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

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

NORTHEAST COMMUNITIES AGAINST SUBSTANCE ABUSE (NECASA)

SOUTHEASTERN REGIONAL ACTION COUNCIL (SERAC)

DMHAS REGION 3

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INTRODUCTION

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

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

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

PROCESS

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

It should also be noted that it was **significantly more difficult this year for provider employees and clients to participate in the Priorities process**, as the impact of budget cuts is already being felt in the region.
- With fewer staff and the need to ensure proper levels of program coverage, client needs made it impossible for many of those who wanted to participate in focus groups to attend scheduled times.

- For clients, lower program staffing levels meant that staff could not be spared to transport clients who wanted to participate in focus groups. With few transportation options available in the region, the result for clients was that they could not attend.

A. *Regional Surveys*

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

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

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

B. *Key Informant Interviews*

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

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

C. *Focus Groups*

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

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

D. *Evaluations*

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

E. *Research*

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

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

F. *Special Projects*

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

KEY FINDINGS AND THEMES

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

I. *Gridlock in System*

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

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

- Individuals who need a higher level of care than residential services can offer, but have nowhere to go, are often placed in respite beds because the services they need either doesn't exist, or has no available beds.
- Respite beds are also used to fill in when there are no safe or affordable housing alternatives, which places a burden on staff to find these individuals housing in order to free up space for those who need respite care for stabilization or to prevent more expensive hospitalizations.

- Providers report receiving calls from those who are in need of immediate treatment, and all they can do is refer the caller to 211. Some programs are trying to devote more staff to the intake process, because of back-ups that are weeks long, with an additional wait to see a therapist. However, taking staff time away from seeing clients is a problem, given the inadequate clinical workforce in many outpatient programs.
- Lengthy wait lists for CSP/RP in Region 3 mean that referring programs can't graduate clients because CSP/RP has to prioritize those who have been externally referred. Program staff report having to "triage" those who can't afford to wait, and trying to be creative with their intake processes, which are also backed up.

Community program staff complain of too many people being released from inpatient without appropriate discharge planning, including no follow-up appointment scheduled, and of individuals who go into crisis, and need much higher levels of service than they would have needed if appropriate follow-up had been planned.

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

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

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

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

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

III.   Over-regulation of Programs
Paperwork: A common theme across the board was the frustration felt by staff over the time required to fulfill documentation requirements and complete necessary paperwork. One program manager said

that if staff didn't have all the paperwork to complete, they might actually be able to serve clients effectively at their current staffing levels.

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

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

CSP/RP: Staff and managers at all of the Region 3 providers feel constrained by the requirements of the CSP/RP and ACT models.
- Pressure to meet service hours and demonstrate skill-building activities, for example, hurts their ability to foster meaningful and trusting relationships with clients. When staff have to be focused on what they need in order to meet fidelity, they are not able to "meet the client where they are."
- Rather than promoting person-centered planning and recovery-oriented care, providers argue, CSP/RP "forces people into a model." As a result, relationships with clients feel forced, unnatural, and disrespectful of the person's actual needs.
- Managers say that with CSP/RP, of the 31 fidelity items, maybe five or six are really important to prepare for the Medicaid rehab option – the rest are just overlays that take time and paperwork. Fidelity measures need to be re-evaluated to determine whether we're measuring something that isn't helping people, so that services can be "client centered, instead of bucket therapy."
- It's harder now for staff to serve on internal agency committees due to the demand to meet service hours, but such opportunities promote staff morale and benefit the clients. The same is true for collaborative client meetings or extra-curricular/training activities. Shared experiences with clients in the community are harder to support because they don't fit the model, but these experiences are invaluable to building a relationship with the client, which is foundational to engagement.
- **Directors like idea of fidelity; it gives a mission to the program, but they would like some creativity and flexibility built into process.** The people that need services the most also need the most creativity and the most outreach, and this needs to be incorporated into productivity.

IV.   *Chronic Underfunding*
Now they're cutting state positions, we don't have that support and are taking on that burden. Not even 1% cost of living increase in the last 20 years, with inflation of something like 25%. We haven't had a COLA, none of our programs with budgets set 10, 20 years ago, and those budgets have never been increased. We have programs with budgets from 30 years ago, trying to make it work with creativity.

The inequitable funding and distribution of resources, and our clients get the short end of the stick. Being asked to do more with less and coordinate with other services leads to burnout of staff. We have great staff, great managers.

80's level of funding. Spend some time writing grants. Have to look for other funding so that people can have experiences in the community. Have made connections with therapeutic horseback riding, sailing program in Mystic. Starting up the hiking club.

V.   *Discrimination and Stigma*
A.   *Public Education*

Despite the dwindling of resources, providers continue to work within their communities to increase understanding of mental health issues and build acceptance and tolerance. They participate in the arts communities, Chambers of Commerce, Councils of Governments, and more. Their clinicians provide free trainings to town employees, including local library staff, community groups, and businesses.

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

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

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

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

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

C. *Opioid Crisis*
Public education regarding the underlying causes of the opioid epidemic, and how to get help is desperately needed, as is greater awareness of how untreated mental health issues contribute to addiction. Continued misconceptions about addictions and persistent beliefs that it can be overcome with strength of will, faith, or prayer need to be addressed with information about addiction as a

disease. Misconceptions also lead to unfair practices like discriminatory disability benefits practices towards those who have alcohol related diseases.

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

SYSTEM STRENGTHS

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

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

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

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

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

V.   *Resource availability in Substance Abuse Prevention*

Where additional resources are available, towns in Region 3 are seeing increasingly good outcomes in substance abuse prevention. One such example is Putnam, which has a Drug Free Communities Support grant, a STOP underage drinking grant, and is pursuing additional funding this year. Putnam's recent survey data is showing good results, largely due to this increased resource availability.

SYSTEM GAPS

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

I.   *Service Needs in Rural Northeast*

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

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

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

II.   *Co-morbid Health Issues*

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

III.   *Young Adult Population*

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

Anonymous model of intervention, which may turn off younger clients; a more age- and culture-appropriate intervention is needed.

IV. _**Senior Population**_

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

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

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

VI. _**Transgender Adults**_

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

VII. _**Homeless Population**_

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

VIII. _**Criminal Justice System**_

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

The reduced hours in Mobile Outreach Team (MOT), or mobile crisis response, located in Southeastern Connecticut, results in a higher volume of calls to 911, and a corresponding increase in police involvement, with a greater risk of crisis escalation, negative interactions, and criminal justice involvement for those experiencing mental health crises. This is aggravated by the fact that many towns

in Eastern CT have no police departments, and rely on the State Police, which historically has fewer officers trained in the highly effective Crisis Intervention Team (CIT) model. Even though local departments have done an excellent job getting officers training, turnover and lack of funds for training make it difficult to maintain a sufficient level of CIT trained officers.

IX. *Veterans*

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

X. *First Responder Needs*

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

XI. *Sex Offenders*

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

XII. *Co-occurring Disorders*

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

EXTRA-SYSTEM CONCERNS AND ISSUES

Focus group participants and interviewees often raised concerns over issues that are not directly related to the DMHAS-funded service system, **and these issues are raised year after year**, without any sense that things are improving. However, we recognize that components of the state-funded systems often overlap and that DMHAS clients frequently face difficulties in multiple areas of their lives simultaneously. Addressing the following issues would allow people with mental illnesses and substance

abuse disorders to more easily access DMHAS services and more successfully meet program requirements and goals. In addition, agencies would be able to more effectively use their DMHAS funding for helping clients meet recovery-oriented goals that promote independence and self-sufficiency, rather than spending valuable service hours solving problems with other state agencies.

I. *Lack of Adequate Public Transportation*

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

II. *Lack of Adequate Housing*

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

III. *Lack of Adequate Employment*

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

IV. *DSS*

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

V. *DDS*

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

VI. *211*

Focus group participants, particularly provider staff and clients, report that calling 211 is stressful and burdensome; the wait time is too long and often the operator is unable to help the person calling. One

provider staff commented, "I think it's a necessary tool, I think you need it, but it needs time and money." As a single point of access, the system has potential to be successful, but is overwhelmed and unprepared to meet the needs of the community.

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

PRIORITIES AND RECOMMENDATIONS FOR BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES

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

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

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

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

B. *Low Wages*

The private nonprofits have not received sufficient cost of living increases in their funding over the years and, as a result, are currently unable to provide adequate compensation to their direct service staff. Feedback from staff members indicates that their wages are not enough to live on: many are forced to turn to state benefits, such as Medicaid and SNAP, to meet their most basic needs. Multiple sources shared that direct service and entry level employees need more than one income to get by. "The working poor are staffing the non profits." Staff shared that high insurance deductibles make medical care too costly. Additionally, positions requiring advanced degrees do not offer a high enough salary for employees to repay their school loans. The low funding levels make it impossible for nonprofits to offer competitive wages or benefits, resulting in high turnover of quality employees.

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

The understaffing and low morale places undue burden on remaining employees, which in turn leads to burnout or compassion fatigue among staff. "Being asked to do more with less and coordinate with other services leads to burnout of staff." Staff reported feeling tired and overwhelmed by the increasing pressure and level of need, and agencies do not have the time or funds available to care for the emotional needs of their staff members.

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

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

F. *Peer Support Staff*
Peer Support staff is not adequately funded, nor is it meeting the needs of the peers or agencies. Agencies have reported that the training is not preparing peers for the realities of working in case management positions – Recovery University graduates are not prepared for the onerous paperwork

and documentation required of them. Feedback suggests that there is a mismatch between the expectations of the peers and the needs of the agencies that needs to be addressed.

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

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

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

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

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

C. *Brief Care/Respite/Residential*

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

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

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

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

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

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

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

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

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

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

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

A. *Discharge Planning*

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

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

B. *Multiple Funding Sources*

Staff at every agency noted that the paperwork they are required to complete is often duplicative due to multiple funding streams – every funding source has its own reporting requirements and its own system for recording information, requiring staff to spend valuable time writing and rewriting their reports. A streamlined system would increase staff efficiency and allow them to spend more time with clients.

C. *DDS Clients*

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

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

D. *DSS Services*

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

E. *Duplication of Services*

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

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

F. *Regional Human Services Coordinating Councils*

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

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

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

CREATIVE SOLUTIONS AND PROMISING INITATIVES

I. *Collaborative Team Approaches*

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

A. *Community Care Teams (CCTs)*

Community Care Teams are proven to be successful in preventing homelessness for high risk individuals and fast-tracking those who are already homeless into housing. Southeastern Connecticut, with its New London and Norwich CCTs, has been a trendsetter statewide, and has provided a great deal of assistance to communities seeking to set up their own CCTs. With the participation of all providers that may be involved in a person's care, and agency releases in place for all shared clients, these groups facilitate the unobstructed flow of information regarding shared clients and promote creative brainstorming that minimizes the impact of homelessness on individuals, the system, and the taxpayer.

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

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

B. *Network Meetings*

II. *Holistic Wellness Approaches*
A. *InSHAPE*

United Services was one of 48 agencies chosen nationwide to participate for the past year in the In SHAPE Implementation Project, a project of the National Council for Behavioral Health and Dartmouth College. The program was created in view of the fact that those serious mental illness (SMI) served in publicly funded mental health organizations have a reduced life-expectancy of 25-30 years compared to the general population, and obesity rates are twice as prevalent among persons with SMI compared to those without SMI.

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

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

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

B. *Older Adult Needs*

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

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

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

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

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

C. *Windham Facility*

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

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

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

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

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

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

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

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

IV. *AXS Center for Young Adults*
Need an open access center in Norwich. Skateboard shop, police department, NFA all potential connections. Police would like to be able to come in and interact with teens on a non-confrontational basis. Wrote a proposal at Cheryl's request. Lots of people have great ideas.

V. *Medication Assisted Treatment Modalities*

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

VI. *Backus Pilot Program*

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

The pilot provides for members of the Mobile Outreach Team (MOT) to be called by Backus emergency department staff when someone presents with an overdose. MOT clinicians visit the person at the ED, and attempt to engage the person in services, or to at least ask for permission to follow up with them after their release. Anecdotal reports suggest that this engagement is working. We would like to get more information about outcomes from this pilot, particularly in view of the recent cutbacks to MOT, and to look at the feasibility of implementing these practices on a more widespread basis.

VII. *Diversified Funding Streams*

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

EMERGING TRENDS

I. *Opioid crisis*

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

Factors to consider in addressing the opioid epidemic include:
- Prescribing practices: even with the new law that was passed last legislative session implementing restrictions to opioid prescriptions, there are several issues of concern. There is increasing evidence that opioids are not the most effective tool for pain management, but they continue to be the first avenue of treatment for many primary care doctors. Due to productivity demands placed on doctors, there is little time to ask about addiction history or brainstorm on other pain management strategies, and follow-up/continuity can be poor at best.
- There have been numerous community forums on the Opioid Crisis, but as a state and as a region, we still have no coordinated strategic plan for addressing the opioid crisis. We are hopeful that the

soon-to-be released plan of the Alcohol and Drug Policy Council will be a significant step in this process.

- A great deal of public education on addiction is needed; for example, many faith communities are still being told that addiction is a sin or a moral failing, and that with enough faith and prayer, it can be overcome. This sets families and individuals up for failure, and also creates a sense of shame that prevents people from reaching out for help.
- The failure in many areas of the community to understand addiction as a medical issue also leads to a continued push for criminalization of drug use, which is not only ineffective, but is discriminatory toward the poor and people of color.

A. *Legislative Impacts*

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

B. *Yale Strategic Plan*

The Alcohol and Drug Policy Council (ADPC), which includes the leadership of all state departments dealing with the issues, continues to meet at its various committee levels. The Executive Director of NECASA sits on the Prevention and Education Committee, representing the Connecticut Prevention Network, along with two other Regional Action Council directors. The committees have sent their recommendations in to the main ADPC. In collaboration with the ADPC, Yale University will create the strategic plan at the request of the Governor's office, and it is due this fall.

C. *Backus Pilot*

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

D. *Law Enforcement and the Gloucester Model*

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

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

II. *Marijuana legalization*

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

III. *Holistic Approaches & Integration of Care*

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

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

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

IV. *Transgender Populations*

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

CONCLUSION

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