whether they understand what their next steps are. "What may seem like a warm handoff to providers may not feel like it to families given what they're facing." "I could barely leave the house; how was I supposed to find the IOP?"
   - Ensure clients are provided with peer support resources as well as treatment resources.
   - Ensure clients know where / how / when to obtain their medication refill while waiting for a follow-up appointment post-discharge.
   - Offer stipend to agencies to incentivize them to do better discharge planning, including follow up to make sure clients get to the programs where they're referred.
   - Create preferred provider network?
   - Families want more information about their loved one's treatment plan. Issue of whether HIPAA requirements are overextended.

10. **Prescription Monitoring Program:**
    - Hospital ERs and old-school providers are getting waivers for e-scripts
    - Don't require the log-in to the system – this is a barrier to using the PMP
    - When pharmacist scans the Rx label, results should just pop up if the patient already got this somewhere else and should flag the date or whether it's too soon for a refill
    - Integrate the systems! Start at the doctors' offices because they ask which pharmacy patient uses and can already notice if it's a different one
    - Incentive system for docs who are helping

11. **Availability**:
    - Make services available when people need them.
        - Many therapists (e.g., DMHAS) work 8:30-3:30pm while people who work are looking for therapy and support when they get out of work.
        - Many parents ask for more access in the evenings, even if by phone or computer.
        - Mobile crisis is not available in the evenings so non-professionals have to step in when kids are involved in
    - Primary care docs are forced to do mental assessments on people, prescribe SSRIs, because no one is available, so not being monitored appropriately. "It represents the marginalization of mental health. You wouldn't ask a podiatrist to do something" outside their scope of work.
    - Need more flexibility in program eligibility, so people can get the services they need. Too many barriers.

12. **Other emerging**:
    - More people are showing up with medical marijuana cards.
    - Staff morale is decreasing. "Demand is greater and we are asked to double our productivity, with fewer and fewer resources."

13. **Models to expand:**
    - STEP! First episode psychosis. Use / expand block grant dollars for this. Cost saving.
    - Patient Centered Medical Homes (PCMH)- as at CHC, Optimus. More holistic. Determine patient's risk level, put on HUSKY+ and access wraparound programs. Primary care is the nucleus. Higher reimbursement rate; provider given more time to discuss these patients. Predicted risk decreases!
    - Behavioral Health Homes at DMHAS
    - Homeless Outreach Team – but needs to be made a priority, not an add-on to someone's main job. Needs to have a skilled MH worker.
    - Community Care Teams (CCTs).
        - Make CCT a priority. In Stamford navigator gets pulled for other duties. Bridgeport no longer has a navigator.
        - Need APRN on CCT teams.
        - Need peer on CCT teams in Bridgeport and Stamford.
        - Stratford expanded CCT to the community level by creating "C2."
    - Recovery Coaches in ED.
        - Also similar program for MH peers (RSS's) in ED.
        - Ensure Recovery Coaches have adequate training around MH resources, not just SUD.
    - Community Health Workers. Currently working on demonstrating ROI to get buy-in from hospitals.
    - Have a continuum of care within agency to facilitate referrals (e.g., RNP)
    - DBT curriculum
    - More Eastern perspectives and holistic self-care models. (Holistic Wellness Center like Toivo)
        - Medicaid won't pay for meditation despite evidence base)
    - Peer respite like Afiya in Western Mass for hospital diversion / crisis & respite care
    - More use of injectable meds for homeless, psychosis
    - Increase use of apps https://newsroom.uw.edu/news/phone-app-effectively-treats-mental-illness-study-shows
    - Hot Spotter program used by Norwalk CCT.

III. RECOVERY SUPPORTS

A. New Resources/ Getting Better:

- Smilow Life Center is a new service center in South Norwalk developed by Open Doors to provide training programs, temporary housing, and in the near future a health clinic.
- The Access Line was recognized by the Norwalk CCT as being a wonderful resource for consumers and providers, even on weekends, although shortly after the focus group there the Access Line was cut back and could no longer take patients directly to rehab unless from detox. However, the Stamford CCT had forgotten it even existed because their initial experience with it was negative so they stopped using it.
- SMART Recovery model is being rolled out throughout CT due to the CROSS and ASSERT grants. In SW CT, we started a SMART group for teens in Fairfield. We are launching a Family & Friends group as well as Spanish-language groups online in September.
- In Norwalk, the CCT noted that the hospital is doing more and also that community connections have improved since the CCT hired a peer to be out in the community (this is different from the CCAR Recovery Coach in the ED model) and since MFAP started the needle exchange. Part of the effectiveness is that there is no bureaucracy or eligibility requirements: just call them and they come help with any social issue, not limited to MH or SUD. Need more unrestricted support / case management!

B. Gaps / Emerging Issues / Getting Worse:

- Need for CASE MANAGEMENT!
    - Move DSS back to Norwalk. (Although CAAWC does a good job and DSS is on camera at the Norwalk Public Library for drop-in at specific times.)
    - Patient navigation. Need for people to follow clients, go to their homes, bring people to appointments, fill med box.
    - CSP fills the gap a bit but quality varies, eligibility is a barrier, focus is on skills building, so many regulations about the fidelity model of CSP and ACT. "Need to make those boundaries more porous."
- Supported / supportive housing
- Support legislation and funding to expand peer support programs.
    - Models like New Reach's former SAMHSA contract where peers could be attached and housing providers could tap into them (mainly for SUD, but for other help as well).
    - Include contractual requirements that providers hire and incorporate peers into all their teams.
    - Do a cross-walk of the AU and CCAR peer training programs to compare content areas and evaluate the effectiveness of each program and the competencies of graduates. Explore creating one integrated curriculum that provides skills in both mental health and substance use disorders.
    - Develop a career path for trained peers who want to move up to a higher level position without becoming a clinician.
    - Peer-run respites like Afiya
    - Revisit our proposed legislation from 2 sessions ago to have all types of insurance cover peer support services for behavioral health
    - More social rehab, more/ expanded clubhouses
- Fill the support group gaps:
    - There are no free local support groups during the daytime, and both the SWCMHS consumer warmline and the JRB Young Adult Warmline are only available in the evening.

    - There are no bereavement support groups for families who have lost someone to the opioid epidemic.
    - There are no weekend groups.
    - More support groups outside AA where people can share skills, strategies and experiences. (Refer to list of peer support groups in region – there are other models, though not many groups.)
    - More support groups for families and youth
- Sober housing is a wild west. Desperate parents are paying $8000/month for glorified babysitting. People are dying from the drugs they get in their "sober living" home. There are no evaluative criteria being used.
    - Create a voluntary evaluation program such as the one CCAR proposed 2 years ago.
    - If DMHAS can't fund it, seek private funding e.g., Face Addiction.
    - Create simple "yelp" type website to allow crowd-sourced reviews. This would require very minimal staffing.
    - Sober housing could be linked with farming in Easton: "horticulture therapy."
    - More group support opportunities where people can start to build a sober support system.
- Expand the DMHAS Access Line so it can take people to rehab from community not just from detox. Develop /disseminate new promotional materials to raise awareness of this resource.
    - Recommendation to expand the Access Line so it can also answer questions about which providers take HUSKY C or Medicare, who has inpatient beds.
    - Link the Access Line and bed registry funding / staffing and integrate more tightly.
- Provide more education for people when they begin receiving community services. Better handoffs. More referrals to peer programs and recovery supports, warmlines, etc. not just treatment options.
- More harm reduction: "Everybody preaches it and nobody pays for it."

GENERAL

Gaps / Emerging Issues / Getting Worse:

- Basic needs are the most important issues. (Cited by CCTs, Beacon, others)
    - Supported housing is essential.
    - Rental assistance, security deposits
    - Emergency discretionary funds.
    - Medication funding assistance.
    - Need for transportation assistance: bus passes, Uber passes…
    - Veyo transportation system is a nightmare.
    - By 2020, national legislation says undocumented clients will have to have a verified address for a real ID. Getting the necessary paperwork is a huge task – who will provide?
    - NB: "Doctors don't ask social determinants of health questions because they don't want to deal with it."
- Recommendation: Increase case management funding, embed case management into all health and BH access points, and ask about basic needs.
- RSS feedback to DMHAS:
    - NO more new initiatives. Lack of follow-through is disheartening and only highlights the lack of transparence and collaboration that exist in the agency.
    - Use the knowledge of peers on staff to educate other staff and become more recovery focused.
    - Listen to service recipients. The DMHAS consumer survey does not capture the true story.
    - Stop taking money from where it is most needed.
    - Better elder care and education for older adults to reduce stigma and access treatment.

    - Additional consumer feedback specific to SWCMHS provided in a separate section
- Increase the visibility and transparency of the state's Planning Council, e.g., website for Council documents.
- Hold meetings via Zoom, conference call, etc.
- Provide funding for trainings in regions.
- "STOP THE SILOES" between MH / SUD / housing and between DCF / DMHAS

OTHER NOTES

- RSS's who get hired have to find a new provider… 120 days to find one who takes your insurance, long waitlist, may be in another town and no car… if can't find in time they reclassify your healthcare
- Increase in people coming from NY and Midwest to our shelters.