Region 2

Regional Priority Planning Report

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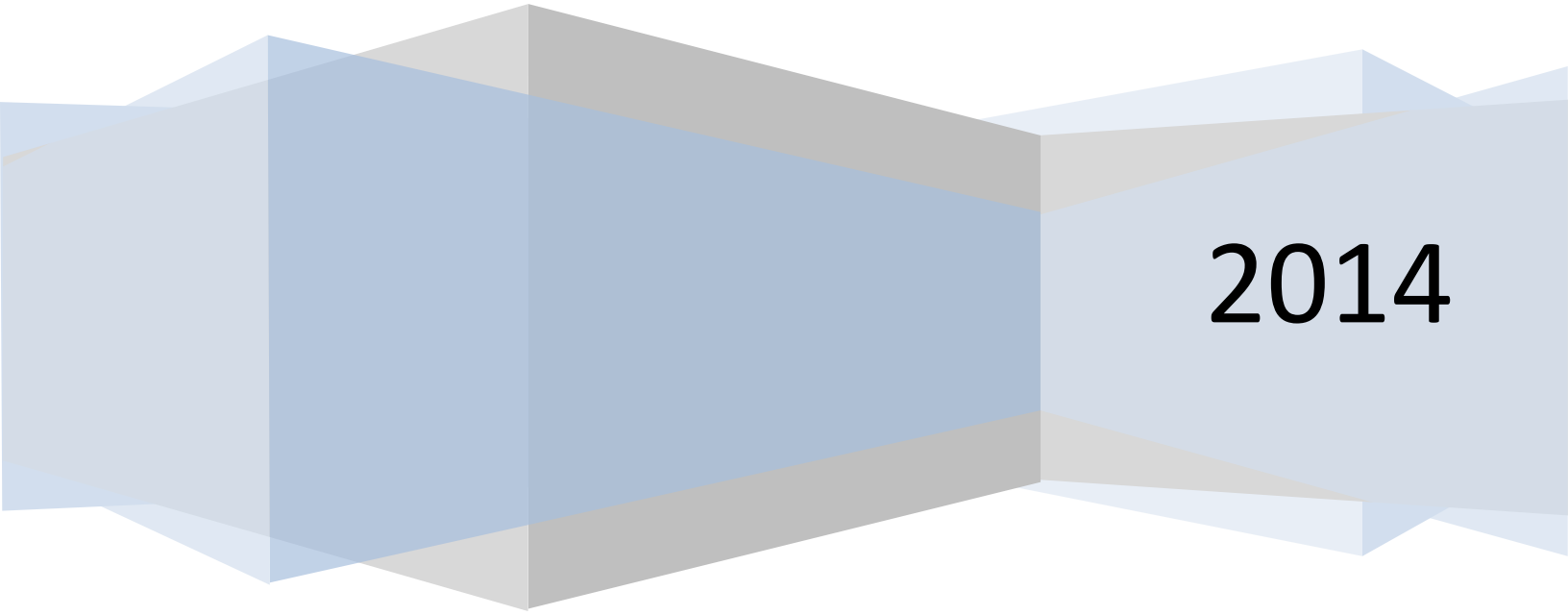

2014

Introduction

These past few years have been eye opening for the general public in terms of why mental health needs are essential to attend to and ignoring or not fully addressing signs and symptoms can lead to prolonged suffering and sometimes tragic outcomes. Notably are the suicides of too many people, including Robin Williams an American Icon, young adults taking their own lives, whose parents are taking up the suicide prevention cause, and others who are taking the lives of many innocent bystanders. These events have propelled the conversation to a National level. While the issue of gun violence needs to be assessed and addressed simultaneously, mental health has been a primary focus of the discussion. It is a critical turning point for mental health and substance use in America and with the right guidance and funding, improved access and individual recovery can lead people to fulfilling, successful lives in the community and society will be not be so focused on illness but rather wellness.

The national health care law and policies have also put an emphasis of access to care for all Americans and a key factor in the model is the coordination of healthcare for individuals. Specifically, as it relates to mental health, the integration of medical care and psychiatric care is in the spotlight and there are many integration efforts underway at the state level.

Process/Data Sources

The DMHAS Priority Setting Process or Plan is a coordinated endeavor between the DMHAS Quality Management division and each of the Regional Mental Health Boards and the Regional Action Councils (RACs) in our state. This report is designed to address mental health and is purposely not split into mental health and substance use as in years past because we hope to move away from the siloed approach of assessment and access to care. Our needs assessment process identifies prevention and treatment trends, service system successes and needs at the local, regional, and state levels. Our findings and recommendations are presented to Commissioner Patricia Rehmer and the DMHAS management team in a formal presentation in addition to this written report. We hope to offer a comprehensive evaluation for DMHAS to integrate into their 2014-2016 strategic plan.

After the initial few meetings with Susan Wolfe, the DMHAS Director of EQMI, our regional team participated in the analysis of the provider survey data and began our outreach to the community.

The survey was developed and distributed by DMHAS and was the initial focal point for this priority planning project. The survey was succinct, four questions in total, and took a qualitative rather than quantitative approach this planning process. In Region II, 29 surveys were distributed to DMHAS funded 20 were returned, yielding a 68% completion rate. These results were used as a comparative tool for our work, reviewing the provider's perspectives of the needs and barriers to service as well as positive outcomes to the community focus group's perspective and input.

The regional board's Catchment Area Councils (CACs) discussed throughout the year their area of concerns in their individual meetings and gave input for the outreach to the community. The regional board and action councils jointly held community forums to engage referral agencies or persons, law enforcement, concerned citizens, citizen's organizations, and other members of our regional community in dialogues. The forums were then held in all six catchment areas within our region. The CAC membership includes consumers, concerned citizens, family members, and providers of mental health and addiction services. The 36 towns in our region are: Ansonia, Bethany, Branford, Chester, Clinton, Cromwell, Deep River, Derby, Durham, East Haddam, East Hampton, East Haven, Essex, Guilford, Haddam, Hamden, Killingworth, Lyme, Madison, Meriden, Middlefield, Middletown, Milford, New Haven, North Branford, North Haven, Old Lyme, Old Saybrook, Orange, Portland, Seymour, Shelton, Wallingford, Westbrook, West Haven and Woodbridge.

These processes informed our assessment of the region as well as our recommendations for the region. In addition, the Region II Regional Mental Health Board (RMHB II) did their review and evaluation of the Community Service Network (CSN) in access to services for housing and vocational services. The CSN review highlighted how a coordinating agency can be a central connecting mechanism for the clients and service system on an outpatient basis. Also, streamlining access is the best way to provide successful outcomes for people seeking services. Throughout this project feedback was also collected by phone and personal interviews with individual members of the CACs, consumers, providers and town officials.

The Regional Action Councils' continuously gather data which informs this planning process and report. This includes local prevention council meetings, school surveys, trainings conducted in the community settings, such as, Mental Health First Aid, Emerging Drugs, QPR & Connect trainings, forums, prevention and treatment committees, town hall meetings, drug endangered children

alliances. In addition, there were various collaboratives the RAC's are involved in, such as, system of care, local implementation service teams, drug free community coalitions and many more.

The prevalence of mental health conditions is noteworthy because as we review the services, and identify gaps in services, it is important to see the "general picture" in terms of how prevalent are mental health conditions. Please see the chart (addendum 1) which gives the prevalence of mental health conditions based on the national average statistic of 1 in 4 people, or 25% of the population. In addition the chart presents 1 in 20, or .05%, people have a severe and persistent mental health condition (illness) (SPMI). The number of people being treated in the DMHAS setting is sometimes more than the national average suggests for persons with SPMI. There are also areas where the concentration of people served by DMHAS is lower than suggested by the national average data. There are many causal factors to the number of discrepancies: one is socioeconomic, untreated mental health conditions, stigma/discrimination related avoidance of care, and people could have private insurance coverage. Another is that there can be a lower number of persons with mental health conditions than the national averages suggest. What is important to note are the thousands and thousands of people who have a mental health condition and their ability to be well served is what determines positive mental health outcomes.

Overall, we find that the 2012 Priority Planning Report identified the status, concerns and recommendations for the areas key to improving the mental health and addictions service system, and that the report's findings and recommendations still stand as an appropriate priority planning guide. These include the concerns about access to services, appropriate housing, knowledge of the service system by providers and the public, emergency departments, insurance coverage, behavioral health in schools and the education of the general public. To the extent that progress has been made in their implementation, we encourage further actions to fully implement the recommendations. We include in this report the progress that has been made since 2012. Also, additional concerns, trends, new ideas for approaching challenges, and highlights of promising practices will be discussed as well. Areas of discussion in 2014 that generated recommendations are summarized below.

Mental health, Substance Use, Co-occurring

A. Prevention and Intervention

Opioids

The Regional Action Councils have been working on multi -pronged approach for prevention, intervention and treatment of opioids since the CDC funded study conducted by Dr. Traci Greene at Brown University in 2010. This study highlighted that our region was already in the mist of the opioid crisis. Since the study concluded, Valley Substance Abuse Action Council (VSAAC) and South Connecticut Substance Abuse Council (SCCSAC) worked on recommendations from the study. Another example of success included the expansion from voluntarily placement of medication drop boxes to the 2014 mandated program. Region 2 Partnership For Success (PFS) grantees added prescription drug misuse as a second substance of concern. The Regional Action Councils worked in partnership with them to develop local strategies and programs. Statewide the Regional Action Councils engaged in a community educational campaign targeting parents and teachers about the dangers of prescription drug abuse. In addition, the opiate forums held by the Regional Action Councils this past spring continued to build capacity in our region and engage new partners. These forums created local task forces that are continuing to work on the issues which tie into the Statewide Plan from the SAMHSA Prescription Drug Abuse Policy Academy.

While the aforementioned work is addressing the opiate / prescription pill epidemic, much more needs to be done at the local and state level. **The following recommendations from the local task forces reflect recommendations in the statewide plan with expansion to include:**

- **Mandate legislatively** the prescription monitoring program for all providers and have it live and not 1-2 months behind.
- **Change the substance abuse confidentiality laws (CRF42 Regulation**)- issues with people in treatment, other providers (doctors, pharmacies) are not allowed to see what patients are taking methadone. It was suggested we look at how the AIDS/HIV community was able to overcome this issue of confidentiality and that it would be used for medical purposes only. It is for the patient's safety.
- It was suggested **that those who have a contract with DMHAS, should have language written mandating use of the PMP system for patients** (especially when admitted into the program and then checked at least 4X a year or quarterly) and that they prescribe or provide the Narcan kits and training. It was shared that some agencies provide the training weekly and it takes about 2 hours.
- **Provide education to communities and business representatives** regarding suboxen and methadone.
- **Mandatory** addiction training for medical providers.

Capacity Building

Collaboratives within Mental Health and Substance Use Service System

Defining and Refining of Collaboratives within the community service system – Get away from individual agency approach and have collaborative teams to develop a person-centered care plan, including both addictions and mental health service components, integrated with physical health, as well as preventive components for families and children. The increasing number of provider collaborations being established by the agencies and providers themselves is a continuing, positive trend to improve provision of appropriate, person-centered and coordinated services.

Recommendations and Forum Feedback included the following:

- **Develop more partnerships with other community providers, programs and service groups with relevant missions to enhance opportunities for effective ways to assist our population**. For example, can we work with local and state health departments to develop mental health prevention programs and campaigns, such as exist for drug and alcohol addictions and smoking?

- **Increase the development of collaborative efforts between addiction treatment providers and other service providers, for example, mental health, housing, social service benefits.** For example, to help someone who is in a domestic violence situation and is using alcohol as a coping mechanism: how might the domestic violence treatment address the total needs of the client?

- **Find natural alliances in the system of care to help facilitate these collaborations.**

Successes:

Recommendation: Replicate and Support with DMHAS funded agencies the "Middlesex Hospital Community Care Team" model. Expand the model to the shoreline towns and outlying suburbs of large cities.

Middlesex County Community Care Team

To combat a local as well as national crisis – the overuse of hospital emergency departments by people with behavioral health issues – Middlesex County agencies instituted the Community Care Team. It is anchored by Middlesex Hospital.

In 2012 the Community Care Team included ten agencies. It now numbers ten agencies including Middlesex Hospital, River Valley Services, Connecticut Valley Hospital (Merritt Hall), Rushford Center, Inc., St. Vincent DePaul Soup Kitchen, Community Health Center, Gilead Community Services, Inc., The Connection, Advanced Behavioral Health, Value Options Connecticut, and the Community Health Network (Value Options).

The Community Care Team (CCT) meets weekly or bi-weekly and discusses 20-30 patients at each meeting. Prior to the meeting, team members research patient histories and psycho-social backgrounds. Extensive records are maintained and shared.

In 2012 CCT was serving 39 clients. They have since nearly quadrupled their client load to 150 patients, 132 of whom have received CCT intervention for 6+ months (6 – 25 months). For this cohort of 132 patients, there has been a **63% reduction** in combined ED and IP visits.

In one case, for example, a woman with both mental health and substance abuse issues was identified as a new CCT client. In one year her ED visits dropped from thirty to eleven. In 2014 she has visited the Emergency Department only twice, both times for serious medical issues not related to substance abuse.

The CCT emphasizes the critical role of community partners who work with the homeless and marginally housed. (In Middletown, the lead partner is St. Vincent de Paul.) Without their input, identification of patients at the time of hospital registration can be difficult.

In June 2013, at its 95th Annual Meeting, the Connecticut Hospital Association presented the Community Service Award to the Community Care Team.

In 2012 we recommend that this efficient model should be supported and duplicated in the New Haven region and it has gotten off the ground in 2014.

In New Haven Yale New Haven Hospital has started a Collaborative modeling the success of Middlesex County. According to Steve Merz, the Vice President of Psychiatric Services at Yale New Haven Hospital, they are reviewing cases and have started care plans for the initial patients who are in the program thus far. It is the first time the various care providers have coordinated client care at this level and there are already exciting results. He said providers are finding out new information about the client to help them treat better and coordinate services that support the patient. Also, notably the majority of the clients reviewed thus far have co-occurring conditions.

- **Expand the Drug Endangered Children's Alliances** – The New Haven Drug Endangered Children's Alliance has all the key players meeting bi-monthly (probation, parole, DCF, hospital, DOC, police, treatment, prevention, community members, etc.). The Alliance also has a regional team that can assist in opening up lines of communication. The Alliance is fact finding and seeking to implement a pilot project called "Tip the Scale" for addiction

treatment with the goal of avoiding incarceration, reducing crime and having immediate access to treatment.

- **Enhance Successful Trainings:** MHFA / YMHFA Trainings:
    - Provide and organize in colleges training for faculty and staff, resident advisors, police and security in the MHFA curriculum or at the minimum training in signs and symptoms of behavioral health disorders as well as emerging drug trends, and resources available.
    - Provide MHFA or similar training to library staff as well as continuing and expanding the library projects to be more than one month.
    - Provide funding to the CT Clearinghouse to provide DMHAS funded providers access to free MHFA / YMHFA training manuals.

Success: MHFA and YMHFA trainings have been ongoing since 2010 in Region 2. More than 1,000 people have been trained within the region through VSAAC, SCCSAC, MCSAC, and Rushford.

- **Continue to Successfully Build Capacity** – suicide campaign trainings - Implemented "Question, Persuade, Refer (QPR) trainings in Durham, Deep River, Guilford, Haddam, New Haven, and Meriden. A total of 135 people were trained.
- **Expand Connecticut SBIRT -**

Several years ago DMHAS established the CT Screening, Brief Intervention and Referral to Treatment (SBIRT) program. The purpose of the CT SBIRT Program, according to DMHAS, is to dramatically increase identification and treatment of adults, ages 18 and older, who are at-risk for substance misuse or diagnosed with a substance use disorder. A primary mission is the implementation of SBIRT services in partnering with Federally Qualified Health Center sites statewide.

CT SBIRT training staff is also interested in expanding use of SBIRT techniques to health providers and social workers in a variety of community settings. MCSAAC is taking the lead in bringing SBIRT training to small towns throughout Middlesex County. Prevention professionals from seven towns are meeting with CT SBIRT staff on September 23, 2014 to learn about half-day training in use of SBIRT techniques for health care providers and social workers in their communities. MCSAAC plans to schedule these half-day trainings throughout 2014-2015, in response to demand.

- **Replicate and expand** the "Dry Dock" program model. In the continuum of recovery services and relapse prevention there is a lack of supportive programming in Region 2 beyond the traditional 12-step programs. Just as social clubs for mental health clients provide opportunities for social interactions, substance abuse clients need opportunities for safe and

sober social interactions with others for friendship, entertainment, education, skill-building and creative outlets. The Dry Dock is a non-profit organization in Wallingford, started by 12-step persons in recovery that hosts drop-in nights, café meals, music festivals, and 12-step meetings in a supportive, informal atmosphere. Because of the organization's excellent reputation, persons in crisis and family members also come to the Dry Dock center and are linked to emergency and residential services, or referred to the local DMHAS-funded clinical treatment provider. The center provides a new access point for substance abuse providers in a non-threatening and accepting atmosphere that allows persons, families and friends to "normalize" activities. This has gone a long way to reducing the stigma associated with addiction and addicts because of community participation. This creates an awareness that everyone contributes to the health of a community. Currently, Rushford Center is developing a working relationship with Dry Dock to support local clients in need of their services.

Support the CT Prescription Monitoring Program for providers to be mandated to use the program and support funding for the program.

- **Enhance Library & Community Outreach**
- Collaborate with libraries and other community responsive organizations to sponsor community educational programs :
    - Provide general information about psychiatric conditions and addictions, the types of treatments available and how to access them, similar to the River Valley Services (RVS) collaboration with the Middletown library to put on an informational series of programs). Such community sponsored education can correct misconceptions which lead to discrimination and fear of discussing problems and seeking treatment.
    - Provide and maintain a supply of up to date resource sheets at all times in libraries and other community locations , for example, schools, police stations, primary care doctors' offices, school nurses, social workers and guidance counselors, and psychiatric and other treatment providers, many of whom lack knowledge of much of the service system .
    - Work with library staff to identify and acquire materials on psychiatric disorders addictions, including general educational references, novels, and movies.
    - Provide Mental Health First Aid training to library staff, including if and when they should contact mobile crisis, or if they should call and wait for police.
- Find funding streams to provide FREE Mental Health First Aid (MHFA) or similar training for community education.
- Devise a public education campaign to increase awareness that behavioral health care is the same as medical care.
- Develop an educational campaign for people to understand HIPPA and family rights.
- Encourage and educate about the use of 211 and not 911 to obtain help.
- Use social media –many people, including young people, prefer to use social media to look up information, seek help and talk to each other. More apps and websites need to be

created like the TurningPointCT website that was designed for young people to chat about their experiences as well as finding resources**.**

- Support grassroots organizations like Coalition For a Better Wallingford which focuses on access to and education about mental health and substance use and works within their community to improve education, assessment tools and support for students. In addition, they engage local officials to provide solution oriented strategies to solve issues within their community.

B. Special Populations

Young adults

According to NAMI the following statistics show the need for comprehensive mental health care and awareness in the young adult population.

Mental health issues are prevalent on college campuses.

- 75% of lifetime cases of mental health conditions begin by age 24.
- More than 80% of college students felt overwhelmed by all they had to do over the past year and 45% have felt things were hopeless.
- Almost 73% of students living with a mental health condition experienced a mental health crisis on campus.

Mental health issues are a leading impediment to academic success.

- 64% of young adults who are no longer attending college are not attending college because of a mental health related condition.
- 31% of college students have felt so depressed in the past year that it was difficult to function and more than 50% have felt overwhelming anxiety, making it hard to success academically.

College students are not seeking help.

- More than 45% of young adults who stopped attending college because of mental health reasons did not request accommodations.
- Overall, 40% of students with a diagnosable mental health conditions did not seek help.
- Concern of stigma is the number one reason students did not seek help.

These statistics were consistent with feedback received by the regional action council directors through their networks and interactions with community colleges, private colleges and state universities. The faculty and counseling center staff all reported that they have students presenting with more complicated issues than before and they don't know what to do with them. In addition, they have students enrolled as part of their recovery plan but staff only becomes aware of this when a student is in crisis. Additional concerns included the discussion of the school counseling centers

vary in what they can offer and many times are not open or available in the evening, and parental notification and consent is another big issue.

Recommendations:

Provide and organize in colleges training for faculty and staff, resident advisors, police and security in the MHFA curriculum or at the minimum training in signs and symptoms of behavioral health disorders as well as emerging drug trends, and resources available.

DMHAS related services

In the DMHAS funded and operated Young Adult Services (YAS) a specialized team provides age appropriate services for the age group of 18-25 years old. Some of the key elements are mental health treatment, employment support, life skills development and housing assistance. It is designed to build a stable foundation for young adults by including the clients, family, significant persons, and provider community.

It has been reported that when young persons receive services from YAS, they have found a "gem". They receive dedicated case management, housing supports, and a well laid out plan. Parents we have spoken with said once they found the services their child progressed wonderfully with the right supports. Also, clients we spoke to felt they had or were receiving good supports and were going back to school or using the vocational services as well. It is such a critical age to be engaged in higher education or working in some capacity. Usually, the onset of mental illness can strike during this critical developmental age group and it is vital to get into services in a timely manner.

YAS incorporates a recovery model that has proven effective in many cases. With the right supports these young people thrive and flourish at their own pace. In addition to these types of services, the coordination effort and level of collaboration with DCF and DMHAS has increased dramatically over the last few years which increases stability in the lives of the young people who have a road map for recovery and treatment. DCF is required because of legislation, (HB 5371) "Implementing recommendations of the PRI study on youth aging out of DCF state care", to prepare a progress report on the steps that DCF has taken to comply with the recommendations put forth in the study. DCF was noted as not having thorough plans for children aging out of this program. Further collaboration was set in place this year because legislatively a bill (HB 5371) was passed "Implementing recommendations of the PRI study on access to treatment to substance use treatment for uninsured youth." This legislation requires state agencies (DCF and DMHAS) to develop or explore certain existing or future programs in order to provide more efficient and effective services to youth and young adults in the state who suffer from mental health or substance abuse issues.

The YAS program is meeting unmet needs of an age group that has been underserved for a long time with the following:

- ✓ **Natural Supports Network**
- ✓ **Case Management**
- ✓ **Supported Education**
- ✓ **Vocational Services**
- ✓ **Housing**
- ✓ **Smooth Transition for Front Door Referrals from DCF system to YAS**

During our community forums barriers were highlighted regarding young adults receiving the mental health services provided by YAS. Many young adults need services and not all are in the DCF system of care so the limited amount of slots is a challenge. While it is understandable that there are specific requirements it leaves out many individuals who may need services. Community members spoke of the challenge of getting appropriate care for young people in crisis, lack of inpatient care, respite care and housing for this particular group. Legislatively a bill was passed to fund DCF's Homeless Youth Program. This program allows DCF to fully establish two regional teams that provide outreach and a drop-in center with walk-in access to crisis intervention and ongoing support services ($1 million). More dollars are needed to have the YAS program available for every area of Region 2. In 2012 we highlighted that Meriden and the shoreline did not have YAS programs. We are happy to report that a new YAS program will be opening by December 2014 at BHcare in Branford. It will provide services to an additional 10 clients plus provide housing supports to 3 additional clients in the Valley and 2 at the Shoreline. Rushford is the only remaining agency in Region II that does not have a YAS program.

There are also a slew of young people who need to have homeless outreach teams to assist them in obtaining services. There are many young adults that are "couch surfing", staying with various friends, etc., because they do not have a home. It is a challenging population to engage and there were many discussions in our forums about the fact that building trust with young adults takes time and dedicated clinical care. Challenges include:

- ✓ **Competing for limited slots, prioritization**
- ✓ **Housing Supports**
- ✓ **Homeless outreach for Young Adults**
- ✓ **Crisis services lacking**
- ✓ **Eligibility Requirements**

Our recommendations include the following:

Access to supports for non-DMHAS eligible clients - "YAS informed training" for non-DMHAS providers would help formally establish and the guiding principles that make the young adult program successful. The providers and community referral persons are searching for ways to help this large at risk population. This could be a revenue generating area for DMHAS to provide outside consultation and training to the community.

Criminal Justice Collaboration – Many young people end up as offenders and get involved in the criminal justice system. There needs to be better coordinated efforts with key players of the criminal justice system to make sure the young people end up getting mental health or addiction services instead of getting criminal offenses on their record and ending up in the wrong system for them. Many officers described wanting to help the youth find a better avenue for their treatment especially after being in crisis.

Increase funding for residential staff to be more experienced and credentialed, and to be able to offer more skills training – There is a need for more experienced staff to teach basic life skills to the young adults. For any young adult this is a critical time to learn skills. Especially for someone with Severe and Persistent Mental Illness (SPMI), it is vital to learn life skills such as maintaining a living space, money management, vocational techniques, managing a transportation system and social skill development. The residential staff is not a highly paid or credentialed position. It is not the primary focus of the staff necessarily to provide such training; however, it is a good setting to incorporate the skills training. We recommend upgrading the staff positions to include more skills training and clinical supports.

Increase partnerships with colleges (Supported Education) – It is necessary for clients to be engaged in higher education, if possible, as they want to increase their chances of competitive employment. Need to assure access to adult education to receive a G.E.D. if needed and literacy volunteer, also if needed. More partnerships with colleges need to be established and fostered to provide this opportunity for the young adults served by YAS.

Increase Bureau of Rehab Services (BRS) connections for vocational services – Foster a stronger bond with the BRS service system to enable the young adults to build their vocational skills and obtain competitive employment.

Modify some of DMHAS's rules regarding access to the internet and emailing or texting clients. In DMHAS state run agencies websites are blocked and it is recommended that access be increased to the intranet and so the staff and clients can research and apply for job opportunities, enhance life skills training, teach computer skills, etc. In addition, emailing and texting is not always allowed and this is a primary form of communication for younger adults.

Support The Turning PointCT.org website – An exciting website created by young adults for young adults, **Turning PointCT.org**, was launched this year by Southwest Regional Mental Health Board. The concept started in the Behavioral Health Planning Council two years ago and to see it "take flight" is exciting because it gives young people the chance to communicate and access service information through the method they utilize the most, web access.

Sandwich generation - the people "in the middle" who are caring for families and also their aging parents

- Families that are caring for elder parents while raising their families can become quite stressed with the extra responsibilities, whether the parents live with them or not, and can also burn out, which can affect their families as well. Support groups for this population can have a major impact. Perhaps this is an area in which NAMI can become involved, particularly for families whose elder relatives may have symptoms of mental illness. In addition, referral assistance should be provided for this group that has many competing priorities to address.

- Focus group members discussed concerns among this age group to include inability to pay co-pays for treatment, high deductibles for treatment is a barrier to both medical and behavioral health care, and lack of knowledge of the service system. In addition, families involved with DCF care are many times not involved in needed family treatment or their young adults who are in need of services but not mandated to comply with treatment. This group also tends to utilize walk in medical centers and urgent care centers as opposed to a primary doctor. Therefore, they are missing essential behavioral health screenings.

- According to the Greater New Haven Community Index 2013, the MOMS Partnership interviewed almost 900 mothers in New Haven in 2012. Three quarters of those interviewed reported an emotional health need, such as depression, stress, or a traumatic event. One third reported receiving treatment for stress, sadness, depression, or anxiety. One mother reflected the sentiment of many when she reported that "Mothers don't get help because of fear, embarrassment, and not knowing where to look for help".

Older Adults, Elderesence –

Elderesence – (taken from ELDERESENCE.org, a book review) This time of life is about change. What emerged were the challenges faced by these "elderescents": accepting the physical process of aging, facing mortality, feeling 'betwixt and between', looking for new meaning and purpose, experiencing times of joy and freedom, dealing with changes in relationships, and guarding against fragmentation in the face of one's sense of a changing self. Change is a paramount theme in elderescence. Change confronts, frightens, disarms, weakens, and delights us. In elderescence change accelerates. It is in elderescence that the reality of change must finally be acknowledged.

The categories for older adults services system needs were discussed in our community forums as well as our CAC meetings and Older Adult Forums held by the UConn Center for Aging. UConn in collaboration with DMHAS, headed by Jennifer Glick and the Older Adult Workgroup are preparing a mapping of services for Older Adults in Connecticut. UConn School of Nursing is also involved with Middlesex Hospital in another older adult focused project:

Geriatric Initiative – Hospital/Nursing school partnership for geriatric care

The UConn School of Nursing and Middlesex Hospital are partnering to explore the reasons behind the elderly population's increasing use of the Emergency Department for everyday medical care needs.

Several departments at UConn will participate, encouraging a team-based approach that is becoming the new standard of health care. Students in the Middlesex Hospital residency program will also participate. Teams will meet with elderly patients in their homes and consult with the patient's primary care doctor. It is hoped that in-home studies will reveal not only the interplay of psychological and physical issues, but complications of income, family structure, and transportation that too often impact elders' health care.

The priority areas generated discussion from some providers because they are seeing **an increase of people over 60 with physical and mental health complications.** This causes challenges to the agencies to ensure that the physical health is taken care of for the clients that are served there. It is also a challenge for the psychosocial clubs who have some members that have attended for 30 years and the needs of their older population are becoming more complex. Activities need to consider their unique interests and mobility issues as well. An additional component is that as people age, **there can be lack of family supports for daily living and service coordination for the elder person.** Another issue is that there are an insufficient number of clinicians trained in geriatric needs and with baby boomers aging it will become increasingly important to fill the gaps in services. Also, outreach to the elderly population is lacking many of whom are isolated and reaching them can be difficult. Participants in the forums described the **fragmentation in the system and that they "cobble together care plans" to address needs**. More case managers need to be tied to where the elderly live to provide supports. There are also many elders who need nursing home level care and vacancies are limited. Transportation to appointments for those living at home can also be a barrier to receiving services. Also, many elders are living on fixed incomes, but are not on Medicaid, or are not aware of what state benefits for which they may qualify. In addition, sometimes once referred for services people refuse to go because they say they do not need the help.

A representative from Hamden said they serve 12,000 of the 60,000 residents and with the aging population; it is complicated to assure access to services. Sometimes the wait time can be months for a mental health appointment in the community and if the older adult ends up in a crisis, the emergency room is a scary place to have to go to receive treatment. One complaint from community members who serve elders is that the family does not know the signs or symptoms to look for and

they can wait too long to refer someone for help. Or families are embarrassed to being up the issue because it deals with the brain and it is not physical, the fear of stigma or discrimination plays a major role in this behavior to avoid seeking services. Other times, the client themselves can refuse to be referred. Another participant said she thought there used to be "SWAT" (crisis) teams to help in a crisis in New Haven and she does not believe they exist any longer.

The following is a list of the top priorities that emerged:

- Access to appropriate services
- Knowledge of physical health and mental health complexities in the elder years
- Lack of education of the community regarding elder services
- Nursing home accessibility
- Lack of Geriatric expertise
- Refusal of assistance

Recommendations:

- **Develop collaborative with Older Adult Workgroup, agencies and towns/cities representatives to create strategic plans to address multiple medical and mental health related issues.**
- **Identify and address needs in larger communities such as New Haven to collaborate with CMHC for services**
- **Provide support or clinical group and settings for elderly clients only. Many older adults do not feel comfortable being in mixed age groups**
- **Expand Gatekeeper program that is a referral organization for people that have daily contact (such as mailpersons, hair stylists) with elders in the community to refer a professional to go out and make a mental health assessment of an individual.**
- **Provide education to the public, family members and legislators to understand access to services, programs available, and limitations of services and availability of crisis services.**

C. Peers , Peers, Peers - People with Lived Experience who are trained Professionals

Connecticut has made great strides, thanks to the advocates and DMHAS' support of the peer professional model. Agencies in our region have also encouraged and embraced the model within their organizations. It is a concept for Connecticut that has had support for many years. It was encouraging this year to attend the International Forensic Convention, a joint effort with Canada; one focal area was creating a model for peers to be incorporated in the forensic sector of the system. There is a professional peer training from Advocacy Unlimited's Recovery University that graduates Recovery Peer Specialists who have a variety of skills that they can bring to the workplace. The Peer Specialists are hired in a variety of capacities within mental health and substance use agencies in the state. It is an evidenced based approach that enhances the service system because it brings someone with personal expertise to the clinical environment and improves recovery outcomes.

Peer Bridger Program

An exciting new area of the Peer movement is the funding for the Peer Bridger Program, run by Focus on Recovery (For-U) in Middletown. The program will take referrals from probate judges and work with clients who traditionally cycle in and out of the court system. These clients have difficulty living in the community because they continually get in trouble with the law for behavioral issues. A Peer is assigned to work with the person to focus on their recovery plan and healthy integration into the community.

- **Recommendation: Continue to enhance the role of existing peer navigator / peer support specialists for clients entering treatment**

- More adults are first-time users of DMHAS services, entering MH/SA treatment with no family history of DMHAS involvement. Loss of job and health insurance, adult-onset substance abuse, domestic violence and other environmental factors all play a part. Peer support from members of the recovery community has proven and effective means of providing experienced guidance to new clients

- **Support role of Recovery Support Specialists** in the agencies that currently have peer positions. The Community Support teams within the agencies should continue their work to increase peer professionals and integrating their knowledge and experience to enhance the rehabilitation focused, person centered, Recovery Support.

- Strategy and service system changes needed: Continue to support such peer organizations as Focus on Recovery-United (FOR-U), presently in Middletown and New Haven, AA and NA groups, faith-based outreach and recovery support, and Dry Dock type organizations. Continue to develop and support the Hearing Voices Model of support groups

D. Levels of Care - (Outpatient, Intermediate, & Hospitalization)

Frankly, the systems of care are overburdened and it leads people who are in need of mental health or addictions treatment to be underserved. Many people in the forums reiterated the lack of access to care after a discharge from the hospital, whether it was from an emergency department visit or a hospitalization. There was **general frustration with the short amount of time a person is kept in the hospital when they have been brought in for both mental health and addiction visits. Participants said they did not feel if the person was discharged from the emergency room that a proper referral is being made for the patient.** In addition, there is no mechanism in place for the hospital to know if the person has followed up for a visit on an outpatient basis. From the agencies perspective who may serve the patient on an outpatient basis, it can be hit or miss whether the clinical team/case manager is informed by either the patient/client or the hospital of the connect to care appointment. While it is understood that the hospital is not responsible for that type of follow up planning, it was brought forth as a big gap in the service system from the perspective of quality of care and better outcomes.

In addition, **an intermediate level of care** was discussed as a significant gap in the treatment system for people who are not "sick" enough to be hospitalized yet need clinical support and care for their symptoms (such as a respite level of care). The intermediate level of care can also be important when someone is discharged from the hospital and needs that transition time to be more stabilized before being fully discharged into the community. This critical time period for people who are in need of clinical staff support while they stabilize and recover makes the difference between successful reintegration or destabilization and/or hospitalization. While it is can be expensive to provide beds, meals, and staff time, it is cost-savings in the long run to steer clients, at this critical juncture, toward long-term sobriety or recovery from mental health symptoms managed on an outpatient basis. It also ultimately saves money because it diverts readmissions to the highest level of care.

Community group members expressed their concern in particular with the lack of intermediate care for the Mental Health (MH)/Substance Abuse (SA) population, especially those with dual-diagnosis. Some people who are stabilized and discharged after 72 hours have nowhere to go, and even willing family members cannot always cope with the severe stress the clients are in.

In one focus group, the theme of "treat 'em and street 'em" reverberated throughout the discussion. A focus group member recalled her successful detox followed by a frightening ten days: the time it took to get enrolled in an intensive outpatient program. Fortunately she had "residential services" in the form of caring family members and twenty years later she is substance free. However, without care during those ten most vulnerable days, this woman doubts she would have made it.

In another focus group the director of the shelter stated that when a person comes out of the hospital and is staying at a shelter, the staff has to try to help the person stabilize when they are

not adequately trained to do so. The person who was hospitalized, treated, and discharged was trying to get used to a medication, which can take weeks, and it was unsettling to be in an environment like a shelter and not feel supported in their recovery by a trained professional. Also, the shelter staff did not feel adequately trained to assist the person manage their challenges during this time. One provider was quoted as saying "Emergency shelters have become mental health facilities without the trained staff".

We understand that there are some intermediate levels of care available to people whether run by hospitals or community agencies. We encourage the development and enhancement of these services.

In addition, **access to outpatient services is lacking in some areas** due to high volume of patients and the shortage of prescribers and staff within our region and the state. There are a few agencies within our region that have timely access for appointments and others where the wait times can be 2-3 weeks for an urgent level of care. Routine visits can be a 2-3 week wait time. Some agencies have implemented same day access for initial appointments which has helped increase the efficiency of appointments for clients as well as reducing no show rates. There is a model of same day access that is being explored by providers in our region, specifically RVS that will allow both initial and follow up visits without a scheduled visit, while some scheduled visits are also built into the model.

Outpatient services are struggling because they are going to a strictly fee for service model and the reimbursement rates for mental health visits are not adequate to support the level of care provided. The outpatient setting provides clinical treatment, supportive services, and requires a lot documentation and required follow up. While Commissioner Rehmer was instrumental in getting a rate adjustment for Medicaid payments this past legislative session, it would require further rate increases to have a positive impact. Unless the outpatient model can shift to be adequately reimbursed at a higher rate, there are financial challenges that the service system might not be able to sustain. In one of the agencies that has a children's clinic supported by DCF there is discussion of closure of the clinic area because it cannot be sustained at the level of current funding.

A new DMHAS initiative of coordinated care is the **Behavioral Health Home service delivery model.** It is an important option for providing a cost-effective, longitudinal "home" to facilitate access to an inter-disciplinary array of behavioral health care, medical care, and community-based social services and supports for both adults and children with chronic conditions. DMHAS funded LMHA's are implementing this large scale project, Behavioral Health Homes, for clients over the next few years. The first client group that will participate are people with Medicaid who are high utilizers of services. We will keep informed of the progress of this new model of care coordination.

Recommendations:

- **Create and build on the current Intermediate Level of Care options which provide the critical bridge between substance abuse, mental health hospitalization or crisis services. This type of care is lower-cost, lower-intensity, and provides immediate support and stabilization for people.**
- **Work with the Legislature to increase and maximize the outpatient rate for Medicaid. Provide technical assistance for providers to maximize billing dollars to offset the rate discrepancy.**
- **Increase DMHAS's capacity and expertise to bill for inpatient services and outpatient services for state funded LMHA's. The Increase in revenue, while going to the state's general fund, will reflect the revenue generating capacity of state services.**

E. Judicial/Law Enforcement

All forum groups felt that people with mental health related issues should not be incarcerated unless they have engaged in a serious crime, and even then they should be provided with psychiatric care. Participants are very concerned that there is not enough supportive housing, and other needed services for people released from incarceration. Others stated that once released from prison, most people do not want anything to do with the mental health system.

When incarcerated, people often refuse treatment because they are viewed as weaker by other inmates and get preyed upon. A number of people felt that mandated treatment does not work. Yet some people also stated that sometimes using law enforcement is the only route to gain access to treatment. Officers expressed their concern that access to treatment usually depends upon a person saying they will hurt themselves or someone else to force a hospitalization.

An overarching theme from police officers was frustration with trying to get someone help by sending them to the hospital when they were in crisis and the person is turned away. Some officers described sending someone in an ambulance to be transported and assessed at the hospital and stressed to the ambulance driver the person is exhibiting severe distress. Either the person would present differently to the hospital staff and be released from the emergency room, or evaluated and were not in a "severe enough" condition to be hospitalized and were released. The officers said someone who was really challenging could be out before their shift was over. The officer has to rely on his or her own assessment to "paper them" and sometimes when a person has been released a tragic event occurs and they feel the service system has let the person down. The officers stated a

"72 hour hold" can be seen as a "72 minute hold" and expressed the need for better collaboration. Conversely, the providers from housing situations said that they would like the officers to evaluate situations and take the call seriously and either get the person sent for treatment or arrest them for the disturbing behavior to other residents. More collaboration is required in both of these situations.

Not all officers were aware of crisis intervention teams or Crisis Intervention Training (CIT) for police officers. It was evident that police departments are not fully aware of how the CIT program operates and they would like more education on the training.

Recommendations:

- **Increase the jail diversion and alternatives in the community (AIC) programs. Use Community Support Services Division (CSSD) programs to divert persons with mental health conditions from going to jail.**
- **Bring back drug courts**
- **To develop broad based crisis intervention trainings (CIT) to include senior staff, community leaders & clergy. Law enforcement on all shifts have a trained officer to respond to mental health related calls.**
- **Incorporate a mental health professional as a staff person at local police departments to respond to behavioral health calls.**
- **Modify the current Narcan access legislations to include EMR's which allows access for police and fire departments to be trained and carry the Narcan kits (not just EMT's)**
- **Skill building and family reunification efforts are needed to engage motivate and support ex-prisoners.** Replicate successful programs that incorporate discharge planning to prevent repeat incarcarations, entail assessment of housing needs, vocational counseling, educational supports, connection with family or natural supports and recovery programs.
- **Develop collaborative with LMHA providers and local police departments to develop a working relationship with law enforcement. We found that both want the expertise of the other to improve their services.**
- **<u>Establish or expand</u> means for community service providers to work with the criminal justice system, pre- and post- incarceration.**
- **Crisis Intervention Teams – Strategic Approach**

Continue to provide police Crisis Intervention training and other first responders, especially ambulance paramedics. Police sometimes don't know when to refer to hospital Emergency Rooms or when mobile crisis teams are is better, if they have access to one unless person threatens harm to self or others.

- Reach out to Police Chiefs to encourage participation in Crisis Intervention Training.
- Reach out to other important groups, e.g., senior citizens and staff at senior centers and senior housing, shelter staff, home health aides and homemakers, family medical practices, and pediatricians, community leaders, clergy and legislators, among others for basic mental health and addictions training and referral sources.
- Create mobile crisis or intervention teams to arrive on scene with police for behavioral health calls.

- Crisis Intervention Training (CIT) for first responders – Throughout the community forums, it was evident that the police departments did not have the appropriate contacts or understanding of the resources available to them for someone with mental health issues. It is important to keep recruiting new officers and departments to participate in this important training which teaches them what to do in crisis situations. **Include a mental health professional with them – integrate a clinician within the police departments**

F. Additional Recommendations

Navigation Expert Positions – In 2012 we identified a key recommendation that developed from the consistent theme of people being dropped left and right when they were trying to access services. A Navigation Expert position was approved this year by the legislature to be a part of the Office of HealthCare Advocate. Hopefully this will be filled by someone who has the expertise and develops contacts across a region or the state. The image of holding someone's hand is the concept and not dropping the person's hand until they are secured with services that are appropriate for them. As it stands two positions are to be filled and we envision 10 or more positions would be necessary to fill this community liaison role and would help bridge the gap between someone in need and the proper providers. Senator Gayle Slossberg was instrumental in getting this passed and we look forward to the adoption of this and expansion to increase access throughout the state.

Liaison for Public Housing Situations – This is an area that was threaded throughout the forums held with the community for all age groups. Housing is one area that people are integrated in the community. While it is a positive step toward recovery and living independently within the community it is also the area where bias and discrimination occur the strongest. Supports are critical within the community setting because social skill development and "fitting in" is a key to healthy integration. There are housing supervisors

who are excellent and those that are not. The caring people want to help a person in recovery transition seamlessly and over and over they request the ability to be a part of the "team" to support a person in their independent living setting. **We recommend a collaborative approach with the case managers and clients (with client's permission) to develop a person centered plan for their living situation with the housing personnel. In addition, we recommend workshops and education about mental health and addictions for the various housing situation.**

Media – Far too often the media portrays negative images about mental health and data suggests that fear and stigma of people with mental health conditions stems from the media's inaccurate portrayal. A picture is created for us that set an image in one's mind of what "psycho" or "crazy" looks like and it is a scary picture. This was echoed at every community forum we held; people described all the negative feelings associated with mental health and/or addictions. The fear of disclosure of a condition hinders people's desire to access services. There are many times when media picks up only the sensational news which stems from a story that paints the worst picture of humanity. Included in this are some of the tragic events that occur and the press highlights the mental health component of the story**. It is recommended that stories of successful recovery and positive outcomes be shared with the media (even if it only gets limited coverage). Also, building relationships with local media representatives is critical to change the negative landscapes. In addition,** forming positive relationships with the press will also help when there is a bad event the coverage will hopefully be presented in a more balanced way. Also, **successful media campaigns such as One Word, One Voice, One Life Campaign, a statewide suicide prevention campaign, should be replicated for additional areas of mental health.** Lastly, legislatively**, it is recommended that a campaign to take off or modify air time of prescription drug commercials be initiated on the state and federal level**. Airing prescription drug commercials to the public used to be illegal and they were simply not permitted on the air. Today, the United States is only one of two countries to have such advertising on television.

We would like to thank all of the people who participated in our regional priority process this year and look forward to improving the service system with your continued support, input and advocacy for appropriate access and funding for mental health and addiction services.

Addendum 1 **Town**	**Population**	**Total Mental Health Conditions** (MHC) (25% of Population)	**General MHC**	**SPMI** (.05% of Total Town Pop.)	**DMHAS clients**	**Uncategorized Persons SPMI**
Ansonia	19,158	4,789	3,832	957	935	22
Bethany	5,550	1,387	1,110	277	49	228
Branford	28,024	7,005	5,604	1,401	920	481
Chester	4,245	1,061	892	169	58	111
Clinton	13,196	3,299	2,772	527	284	243
Deep River	4,603	1,150	966	184	102	82
Derby	12,830	3,207	2,694	513	459	54
Durham	7,368	1,841	1,548	294	83	211
East Haddam	9,158	2,289	1,923	366	68	298
East Hampton	12,940	3,235	2,718	517	226	291
Essex	6,648	1,662	1,398	264	49	215
Guilford	19,158	5,600	4,704	896	362	534
Haddam	8,358	2,089	1,755	334	33	301
Hamden	60,863	15,215	12,781	2,434	1,171	1,263
Killingworth	6,504	1,626	1.366	260	79	181
Lyme	2,403	600	504	96	no data	no data
Madison	18,291	4,572	3,841	731	224	507
Meriden	60,638	15,159	12, 734	2,425	2,447	0
Middlefield	4,416	1,104	928	176	41	135
Middletown	47,325	11,831	9,940	1,891	1,886	5
Milford	52,981	13,245	11,126	2,119	1,510	609
New Haven	130,741	32,685	27,456	5,229	7,113	0
North Branford	14,379	3,594	3,019	575	177	398
North Haven	19,158	6,008	5,047	961	464	497
Old Lyme	7,592	1,898	1,595	303	101	202
Old Saybrook	10,238	2,559	2,150	409	142	267
Orange	13,935	3,483	2,926	557	159	398
Portland	9,472	2,368	1,990	378	176	202
Seymour	16,561	4,140	3,478	662	519	143
Shelton	40,261	10,065	8,455	1,610	888	722
Wallingford	45,179	11,294	9,487	1,807	667	1140
Westbrook	6,914	1,728	1,452	276	142	134
West Haven	55,404	13,851	11,635	2,216	1956	260
Woodbridge	8,965	2,241	1,883	358	67	291

Prevalence of **Mental Health Conditions (MHC)** based on National Statistic (25%) of Total Population

Prevalence of **Severe and Persistent Mental Illness (SPMI)** on National Statistic (.05%) of Total Pop

Please note these are estimates for persons in each town, this is a guide, not hard factual data