

CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES



2016 REPORT ON STATEWIDE PRIORITY SERVICES

January 26, 2017

2016 Statewide Priority Setting Report

Priority Setting Process:

DMHAS' priority setting initiative, designed to engage and draw upon the existing and extensive planning, advisory, and advocacy structures across the state, began in December 2001. Fundamental to this process are Regional Mental Health Boards (RMHBs) and Regional Action Councils (RACs) which are statutorily charged to determine local and regional needs and service gaps. Both of these entities, working collaboratively, facilitate a process in each of the five DMHAS regions to assess the priority unmet service and recovery support needs across the mental health and addiction service systems. Since inception in 2006, DMHAS has conducted its priority setting process every other year (in even-numbered years). In the intervening years (odd-numbered years), the RMHBs and RACs provide updates to inform DMHAS of progress made in addressing the identified unmet needs and to alert the department to any emerging issues. As part of this process, RMHBs and RACs use aggregate profile data provided by DMHAS to describe usage of services within their region, provider survey results based on an on-line survey asking for responses about the DMHAS service system, and other sources of information from local needs assessments/surveys and activities. Armed with this information, RMHBs and RACs orchestrate key informant constituency groups (consumers/persons in recovery, family members, providers, referral agencies such as shelters and criminal justice representatives, and local professionals, law enforcement, and town officials) to participate in community conversations, focus groups, and/or structured interview sessions asking about service system barriers, gaps, and concerns. This process results in Regional Priority Reports across the behavioral health continuum. These reports are presented to DMHAS leadership at regional meetings, providing an opportunity for dialogue between the department and regional stakeholders. From the regional reports, a synthesized statewide priority report is created that examines cross regional priorities and solutions. The statewide report is shared and discussed with the Adult State Behavioral Health Planning Council and the Commissioner. DMHAS is indebted to the RMHBs and RACs for their ongoing efforts on behalf of the behavioral health needs of the citizens of Connecticut. Their passion and commitment are evident as they continuously strive to better the lives of persons living with mental health and substance use conditions.

It should be noted that some of the concerns identified in this report exist outside of DMHAS' purview. Matters related to other state agencies or private entities are duly noted, but will not be addressed by DMHAS. Other issues, such as transportation or housing concerns, while beyond DMHAS' ability to manage independently, are topics related to larger behavioral health issues statewide which DMHAS attempts to address jointly in ongoing efforts with other state agencies. Further, there are federal regulations governing the use of block grant funds within which DMHAS must operate. A new feature of this report is the inclusion of DMHAS activities related to identified areas of concern. While there may not be a response for every concern raised, in many instances there are activities ongoing or planned which the reader of the report may have been unaware of.

State Profile of Services:

The number of unduplicated clients served in FY 2016 was 112,864 comprised of 61,341 clients treated in substance use services and 59,225 clients treated in mental health services (including 7,702 clients receiving both). The greatest numbers of clients served came from the most populated regions. There were 107,212 admissions, 60,703 for substance use and 46,509 for mental health. To access the Annual Statistical Report: <http://www.ct.gov/dmhas/lib/dmhas/eqmi/annualreportsfy2016.pdf>.

Demographics of DMHAS clients SFY 2016

	Substance Use	Mental Health	Total
Female	30.4%	51.3%	40.6%
Male	68.6%	48.6%	58.9%
White/Caucasian	65.5%	62.6%	64.0%
Black/African American	13.6%	17.4%	15.7%
Other or missing race	21.0%	20.0%	20.5%
Hispanic/Latino	21.4%	19.5%	20.4%
Non-Hispanic	71.0%	74.5%	72.9%
Unknown ethnicity	7.7%	5.9%	6.7%
18 - 25	17.3%	11.9%	14.4%
26 - 34	29.1%	16.4%	23.0%
35 - 44	20.5%	16.5%	18.8%
45 - 54	18.6%	23.5%	21.4%
55 - 64	10.4%	21.5%	15.7%
65+	2.3%	9.2%	5.4%
Unknown age	1.8%	1.0%	1.3%

While males and females are almost evenly divided in mental health services, in substance use programs, two-thirds of the clients are male. Most clients served in the DMHAS system are white/Caucasian (64%) while the July 1, 2015 census data finds that 81% of Connecticut residents are white/Caucasian. Ostensibly it appears that white/Caucasian clients are underrepresented and black/African American clients are overrepresented in the DMHAS treatment population; however, the category “other or missing race” is sufficiently large to caution against such a conclusion. Similarly, Hispanic/Latino clients comprise 15.4% of Connecticut’s population based on census data and are 20.4% of the DMHAS treatment population. Finally, as to age, clients in substance use services tend to be younger than clients receiving mental health services.

For clients receiving mental health services, the primary diagnostic categories are major depression (18.2%), schizophrenic disorder (12.5%), and bipolar disorder (10.4%). When examining primary and non-primary diagnoses, just over half of the clients qualify for an SMI (Serious mental illness) diagnosis, which involves having one or more of the following: schizophrenia (and related disorders), bipolar disorder, and/or major depression. It is interesting to note that two out of three (68%) of all clients (mental health and substance use) have a substance use diagnosis. This is the first year in which heroin has been reported more frequently than alcohol across total new admissions. For clients admitted to substance use services, primary drug use was reported as heroin/other opioids (46.0%) followed by alcohol (33.9%) and marijuana (10.0%).

Most clients in both systems of care participated in outpatient treatment, followed by residential and then inpatient, as can be seen from the table below.

Levels of Care	Substance Use	Mental Health
Outpatient	55,256	58,387
Residential	11,323	2,922
Inpatient	2,717	1,428

With respect to young adults in SFY 2016, DMHAS Young Adult Services (YAS) served 1,225 clients, which represents 7.5% of the total 18 – 25 year old population served by DMHAS (16,235) and reflects a 3.5% increase over the number served in YAS in SFY 2015. YAS serves clients aged 18 – 25 with a history of DCF involvement and major mental health problems.

Structure for Evaluation:

As budgets were tightening, each state agency was required to identify their core functions so a prioritization process with respect to what would be funded could be established. The result of DMHAS’ efforts to consolidate its many and varied services into a handful of categories produced the following:

	Inpatient	Outpatient	Residential; Crisis & Respite	Recovery Support Services	Education; Research & Prevention
Mental Health	Psychiatric Forensic Enhanced Security	PHP, IOP, Forensic community, ACT, Case Management, Care Coordination, BHH, Outreach & Engagement, Community Support	Group homes, Transitional, Sub-acute, Mobile Crisis, CIT, Respite, Intensive Residential	Housing/Housing Supports, Supportive Housing, Supervised apartments, Peer Services, Advocacy, Social & Vocational Rehab, Supported Employment & Transportation	Supported Education, Staff Training, Suicide & Violence Prevention
Substance Use	Medically managed & monitored detoxification	IOP, MAT, Ambulatory detoxification, Case Management & Community Support	Intensive, Intermediate & Long-term Residential & Halfway Houses	Recovery Houses, Peer Services, Advocacy	Staff Training, Tobacco Retailer Compliance, Violence Prevention, Substance Use Prevention

The biannual priority setting process created a grid to assist in the prioritization process within each region which utilized the 5 core functions identified by DMHAS found in the table above. Based on the various surveys and focus groups held across the state, each region established overarching issues, strengths, top 3 priorities, system gaps/barriers, and emerging issues as well as recommendations. The report which follows covers all these elements, although system gaps/barriers and recommendations are embedded within the topic areas rather than separated out. Again, as noted above, some concerns/recommendations are outside DMHAS’ purview/mission or require funds which either may not currently be available or may not be permitted by regulations associated with the federal block grant. DMHAS applauds the efforts of the RMHBs and RACs in their priority setting process, but does not necessarily endorse every finding/recommendation which follows.

Overarching Issues

There was widespread concern about the state’s budget and the as yet unknown total impact of cuts of services for persons with behavioral health issues. Even prior to the most recent budget reductions, capacity concerns across levels of care were expressed. Individuals with behavioral health issues sometimes end up in an inappropriate level of care due to a lack of availability at the appropriate level causing a cascade of capacity issues and a system without an adequate flow of clients to meet the demand. Repercussions of current and possibly future additional cuts are expected to make accessing

appropriate care even more challenging; lengthening already long waits, reducing already reduced services, and costing the state more in the long run due to more expensive emergency/crisis situations resulting from lack of timely medication management, psychiatric and substance use assessment, and access to the appropriate level of care when indicated. Access to limited treatments slots is further compounded by perennial basic needs challenges, especially housing and transportation. *DMHAS Activities on this issue: Over the years, during times of budget shortfalls, DMHAS' top priority has always been the maintenance of treatment services. Shortfalls are always applied to non-service related areas first.*

The lack of safe affordable housing contributes to homelessness which results in transient persons not receiving services and being at increased risk for adverse events of all kinds. These individuals are more likely to end up in Emergency Departments (EDs). Despite progress in reducing *chronic* homelessness, those who are more *recently* homeless appear unlikely to get services and providers accuse the Coordinated Access Network (CAN) of being an unfunded mandate that has shifted the homeless from shelters to EDs. Supportive housing can prevent homelessness, promote self-sufficiency, and reduce use of more expensive levels of care. Adequate rental subsidies and support services are needed to provide stability and prevent re-institutionalization. Likewise, sober housing, which can vary dramatically in quality, requires more oversight, licensing, training, and support. "Mixed" housing was viewed as problematic given the different needs of the populations in need, such as older compared to younger adults. *DMHAS Activities on this issue: The 8 CANs in Connecticut are a federal Department of Housing and Urban Development requirement which have resulted in approximately 400 new federal housing subsidies being awarded in 2015 and 2016. Targeting chronic homelessness - the most severe and costly form of homelessness - doesn't end all homelessness as it is a dynamic problem. The Partnership for Strong Communities, through the Reaching Home Campaign, has developed workgroups to address all types of homelessness, including chronic, short-term, Veterans, youth and family. Related to sober housing, Supported Recovery Housing Services (SRHS) are defined as non-clinical, clean, safe, drug and alcohol-free transitional living environment with on-site case management services available. DMHAS's agent, Advanced Behavioral Health, Inc. (ABH) credentials SRHS providers, and contracts with them, to provide housing and case management services to people in recovery. ABH currently contracts with 14 Supported Recovery Housing Service Providers with a total of 48 locations and 208 beds (male/female). Providers may have additional beds not contracted under BHRP, as self-pay beds.*

Lack of transportation is particularly problematic in the more rural areas of the state (Eastern and Northwestern) where there are fewer services to begin with, an argument for greater use of telemedicine or a mobile service that comes to the person. Problems related to Logisticare cite rude drivers and extensive waits which at times result in clients missing/late for appointments and being penalized by the provider. *DMHAS Activities on this issue: Department of Social Services (DSS) which contracts with Logisticare, along with DMHAS and Beacon Health Options have collaborated in response to the feedback concerning Logisticare to address the most egregious concerns.*

Across inpatient, hospital and correctional settings there was concern not only that people are discharged prematurely without being sufficiently stabilized, but also that inadequate discharge planning and follow up are contributing to recidivism, re-institutionalization, and even suicide shortly after release. While medications may be managed while the person is in the inpatient setting, longer-term wraparound supports are needed for the client and their family to increase the odds of a sustained recovery. Family members of a person with behavioral health issues need support and assistance with keeping their family intact. More follow up is needed to make sure that persons discharged get connected to the next level of care. *DMHAS Activities on this issue: There are emerging initiatives between Department of Correction (DOC) and DMHAS outpatient substance abuse services to ensure*

better connections to care for persons pre-release from DOC. These efforts are an extension of such programs operating in Bridgeport and New Haven that will now be expanded to Hartford.

Opioid Epidemic

The structure of the priority setting process in 2016 was based on large service categories and did not lend itself to organizing around topics like the opioid epidemic; however, given the scale of the problem it is being separately addressed. Admissions rates for persons with a primary diagnosis of heroin continue to climb, as, unfortunately, do the number of opioid-involved overdoses across the state. Often the overdoses occur within a few weeks of release from hospitals, prisons, and other institutions due to a decrease in tolerance to the substance caused by a break in use. Some concern was expressed about an apparent emphasis on methadone in response to the opioid epidemic. Other treatment options are, of course, available at DMHAS programs, but medication assisted treatment (MAT) is an evidence-based practice proven to decrease illicit drug use, criminal activity, and infections. The suggestion to allow Advanced Practice Registered Nurses to be able to prescribe Suboxone and thereby further expand access to this medication has been accomplished by federal law via the Comprehensive Addiction Recovery Act (CARA 2016). Safe disposal of unused and expired medications has received much attention as about 75 police station lobbies across the state now have medication drop boxes, however, it's been suggested that more convenient drop box locations are needed outside of police stations for those who are uncomfortable with this location or have difficulty accessing it due to age or disability. The new DMHAS call line meant to assist those with opioid use disorders to access services was commented on during the priority setting process with the feedback that some callers had been told the number was only for persons using certain substances, not all substances, and only for those in need of detoxification. Those needing other services were advised to call 211. The 211 call number has also received comment, including that most people lack awareness of this service and that the 211 system needs more staffing and more training, including in customer service skills. *DMHAS Activities on this issue: This topic has resulted in positive cross agency and community stakeholder collaborations. Significant resources have been dedicated to raising awareness and educating the public via community forums and public service announcements. Expansion of (MAT) through methadone clinics and suboxone prescribing are underway and more is expected as DMHAS received a SAMHSA grant for this purpose. Training on Naloxone for opioid overdose reversals is ongoing with clinicians, administrators, police officers, school personnel, and other organizations and community members.*

Strengths

Responding to Current Conditions:

Much positive legislative activity has occurred related to current crises situations. Related to the opioid epidemic, reestablishing the Alcohol and Drug Policy Council (ADPC), establishing a 7-day limit on prescribing of opioids, raising the capacity for physicians with the DATA waiver to prescribe buprenorphine, medication drop boxes for safe disposing of prescription medications, more first responders armed with naloxone, RAC funding, and pending agreements to place recovery coaches/crisis workers in EDs are all underway.

Mental health clients in crisis have the benefit of staff expertise and services that continue to become more integrated. Local Mental Health Authorities (LMHAs), working with law enforcement, other emergency responders, and town personnel continue to coordinate to serve those in need. Both Crisis Intervention Training (CIT) for police and Mental Health First Aid (MHFA) training for community members continue to be offered and seem to be making a difference in terms of greater understanding and recognition of common behavioral health crises. In response to barriers in accessing timely mental health services, some programs now offer same day or next day access.

Integration Efforts:

Community Care Teams (CCTs) have been developed in many locales and are targeting frequent ED users/Inpatient admissions and assisting those clients with wraparound services which address the wellness of the whole person. It was suggested that the cost savings realized from the activities of the CCT should be sufficient to fund a navigator for each CCT. It was recommended that there be coordination amongst the existing CCTs to ensure consistency of services provided.

Behavioral Health Homes (BHHs) are serving those with complex medical needs by either establishing medical clinics onsite or establishing a close working relationship with a nearby hospital for medical services. Some providers have become certified Federally Qualified Health Centers (FQHCs).

Greater awareness and collaboration between behavioral health and law enforcement providers is benefitting both systems and has resulted in more training and greater familiarity of mental health and substance use initiatives.

Homelessness:

Coordinated Access Network (CAN) has made progress toward ending chronic homelessness and there are two supportive housing options in Manchester described as “stellar”.

Wellness:

The concept of treating the whole person known as “wellness” continues to gain momentum. To a certain extent, dissatisfaction with the existing system (including instances of doctors not listening to clients or minimizing their medical issues or focusing only on medication) has been the impetus to the rise of the wellness phenomenon in which clients are empowered and the focus is on meeting their own needs. This is consistent with recommendations to teach clients self-awareness and self-care and having them develop skills rather than having providers do it for them. The need for less focus on diagnosis and more on providing alternatives and actual help, as was noted from the respondents, captures this. Involving more people in the wellness movement as a prevention effort was recommended because of its increased client participation and cost-effectiveness. This would include mindfulness, art and self-expression activities. Others propose having actual tutoring in math and writing skills. The TOIVO program offers education, support groups and alternative approaches to healing and wellness. The In Shape program, which focuses on exercise and nutrition, uses positive reinforcement with participants and is successfully reducing stress and anxiety. Some clubhouses are offering activities and groups that people want to participate in, like smoking cessation, yoga, healthy eating, and spirituality, and in an environment where those participating also develop friendships. Another provider has incorporated skill building, wellness groups and activities that are also drawing people in that might not otherwise be interested.

Recovery Supports:

Connecticut has invested in training certified Recovery Support Specialists through Advocacy Unlimited (AU) and Recovery Coaches through Connecticut Community for Addiction Recovery (CCAR). Many are working in the system, providing support for socializing, recreation, self-advocacy, employment, and community living skills.

DMHAS and its providers are committed to recovery support services, including services provided by CCAR (Recovery Coaching training, telephone support, and volunteer opportunities). Clubhouses and social programs are helping people develop relationships and success in the community by assisting them with education and training, support, activities, and stress reduction.

Top 3 Priorities

#1- Outpatient Services:

Outpatient services were of greatest concern statewide due primarily to limited access/capacity. Some programs have closed due to budget reductions or financial losses associated with insufficient Medicaid reimbursement amounts. The other barriers identified were a shortage of psychiatrists/prescribers and, of those practicing, many not accepting public insurance, including Medicaid. This situation is characterized by extended waits for outpatient appointments and larger caseloads for outpatient personnel. In response to the situation, some outpatient providers, rather than close, have cut back on services and hours, including replacing individual with group sessions, focusing on medication management rather than client skill development, and eliminating the possibilities of any extended service hours or bilingual staff. On the other hand, some providers have opted to attempt a same day access model, which was applauded by respondents and considered worth attaching incentives to.

More provision of services by case managers, CSP and ACT providers and other support services were recommended not just to assist targeted clients in maintaining treatment gains, but to make available to the overall population. Likewise, Outreach & Engagement, which is also part of the "Outpatient" category, were recommended for those in transition between different levels of care (including release from prison to community), persons who drop out of treatment, those in crisis, persons without transportation, persons with substance use disorders, seniors with behavioral health issues, and homeless persons. A number of participants felt they weren't adequately informed of all the outpatient services that were available to them, including peer supports. There was also the mention of having navigators available to assist clients with identifying and accessing resources. *DMHAS Activities on this issue: DMHAS just completed a redesign of residential support services and converted many programs to Community Support Programs (CSPs) to provide better standardization of services. There are now 28 agencies and 39 distinct CSP programs available.*

For persons with substance use disorders, accessing suboxone providers for opioid replacement therapy (ORT) has been a challenge given federal limits on the number of persons a prescriber can have on their caseload. The Department of Health and Human Services (DHHS) has recently expanded this capacity which should make this care more accessible. It was also reported that Ambulatory Detox is an underutilized level of care that more people could access. *DMHAS Activities on this issue: DMHAS was awarded a grant for high risk communities to expand access to Buprenorphine. The communities of Torrington, Bristol/New Britain, and Willimantic/Windham will not only receive funds to support expansion of Buprenorphine treatment but will also be able to hire a recovery coach at each site to assist in the process.*

The nationwide shortage of psychiatrists will not be resolved quickly given they are an aging profession with many working only part time.

#2-Inpatient Services:

Extended waits to access inpatient beds were reported with many persons occupying general hospital beds/"boarding" in EDs for the interim. The hospitals believe they are seeing more clients coming to them with behavioral health concerns. It was reported that it is particularly challenging to access inpatient beds for clients with co-occurring conditions and that community inpatient programs are reluctant to accept these more complicated co-occurring clients, preferring to leave such clients to state-operated programs like Connecticut Valley Hospital (CVH). One recommendation in this regard is to shift designation of some inpatient beds to be strictly for co-occurring clients.

For clients with substance use disorders, it's reported that accessing an inpatient bed is difficult unless the person is referred through the court/criminal justice system. Complaints about persons needing to be "high" at the time of admission screening or that they need to "fail" at a lower level of

care to be admitted suggest that improper use of the American Society of Addiction Medicine (ASAM) admission criteria is occurring. Other unnecessary barriers include programs refusing persons prescribed psychotropics or certain arbitrary dosages of methadone. Complaints about insurance company barriers included dictating treatment options and caps on number of treatment episodes.

Mental health clients at CVH were reported to not be receiving sufficient therapeutic groups, adequate visitation opportunities or sufficient coordination with lower levels of care (LOCs) and housing options.

Across all inpatient settings there was concern that people are discharged prematurely – staying only long enough to have their medications managed, but not long enough to be stabilized and to acquire the skills needed to be successful at discharge. Better discharge planning/aftercare arrangements are needed including longer-term transitional wraparound supports for the whole family, in order to increase the chances for a sustained recovery. *DMHAS Activities on this issue: DMHAS is about to conclude an inpatient services study which includes recommendations aimed at improving appropriate and efficient utilization and bed flow at higher levels of care (including respite).*

#3a- Workforce:

The first priority that was part of a 3-way tie for third most important is workforce. The state-operated system has been affected by layoffs which result in “bumping” per union contract. Impacts of this “bumping” include disruption for services and clients, including potential loss of a particular expertise/specialty.

At the private non-profits (PNPs), those providing direct services to clients are described as the “working poor”, unless they are part of senior management. Not surprisingly, this leads to substantial turnover of direct care staff which, as for clients in the state-operated system, is disruptive. The perspective of the PNPs is that their funding should be increased.

Impacts for the DMHAS-operated and –funded system include increased workload, stress, and difficulty being released for training. Having to “do more with less” is the mantra.

There is a state as well as a nationwide shortage of psychiatrist/prescribers, along with, in some regions, bilingual staff, social workers, and case managers. Training of the existing workforce was also recommended, including educating providers about trauma-informed care, evidence-based practices (EBPs), cultural competence, and safe opioid prescribing practices. *DMHAS Activities on this issue: A review of training opportunities for DMHAS staff from the Winter Catalog 2017 and Web-based Trainings: Trauma-informed practice in Behavioral Health Care; Best Practices in Anger Management; Best Practices in the Treatment of Depression and SUD; Addressing behavioral health needs of veterans; Gender-responsive substance abuse treatment for women; Cultural competence primer for behavioral health practitioners and settings; Cultural Elements in treating Hispanic and Latino populations; Understanding Trauma related to Trauma-informed care; and a variety of trainings related to opioids and addiction. Additional training resources are available, but not listed here.*

Issues related to peers also fit in this section. Recovery Coaches serve as mentors/guides for individuals with substance use disorders. The Coach empowers the individual in their personal journey toward recovery by offering hope while providing advocacy, guidance, support and knowledge. Because these positions aren’t reimbursable, they’re underutilized and not enough positions are available. Use of peers to bridge service gaps is recommended as a cost-effective solution, especially to assist with compliance and follow through for persons being discharged from EDs or otherwise transitioning. Persons experiencing some sort of crisis, including overdose, are at a critical point at which engagement may be most advantageous. The Yale Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence program was put forward as an example of an innovative model to be replicated. Some misunderstandings have developed in terms of the role of the peer, in which some

peers conceptualize of themselves as advocates, not actual service providers. There is a waiting list for Recovery University. Creation of more groups with persons in recovery like the Consumer Action Panel in Torrington was suggested. *DMHAS Activities on this issue: DMHAS has an initiative in process to expand the peer workforce into hospital emergency departments. Trained recovery coaches will reach out to ED patients and their families to provide assistance when a desire for recovery is indicated. Manchester, Windham, Norwich and New London Hospitals will have Recovery Coaches connect with patients who have overdosed or with alcohol/substance-related ED visits. The goal is for a rapid response by the recovery coaches (≤ 2 hours) to engage the patient and connect them to a provider/recovery supports and with transportation as needed, including resource materials that can be taken with the patient/family at discharge. A second DMHAS initiative is a project covering calendar year 2017 designed to assist agencies with integrating Recovery Support Specialists. This initiative is designed to assist up to ten (10) agencies in supporting and maximizing the contributions peer staff can make to promote the recovery of persons with serious mental illnesses and co-occurring substance use disorders. The training and technical assistance will be provided at no cost to the selected agencies and is funded by DMHAS through the Yale Program for Recovery and Community Health (PRCH) and Advocacy Unlimited.*

#3b-Education/Research/Prevention:

The second priority that was part of the 3-way tie for third most important is Education/Research/Prevention which many expressed were critical across all levels of care. Each element will be addressed separately.

Education of town services staff was suggested along with more required funding and training for Crisis Intervention Training (CIT) for police officers. Additionally, providing accurate information about the negative effects of marijuana was recommended, particularly for young adults. Raising awareness of common mental health conditions and wellness were recommended. *DMHAS Activities on this issue: There were 194 MHFA training sessions and 91 YMHA training sessions in FY 15. For FY 16, there were 152 MHFA training sessions and 74 YMHA training sessions. As a result of ongoing CIT training sessions, there are now 95 police departments with at least one trained officer and 1754 individual officers trained.*

Research recommendations included collecting data on wait lists, assessing the impact/cost-savings of providing mental health supports, monitoring the impact of budget cuts, and legislative review of standards for merchant education on tobacco, alcohol, medical marijuana and gambling.

Prevention recommendations primarily focused on substance use and suicide with few exceptions. More prevention efforts in K-12 public schools targeting primary substance use prevention and other behavioral health issues was expressed with the concern that social media is playing a role in children trying out substances earlier. Directing prevention efforts toward those at greatest risk of overdose, making naloxone more accessible to reverse opioid overdoses, and placing medication drop boxes in places where people will be more comfortable using them rather than in police station lobbies were all suggested. Related to suicide prevention, more was recommended, including the Zero Suicide Initiative, along with integrating these efforts to deliver local level support. *DMHAS Activities on this issue: The Governor's Prevention Partnership provided 810 services reaching over 19,000 individuals targeting schools, colleges, workplaces, media and communities. Through the Garrett Lee Smith (GLS) Suicide Prevention Initiative, comprehensive evidence-based suicide prevention/early intervention efforts on college campuses across the state served students with screening and professionals with training. Information on mental health and substance use issues was disseminated through a variety of media outlets to thousands of residents via the Connecticut Center for Prevention, Wellness, and Recovery. The*

most recent GLS grant “Connecticut Networks of Care for Suicide Prevention” (NCSP) provides funding from 9/30/2015 to 9/29/2020.

There were a few comments related to stigma, including a point of view that the term “behavioral health,” which has been adopted by the Substance Abuse and Mental Health Services Administration (SAMHSA) as well as many other organizations, is “misleading and increases stigma.” Changing society’s attitudes is still needed for those with mental health and substance use disorders and their families. DMHAS Activities on this issue: DMHAS has several new public service announcements specific to the opioid epidemic and its consequences on individuals, families, and the community and these have been presented to the Alcohol and Drug Policy Council and are available on the DMHAS website.

It was suggested that the Strategic Prevention Framework (SPF) which has been in place for years be replaced with a new prevention model and that prevention efforts reach across the life span. Changes were also recommended to the secondary prevention plan to include the programs: SOS, A-SBIRT, QPR and MHFA, some of which are already being offered. Another recommendation was to fund the Connecticut Prevention Network (CPN) to conduct twice annual prevention forums to improve delivery of EBPs.

#3c- Residential/Crisis/Respite:

The third of the 3-way tie for third most important priority is Residential/Crisis/Respite care which covers a wide swath of services. While each element will be addressed separately, some common themes were expressed which applied across the entire range. A lack of capacity across this category was identified and it was pointed out that two transitional residential programs had closed. Stigma was described as a barrier to new housing as everyone is familiar with the NIMBY (Not in My Backyard) phenomenon. A lack of transitional support from 24/7 to step down levels of care was also expressed. Inadequate reimbursement rates for residential treatment and poor pay for residential staff make it difficult to maintain staff and services. For some clients, especially complicated co-occurring clients, the maximum length of stay may still not be enough to result in a successful discharge. Finally, inmates being released from prison with behavioral health needs are challenged to find housing.

Residential services for those with substance use disorders were described as having insufficient capacity to meet the demands. During the waiting period for admission to certain programs, people are expected to call daily to retain their spot on the waiting list, often while they are on the street and at risk of relapse. There are no sobering centers at which to safely wait for residential treatment and no “wet houses” to safely sober up for those not ready for a higher level of care. Some programs won’t admit potential clients unless they already have a place to discharge to afterwards which is problematic for clients that are homeless. As mentioned previously, there are also insurance barriers reported such as needing to fail lower levels of care first, needing to be intoxicated at the point of admission, or arbitrary caps on number of episodes of treatment that will be covered. Again, these barriers suggest incorrect interpretation of the ASAM criteria. It was suggested that more services be directed toward direct client contact early in the recovery process.

Residential housing for those with mental health conditions (group homes or supervised apartments) was described as having insufficient capacity to meet the demands. The Greater Danbury area has no group homes. Residential options for interim and higher levels of care are recommended. Clients become comfortable with their current level of care and stepping them down to a lower level of care becomes a challenge that they resist. They may not have the financial resources to move their belongings. They may have difficulty in relating to others in the household or other issues like hoarding which serve as a barrier to housing options. It was suggested that those persons who hoard should have this condition addressed by both health providers and municipal services. The transition from group home to independence is dramatic and needs an interim level if the person is to succeed. Medicaid

Rehab Option (MRO) group homes have requirements including 40 billable hours of services/month which can be a challenge to meet. Also, group homes with more flexibility than the MRO requires were recommended. *DMHAS Activities on this issue: DMHAS is about to conclude an inpatient services study which includes recommendations addressing the need for higher intensity mental health residential treatment beds for the more disabled clients challenged by program demands and in need of more extensive assistance than other clients.*

Crisis services are understaffed and lack capacity which translates into reduced hours of service, extensive waits for service, and reliance on a law enforcement response. Strict fidelity/model requirements of mobile crisis limit flexibility and serve as a barrier for some. It was recommended that the evaluation of crisis services be modified to target understanding what the client's experiences were. It was suggested that 23-hour crisis beds be created.

Respite care was described as lacking capacity and as being misused long-term by persons who had no other placement option. Similarly, it was suggested that increasing respite bed capacity might alleviate other capacity issues in the system. *DMHAS Activities on this issue: DMHAS is about to conclude an inpatient services study which includes recommendations aimed at improving appropriate and efficient utilization and bed flow at higher levels of care (including respite).*

Other Priorities

Recovery Support Services:

Recovery Support Services did not rank in the top three priorities, but received a number of comments and recommendations. Related to housing, concerns were expressed about trying to access a shelter bed through 211 and CAN, needing a certain income for eligibility for public housing, long waits for Section 8 vouchers and the challenge of housing persons released from prison. Specifically for persons in recovery from substance use disorders, having halfway houses and *supervised* sober houses was emphasized along with a request to maintain people in recovery support services even if noncompliant. Also related to recovery from substance use disorders, it was suggested that alternative to traditional 12-step self-help groups be made available and that services be available 24/7. Concern was expressed over inaccurate online information about mental health services and that clients with such issues weren't always informed about available services, including clubhouses and vocational services.

There were a number of comments and recommendations related to supported employment. Despite efforts to educate clients to the contrary, many still believe that they will lose their benefits if they become employed. Challenges to employment include the overall high unemployment rate, clients with a substance use or criminal justice history, and lack of access to Employment Specialists. Referrals to the Supported Employment program are low, which respondents attributed to Waterbury Hospital not participating in the referral process. This underutilization could be an opportunity for those wishing to participate in supported employment programming. Staff that operate in the Supported Employment program are challenged by having to develop job opportunities for clients at the same time that they have to support their clients in their recovery process. A suggestion was made to assist clients' efforts at starting their own businesses. The IPS model was described as limiting flexibility and budget cuts to DOC apparently eliminated an option to IPS. *DMHAS Activities on this issue: This concern about lack of flexibility with IPS has been addressed as programs wishing to use an alternate model simply need to put their proposal for an alternate plan in writing for review by the program manager. The Supported Employment Grant that DMHAS was awarded is currently working with two priority populations: the Latino population in Hartford and individuals with criminal justice involvement in New Haven.*

Transportation issues were again a significant concern in the priority setting process. Complaints about Logisticare, especially the rudeness and lack of promptness of the drivers, continue and a barrier to being able to lodge complaints against them was described. Recommendations related to

transportation included: having mental health and substance use transportation resources shared, enforcing the med cab contract with an emphasis on respectfulness being a must, having the med cab operate in isolated parts of the state, working with towns for use of available town vehicles, replicating the Reliance House model of “punch cards” for rides, supporting a limousine service, funding a mobility coordinating position, and investigating other transportation possibilities. *DMHAS Activities on this issue: Department of Social Services (DSS) which contracts with Logisticare, along with DMHAS and Beacon Health Options have collaborated in response to the feedback concerning Logisticare to address the most egregious concerns.*

Special Populations of concern:

As in previous reports, the majority of concerns expressed for special populations were age-related.

Young Adults (YA) – tailoring services for the unique needs of young adults was emphasized. Providing younger adults with services designed for older adults (example provided was traditional AA meetings) is not a good match and fails to engage them. It was recommended that services provided by CCAR be tailored for adolescents.

Special concern was expressed for young adults in college with behavioral health symptoms. Symptoms significant enough to interfere with the student’s ability to succeed in this environment are reportedly common, but infrequently reported. College personnel, in turn, are unaware of which students are in trouble and the behavioral health services that are available on campus are often limited. Further complications regard parental notification and consent. For college students with substance use problems, sober campus housing and activities were recommended. This recommendation aligns with suggestions for a Recovery High School for students still in public school who have substance use disorders. Additionally, developing Alternative Peer Groups (APGs) to support young persons in their recovery from substances were recommended. The APG model is a program involving peers to provide positive peer pressure and support.

Persons aging out of DCF appear to have the advantage in accessing young adult services (YAS) which means those without a DCF referral are at a disadvantage. A lack of capacity for YAs at CVH was specified. Not being informed of other available services, including peer supports and treatment outside of DMHAS, was a concern. For those actually receiving services, some reported disrespectful/unhelpful staff, the need for assistance with furthering their education/employment, and clients aging out of YAS without being fully prepared for discharge. *DMHAS Activities on this issue: DMHAS YAS program is designed for clients 18 – 25 with a history of DCF involvement and major mental health problems. In SFY 2016, YAS programs served 1,225 clients, an increase of 3.5% over the number served in the previous fiscal year. Almost 50% of clients were able to live independently after discharge from YAS, more than a third had earned a GED/high school diploma, more than a quarter were employed, and over 59% were living stably in the community.*

Older Adults - a service gap identified was older adults with complex medical needs with or without substance use problems who are either house-bound and need services brought in or without residential placement options. In addition, there are older adults with mental health issues who lose family support as they age and are sometimes put in the demanding role of caregivers to other family members. *DMHAS Activities on this issue: The asset mapping project has been completed by the Older Adult Workgroup and subcommittees are actively working on the top priorities which are: 1) Developing and embedding training on older adult mental health issues into other training as part of a professional development effort; 2) identifying existing databases on older adults; 3) creating a process of “no wrong door” for older adults in need of services. Additionally, they are collaborating with DMHAS Workforce Development to create an online training on older adult behavioral health issues for the Learning Management System.*

Co-Occurring Clients –For person struggling with co-occurring conditions, integrated mental health and substance use services should be an expectation, not an exception. It was reported that some mental health services don't want to treat clients on methadone maintenance. *DMHAS Activities on this issue: All DMHAS LMHAs are involved in a learning collaborative to offer Buprenorphine as part of MAT. LMHAs have also been participating in naloxone training. Additionally, monitoring conducted by the DMHAS Community Services Division (CSD) of substance use programs examines the extent to which mental health services are provided and at this point, many substance use programs now provide mental health services to the clients they serve.*

Criminal Justice Involved Clients – Many persons who are incarcerated struggle with mental health and/or substance use disorders. Treatment, rather than incarceration, should be indicated. Jail diversion was recommended for expansion along with providing education to judges about the option.

Other populations – Persons in these other special subpopulation groups were only mentioned in terms of needing access to services: hearing impaired persons, hoarders, undocumented persons, persons whose primary language is other than English, minority LGBTQ youth and young adults, and transgender persons who were described as not supported in the region. *DMHAS Activities on this issue: With respect to supporting transgender persons, there are three activities of note: 1) DMHAS has made available an online training entitled **Gender Dysphoria: A Behavioral Health Perspective on Transgender People** available to all DMHAS employees; 2) A 25 minute video entitled **Becoming Myself: A Transgender perspective on Behavioral Health** has been created which tells the story of 4 transgender persons and the behavioral health challenges they face. The video is available on the DMHAS website along with links to other services; 3) Gay-Straight Alliances (GSAs) have been started in DMHAS-operated facilities. They support lesbian, gay, bisexual, and transgender persons and their allies by creating safe and supportive environments. The following programs currently have GSAs in place: River Valley Services/Connecticut Valley Hospital; Greater Bridgeport Mental Health YAS, Western Connecticut Mental Health Network YAS, Capitol Region Mental Health Center, United Services of Willimantic YAS, Southeastern Mental Health Authority, BH Care, Connecticut Community for Addiction Recovery (CCAR), Community Health Resources (CHR), Institute of Living (IOL), Lifeline program of Wheeler Clinic, Marrakech, and Reliance House.*

Insurance issues:

Barriers due to insurance practices were illuminated including: spend down requirements, short re-determination periods, Husky C not covering substance use services/residential treatment (a check of this reveals that while Husky C does not cover residential, it does cover inpatient and outpatient services), high co-pays and deductibles, and insurances that aren't accepted by providers (ex. Medicaid). There was a complaint about a young adult being "forced" into Husky insurance even though the person was covered by private insurance.

Integrated/Coordinated/Technology Informed Care:

There was a general call for developing coordination mechanisms to bring providers together on a regular basis to coordinate care for clients that they share. The care provided should be "wraparound" including areas such as housing and medical services.

CCTs and BHH are positive examples of how this can work, but at least for the BHHs, some problems were identified, including that dual eligible clients (Medicare and Medicaid) may not be eligible for BHH, high caseloads, lack of communication across primary and behavioral health providers, "spillover" to CSP or waiting lists, and physicians ignoring medical complaints of mental health clients. A call for integration of medical services at other levels of care outside BHHs was indicated.

Using current technology, including social media to improve centralized registry, help clients find therapists or social/recreational opportunities for clients and those who support them and recommended resources can all be possible with technology.

Emerging Issues

Cuts associated with the budget deficit are foremost on everyone's minds in terms of what the impact will be for services in the state. This concern has overshadowed other issues and was described earlier in this report.

The most frequently identified emerging issue was the Opioid crisis, despite the fact that the epidemic was identified in 2012 and has seen a significant response from the state since that time. The magnitude of the impact of such widespread opioid use, including overdoses, has attracted a lot of attention and consequently this topic was addressed earlier in this report.

Marijuana is an emerging concern as more states around the country are legalizing the drug for medical and recreational use, including neighboring states. Data is just becoming available from states such as Colorado that legalized marijuana a few years ago and can serve to inform Connecticut about likely consequences to be faced. Respondents continue to ask for accurate information on the negative consequences of marijuana use. *DMHAS Activities on this issue: A few of the providers in the Connecticut Strategic Prevention Framework Coalitions (CSC) initiative are targeting marijuana in their prevention efforts based on community needs assessments. They include: the Town of Clinton, Rushford (Middletown), Child & Family Agency of Southeastern CT, Inc. (Lyme/Old Lyme), and Ledge Light Health District (Groton). The CT Clearinghouse continues to serve as a resource for education on marijuana and distribution of related materials. Additionally, many prevention evidence-based practices address substances as a whole which may include marijuana.*

Problem gambling was identified as an emerging issue in light of Keno and new casinos being built which will increase accessibility to gambling.

Greater awareness of transgender persons, the stigma they face, and lack of support that appears to be available for them is an issue that has moved to the forefront. *DMHAS Activities on this issue: With respect to supporting transgender persons, there are three activities of note: 1) DMHAS has made available an online training entitled **Gender Dysphoria: A Behavioral Health Perspective on Transgender People** available to all DMHAS employees; 2) A 25 minute video entitled **Becoming Myself: A Transgender perspective on Behavioral Health** has been created which tells the story of 4 transgender persons and the behavioral health challenges they face. The video is available on the DMHAS website along with links to other services; 3) Gay-Straight Alliances (GSAs) have been started in DMHAS-operated facilities. They support lesbian, gay, bisexual, and transgender persons and their allies by creating safe and supportive environments. The following programs currently have GSAs in place: River Valley Services/Connecticut Valley Hospital; Greater Bridgeport Mental Health YAS, Western Connecticut Mental Health Network YAS, Capitol Region Mental Health Center, United Services of Willimantic YAS, Southeastern Mental Health Authority, BH Care, Connecticut Community for Addiction Recovery (CCAR), Community Health Resources (CHR), Institute of Living (IOL), Lifeline program of Wheeler Clinic, Marrakech, and Reliance House.*

Suicide rates have risen and there is concern that at least some of the overdoses reported as accidental-drug-related-deaths might, in fact, be intentional rather than accidental. *DMHAS Activities on this issue: DMHAS has been very active and supportive of various suicide prevention programs (e.g., QPR; one word, one voice, one life) which are ongoing across the state. The most recent GLS grant "Connecticut Networks of Care for Suicide Prevention" (NCSP) provides funding from 9/30/2015 to 9/29/2020.*