2017 UPDATE ON REGION 1 PRIORITIES IN BEHAVIORAL HEALTH

Region 1: Southwest CT

July 28, 2017

COMMUNITIES 4 ACTION REGIONAL ACTION COUNCIL WORKING TOGETHER FOR HEALTHY CHANGE

HUMAN SERVICES COUNCIL

RYASAP catalyst for community change

Southwest Regional Mental Health Board

Every other year, the behavioral health regions of Connecticut provide a needs assessment and priority planning recommendations to the Department of Mental Health and Addiction Services. This document is an update on the biannual needs assessment conducted in 2016 in Southwestern CT (Region 1). It is based on the work done by the Southwest Regional Mental Health Board (SWRMHB) and the three Regional Action Councils (the RACs include Communities 4 Action, Mid-Fairfield Substance Abuse Coalition, and RYASAP) that serve the region. The regional team was asked to answer four questions and to indicate whether needs are increasing, decreasing, or remaining the same, as well as to highlight new resources.

I. Mental Health and Substance Use Prevention/Treatment

In Southwestern CT, the top three priorities identified in 2016 were (a) Outpatient Behavioral Healthcare, (b) Workforce/Capacity, and (c) Inpatient Services. All three areas remain priorities for treatment and prevention. Below we provide an update on each of these areas, including changes in the level of need and any resource or environmental changes. In addition, we provide comments on (d) Referral Sources and (e) Prevention.

A. Outpatient Services: Increasing Need

Outpatient behavioral healthcare continues to be a top priority, with the need for outpatient services continuing to grow in an environment of shrinking budgets.

Needs include:

- Behavioral health workers and other human services providers report **increasing anxiety** in all demographics:
  - Political and budget issues—at both the federal and state level—leave **people who receive public support, state and nonprofit employees, and even those with full-time employment** in a land of limbo, uncertain about their jobs, health insurance, and other benefits and stressed about the political landscape.
  - **Immigrants**, in particular, are experiencing tremendous anxiety due to Executive Orders and other actions related to immigration, including fears of further rollbacks of programs such as Deferred Action for Childhood Arrivals (DACA). The fear factor extends to school-aged children who are stressed about the potential for their parents to be deported. This fear is warranted: Nury Chavarria, a single working mother from Norwalk, is currently slated for deportation after working and paying taxes for 24 years and despite the fact that she would leave behind a 19-year-old with cerebral palsy to care for his three younger siblings.
- **Latinos**, a large demographic in the region, have increased risk. At the same time, one large case management agency observes that far fewer Hispanics are seeking services as a result of current immigration politics. Providers report that it is particularly difficult to get Spanish-speaking people who are uninsured into any form of counseling.
- Communities continue to point to the need for supports for **young adults** with "failure to thrive" who are living at home and isolated. Some DMHAS providers observe that young adults are not well served in their

residential programs, which primarily house older people. A high school counselor from Stamford identified several suicides among young adults with special needs who are particularly isolated and at risk once they exit the supports available through the public school system.

- The **opioid epidemic** is leaving a wake of bereavement, bewilderment, and guilt among families and friends who have lost someone to an overdose.
- In Bridgeport, **increased violence** may reflect all these factors and is certainly taking a toll on affected neighborhoods and families. The average number of homicides from 2001-2016 was 16.6; this year the 17th homicide occurred on July 5th, only half-way through the year.
- On the **services** side, programs report high demand. One example is a local hospital that had a waitlist of 100 people seeking behavioral healthcare last summer; that waitlist is now 150.

Major changes in terms of **resources** in the area include:

- Six Residential Support Programs in the region were converted to Community Support Programs (CSP). As a result, some clients were discharged and some staff were let go. Program staff saw their caseloads double and even triple. The RSP funding in Fairfield had previously been used to help house people off the VI-SPDAT, so the program conversion created a gap in services for individuals using the Coordinated Access Network for shelter/housing.
- Optimus Health Care, an FQHC, is increasing its behavioral health portfolio in Bridgeport thanks to new funding. They are hiring doctors, nurses, and other staff.
- The C.A.R.E.S. Group is continuing to expand its family support groups for those affected by the opioid epidemic.
- The SUD access hotline has been expanded. Hospital staff report that it is working well.
- Substance use treatment providers are beginning to roll out suboxone, and CT Counseling Centers has a new CSSD grant.
- A new drop-in center, the "Young Adult Space!", has opened in Norwalk as a partnership between DMHAS and Triangle Community Center.
- There is increased screening for behavioral health, due to SBIRT initiatives with providers through the RACs and adoption of an integrated screening tool developed by SWRMHB and the Primary Care Action Group for use in urgent care settings, which is now in use at some area colleges, Greenwich human services (with other municipal human services coming online), and at SWRMHB's free community screenings initiative in October.

B. Workforce: A Continuing Priority

As budgets shrink, behavioral health and other human services providers are seeing their caseloads grow.

Needs and obstacles include:

- With the state budget crisis affecting housing and other sectors as well as mental health, many existing clients and community members are seeking **case management**. There are several obstacles:

- As already noted, Spanish-speaking clients are now less likely to come forward because of immigration policy.
- Case management resources in the community are limited and often targeted for specific needs. Some supports that until recently were available through case management programs, such as security deposits, have been lost as a result of DSS cuts.
- Case management in the context of state-funded mental health programs such as CSP is complicated by program requirements. For example, CSP staff must provide both case management and skills building to caseloads of 20 individuals with severe mental illness.

- The shortage of **Spanish-speaking providers** continues to be highlighted as an important priority.
- There is a continuing issue of access to **psychiatrists and other prescribers,** as highlighted in past reports.
- **Peers** continue to report difficulty in finding employment. Peer positions are almost entirely found in the public sector, which poses its own risks. While SWCMHS recently posted several peer jobs, some applicants withdrew their names from consideration due to job insecurity. Obstacles include:
  - Some peers who are otherwise qualified for recent positions are stymied by the requirement for a driver's license.
  - The Community Bridgers program seems to require increased funding and management attention to fulfill its promise. It has been launched twice in the region and no longer has a staff member for Region 1. While the program is trying to be flexible about its clients, its current target population is individuals with forensic involvement.
  - Peer support is siloed in Connecticut, with Recovery Support Specialists focusing more on mental health and certified through Advocacy Unlimited and Recovery Coaches focusing more on substance use and trained through CCAR.
- **Client engagement** is of critical importance to the success of virtually all behavioral health programs. However, the level of effort required of staff (outreach and case workers, recovery support specialists, clinical providers) is significant. In the current funding climate, resources must be provided to fund engagement efforts throughout the system. Peers are an underutilized source to tap for this work.

New **resources and opportunities** include:

- Workforce members continue to benefit from many trainings, including those offered by the Regional Action Councils and SWRMHB:
  - Regional Action Councils continue to train more providers in SBIRT and A-SBIRT.
  - Narcan trainings offered by RACs to staff working in judicial and to community members-at-large. Over 400 Units of Narcan were distributed to CT Counseling for distribution to staff and clients in 3 locations.
  - ATODG trainings to clinical staff.
  - Behavioral Health Forum for providers on "Ethical Dilemmas in the Digital World," which included a look at HIPAA as it relates to digital communication. This annual forum is organized by Communities 4 Action.
  - QPR suicide prevention training provided by RYASAP and Communities 4 Action to Community Health Workers at an FQHC as they expand their behavioral health services in the Bridgeport area.
  - Mental health workshop for librarians provided by SWRMHB and MFSAC.

    - Training on use of an integrated behavioral health screening tool provided to urgent care workers and municipal social services by SWRMHB.
    - Mental Health First Aid offered throughout the region on a regular basis by all parties.
- House Bill 6483, which was generated by SWRMHB and its Catchment Area Councils, was signed into law as part of Public Act 17-146. This act creates a task force to consider options around the psychiatric workforce shortage and negotiate among different stakeholders to make recommendations.
- There are two initiatives in the region around the federal "CLAS" standards: Culturally and Linguistically Appropriate Services Standards. One is a learning collaborative for child-serving agencies, funded by DCF. Another is through the Greenwich Community Health Improvement Project, co-funded by YNHH and SWRMHB, with an upcoming leadership retreat for health and human services agencies.
- Non-clinical workers open up new avenues:
    - Senate Bill 126 passed and will define the roles of Community Health Workers in the state, including the possibility of certification. This could open up options for outreach workers in behavioral health and could dovetail with peer support specialist initiatives.
    - SWRMHB's House Bill 6887, to provide insurance coverage for peer support services offered in the context of a behavioral health program, did not pass during the 2016-17 legislative session but did gain traction. This bill will be revisited during the upcoming legislative session with continued consultation with all peer advocacy groups.
    - There is now a national peer certification program, developed by peers at Mental Health America, that is based on a national survey of employed peers as well as a workforce needs assessment by hospitals and health organizations. Peer work in CT should build on this.

C. Inpatient Services: A Continuing Priority

The **need** for inpatient care continues:

- Inpatient admissions for psychiatric evaluation as well as detox beds remains difficult. As an example, in May one Darien family struggling to get a placement for their 11-year-old boy ended up requesting assistance from Senator Duff's office after their son was deemed unsafe by Child Guidance, sent to the local Emergency Room and kept there for more than a day, then sent to Yale. Yale was unable to find any other hospital to discharge him to.
- SWCMHS notes highly complicated cases that have been extremely difficult to get into hospitals as well as to find placements for following discharge.
- The "revolving door" of people going in and out of hospitals continues. Hospitalizations in many cases are simply not long enough, with individuals going from IOP to the hospital back to IOP and right back to the hospital.

An important **resource** in reducing inpatient hospitalizations is the Community Care Teams (CCTs) in Bridgeport, Norwalk, and Stamford. The CCTs have been able to help individuals to significantly reduce the number and length of stay of hospitalization:

- Data reported in 2017 by the Norwalk CCT showed a 43% decrease in total ED visits and a 29% decrease in inpatient days among CCT clients when comparing two six-month periods. From 2016-2017, average ED visits per patient decreased by 39.6% and average inpatient days decreased by 41.7%.
- Data reported in 2016 by the Bridgeport CCT showed a 41% decrease in total ED visits, a 53% decrease in inpatient days, and a 52% decrease in total psychiatric inpatient days as a result of CCT intervention.

All CCTs meet weekly to identify challenges in their catchment area and address patient needs. One of the common themes is the need for affordable and subsidized housing which is an important contributor to reducing hospitalization. Continued investment in the CCTs is needed.

D. Referral Sources: Need for Adequate Support

It is essential for people to be able to find resources when needed. The state has multiple **referral resources**—not only 211 but Network of Care, CT Clearinghouse, Beacon Health Options, etc.—and local agencies, including the RMHBs and RACs, work to ensure that there is "no wrong door." However, there is a critical **need** to make sure that the referral resources are well-enough funded to be relied upon, while also ensuring that information is available through multiple media: online, phone, posters, social media, etc. Specific recommendations follow:

- 211 is a critical resource, however, providers and clients regularly report long wait times to get through. One local FQHC trains its entire staff to use the 211 InfoLine website rather than even try to call.
    - We strongly support efforts to improve this resource.
    - We recommend that 211 create a way for agencies to update their own online profile so that the site can always be up to date. There could be one user and password per agency, with an annual reminder emailed out through state agency networks to update the profile.
- Mobile crisis for children is swamped. On the adult side, the mobile crisis service operates with different hours in different regions of the state. As a state resource, it should be consistent.
    - Within Region 1, the service was decentralized, then centralized, then decentralized again.
    - Hours of operation have changed without communities being informed.
    - The service has not been available on holidays.
- Access Mental Health CT provides a very effective and much-needed service throughout the state and should be protected at its current funding level. As a three-year average, this service has provided over 100 psychiatric consultations per week to support pediatric mental health in the state.
- The expanded substance abuse hotline is a useful service, but not enough people know about it.
- Within hospitals, it is very difficult to ensure that all case workers and other staff know enough about community options for referrals. We recommend embedding referral information in the Electronic Medical Records if possible.
- Public media (e.g., highway billboards, bus posters) and social media should be used strategically by state agencies to raise awareness of 211, mobile crisis, and resources targeted to different populations (e.g., TurningPointCT.org and the Young Adult Warmline).
- Community networks (e.g., pharmacies, libraries, churches) should be targeted directly both by the appropriate state agencies as well as by RMHBs and RACs which can provide regional resource guides, "Need Help?" posters, wallet cards, etc.

E. Prevention/Promotion: Constant Need

As noted in last year's report, investments on the community wellness and health promotion side of the continuum are more cost-effective and preventive than investments in residential and inpatient treatment. There is always a **need** to educate the public around mental health and substance use because there are always new populations and unmet need. In addition, a few specific issues include:

- Currently the most visible prevention efforts are related to the opioid epidemic, yet mental illness, alcohol, and marijuana all play a role in this epidemic and are continuing issues. Furthermore, emerging issues such as increasing supply of purer, cheaper meth should be addressed.
- Not only young people but their parents have no perception of harm from marijuana. National statistics, other state laws, and the current budget crisis point to the likelihood that the state of CT will legalize recreational marijuana in the near future. There is a need to educate the public and legislators in advance.
- Public education efforts should make use of mass media and social media. Messages developed in one community can be used in others without reinventing the wheel.
- There is a need to continue to reinforce the message around storage and disposal of opioids. This includes working to reduce access such as through efforts to increase blister packaging.
- Funding needs to be maintained for the efforts and agencies that help raise awareness, provide community education and resources, support screenings, and assist with information and referrals. These agencies include the RMHBs and RACs!
- To prevent overdoses, it is essential to have Narcan in all emergency departments, police departments, and provider agencies, and to make it available to all users and their loved ones.
    - The supply of Narcan needs to be increased. Bulk shopping for supplies should be considered, including negotiated prices between DMHAS and DPH.
    - Emergency departments should be supported in developing policies to distribute Narcan kits to people who have overdosed.
    - Police departments should be encouraged to update their policies and procedures so they can get more Narcan when the initial supply is used up.

Resources worth highlighting include:

- Multiple behavioral health screening efforts in the region – including the efforts described above to integrate screening into social services, urgent care and other points of contact with the public, as well as ongoing efforts to work with providers around initiatives such as A-SBIRT.
- The RACs have a strong focus on educating prescribers and community members around the opioid epidemic.
    - Through the new STR grant, Mid-Fairfield Substance Abuse Coalition, in collaboration with RYASAP and Communities 4 Action , is supporting Local Prevention Councils to address this issue.
    - Communities 4 Action has developed a new regional website to raise awareness about opioids, NoRXabuse.com.

- RYASAP is managing an AmeriCorps grant for opioid abuse and related risk factors. There will be 30 AmeriCorps volunteers embedded in RACs, Local Prevention Councils, and identified agencies from New Haven through Greenwich.

- SWRMHB's TurningPointCT.org project supports mental wellness in teens and young adults by providing peer information and support. New elements include:
  - A new podcast that will post biweekly discussions of relevant topics among young people. (Five podcasts have been recorded to date but not all have been posted yet.)
  - A blog about recovery from heroin addiction ("The Monkey on My Back") by a young adult advocate who has lived experience with mental illness, addiction, and incarceration. The blogger and project's Communications Specialist, Allison Kernan, is an outstanding public speaker who has been giving talks at high schools, colleges, and to parent and provider groups around the state, as well as serving on the Alcohol and Drug Policy Council.
  - TurningPointCT is a subcontractor on DCF's new ASSERT grant. The project staff will play a role in identifying and making available information about Alternative Peer Groups for substance abuse.

II. New Trends and Emerging Issues

A. Budget Decisions at the State Level

A critical issue is the **crisis-based decision-making** by state agencies attempting to respond to the state budget. State agencies are protecting direct and costly services (such as inpatient care), but this comes at the expense of preventive and cost-effective services in the community. **If this trend continues over the next 10+ years of projected significant budget deficits, the gains made by Connecticut in developing a continuum of community-based recovery support services will be lost.** Effects are already being felt:

- The siloes between mental health and substance use, and even within substance use prevention (opioids vs alcohol) are becoming worse because of how funding is targeted (e.g., the STR grant). Grants and contracts should be written to enable funds to be used for joint programming for mental health and substance use.
- Needed, effective programs are being cut or reduced despite their demonstrated benefits to the public and their overall cost savings to the state:
  - The Local Mental Health Authorities (LMHAs) in Danbury and Torrington that were slated to be privatized were *not* the lowest-functioning ones but some of the high achievers.
  - Access Mental Health CT, which uses telepsychiatry to provide access to prescribers and earlier specialized intervention for children and adolescents, is threatened with the same 10% (or more) cut as other providers, even though it provides a unique niche service that should actually be increased.
  - Melissa's Project (a program of Guardian ad Litem), which serves some of the most vulnerable and indigent people, has received a 33% cut despite data showing impressive cost-savings as well as improved care coordination and outcomes for a population that will not receive this service otherwise.
  - Ancillary and supportive services, such as CLRP, the RACs, and the RMHBs are all at risk yet provide vital, extremely low-cost prevention, education, system coordination, information and referral,

evaluation, and advocacy services. Without these services, both individuals and communities will find it harder than ever to navigate the system, provide education, or benefit from ideas and opportunities in other communities.

- In this context, there are no resources to develop intentional and systematic programs like widespread screenings or low-cost technology solutions such as apps and robocalls that support recovery.

These decisions will have a tremendous impact on the health outcomes and quality of life of the behavioral health population. As noted last year, many question the priority given by DMHAS to inpatient care over outpatient services and community supports. Many recommended a complete inversion of DMHAS's priorities. Questions have been raised about the decision-making process and the extent to which community representatives such as the State Board or RMHBs are able to provide input into DMHAS's decisions about program closures and reductions.

B. Other Trends and Special Populations

Other issues affecting our communities (some of which were mentioned earlier) include:

- **Federal policies**:
  - Immigrants fear deportation; they aren't seeking the help (medical/addiction) they need.
  - Risk of repeal and replace of the Affordable Care Act
- The **budget** being unresolved, both at the federal and state level. This impacts:
  - *Clients:* Because the components of the service system are interrelated, many social determinants of health have been already impacted by the budget cuts. As a result, the same individuals may experience reductions of service in multiple aspects of their life: shelter, mental healthcare, etc.
  - *Provider agency staff:* Personnel at all levels are uncertain about their job security.
  - *Services:* Agencies are unable to do long-term planning or even project their FY18 budget. While aware of the need to reduce hours, staff, and programs, they do not know when or by how much.
- Intensive **focus on the opioid epidemic**, leaving gains in other areas of prevention at risk. Prevention has focused for many years on alcohol and tobacco, and rates of use have decreased as a result. Prevention strategies have to be instilled and maintained for all substances, and mental health promotion must be supported as well.
- The **impact of medical marijuana laws** continues to develop as new diagnoses are added and new dispensaries are opened. There is a reasonable probability that recreational marijuana will also be legalized. Issues include:
  - Mobile crisis reports a negative impact of medical marijuana on people with severe mental illness.
  - There have been reports of people getting their medical marijuana cards without due diligence. One doctor in Region 1 was already closed down for this reason.
  - Direct-to-consumer advertising is promoting the ability get evaluated and signed up for a medical marijuana card, which is likely to lead to increased usage.
- **Special populations** include:
  - the undocumented
  - suicides in the LGBTQ population

- suicides among those with developmental disabilities
- young adults, especially those experiencing or at risk of homelessness (see 2017 Youth Homeless Point-in-Time Count). There is a need for group housing aimed at young adults as well as for services and supports within provider agencies that are age-appropriate.

Emerging areas of interest for providers in Region 1 include:

- Culturally & Linguistically Appropriate Services (discussed earlier).
- Citizenship initiatives, which were presented by Yale PRCH at the SWRMHB Annual Meeting and will be followed up this year.

III. Most Important Priorities

Priorities identified in our region include:

- Consistent approach to **screening** is needed. Although we are making headway by increasing the number of people trained in SBIRT and A-SBIRT, this does not always translate into consistent, systematic approaches to screening. Unless screening is part of a systematic process, individuals who may benefit from screening are missed. In addition, consistent screening provides the opportunity for positive feedback for healthy choices; something that has been shown to be very effective to reduce risky behavior in youth.
- **Remove the siloes** between mental health and substance use. Consistent regional MH/SA provider meetings facilitated by the DMHAS regional manager and CCT teams have helped to identify and address gaps for clients, most of whom require both mental health and substance use services. However, further steps to de-silo these services would strengthen the co-occurring services that are in increasing demand. One step could be to explore DMHAS increasing the contracts for Co-occurring Disorders services versus strictly Mental Health and Substance Use separately.
- As noted above under Question 2, it is important to continue to advocate for services needed for a **holistic approach to community-based treatment**. Mental Health and Substance Use Disorder service providers continually identify lack of services essential to their clients' recovery, e.g. affordable housing, employment, etc.
- Region 1 RACs, SWRMHB, and their respective members have been instrumental in introducing and/ or providing strong advocacy support for **legislation** that has had a significant impact in a number of areas such as in harm reduction (e.g. Expansion of Good Samaritan Law for Narcan administration) or addressing workforce issues (as noted earlier in the report). We recognize the importance of legislation and regulations and have identified the following priority areas:
    - Reintroduce peer support services bill that would increase employment by peers and expand access to peer supports to individuals with private insurance .
    - Work on amending building codes to include lockboxes.
    - Promote regulations to ensure opioid prescriptions are in blister packs (we already have a workgroup addressing this).

- As suggested by Region 1 members of the Joint Behavioral Health Planning Council, requiring netting and signage on bridges could be an effective means of reducing suicide. This suggestion met with a favorable response, and we recommend exploring it as a possible legislative mandate.

IV. Additional Comments

To help facilitate planning and monitoring of client services with fewer resources, the following suggestions for DMHAS were identified:

- Ensure that stakeholders know what happens as a result of feedback provided in surveys and other forms that are submitted, so that people know they have been heard.
- Strengthen communications systems so that DMHAS departments are well connected and informed and so that providers are clear about communications requirements.
- Engage stakeholders in the tough decision making. Use State Board, RMHBs and RACs for this process.
- Provide better transparency on DMHAS initiatives and incidents. For example, send out email blasts on all RFPs so that RACs and RMHBs can ensure that local providers such as hospitals are aware of these opportunities. Many of us have relationships and connections and can ensure that information is passed on or, in the case of concerns such as the issues at Whiting, reduce the risk of inaccurate messages.