REGION IV

SERVICE PRIORITIES AND

RECOMMENDATIONS

Report in Follow-Up to
Presentation to DMHAS July 27, 2012

Submitted by:

North Central Regional Mental Health Board
East of the River Action for Substance Abuse Elimination

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Introduction

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

This report summarizes the findings of the 2012 DMHAS Region IV biannual needs assessment and presents recommendations for improvement in mental health and addictions services for Hartford County, Connecticut. Region IV is comprised of 37 towns surrounding Hartford: Andover, Avon, Berlin, Bloomfield, Bolton, Bristol, Burlington, Canton, East Granby, East Hartford, East Windsor, Ellington, Enfield, Farmington, Glastonbury, Granby, Hartford, Hebron, Manchester, Marlborough, New Britain, Newington, Plainville, Plymouth, Rocky Hill, Simsbury, Somers, South Windsor, Southington, Stafford, Suffield, Tolland, Vernon, West Hartford, Wethersfield, Windsor, and Windsor Locks.

I. Process/Data Sources

In January, 2012 the Executive Directors of the Regional Mental Health Boards (RMHBs) met to plan the 2012 DMHAS Priority Process. Discussion centered on how the RMHBs could implement a uniform needs assessment and priority planning process in 2012 that would provide more in-depth information regarding DMHAS service system gaps and barriers, discern emerging or innovative strategies, and result in recommendations for system improvements that are specific, achievable and meaningful and do not re-iterate previously identified chronic needs in transportation, housing and employment.

To carry out a more in-depth process, the RMHB directors recommended that the planning process focus on three emerging topic areas: **1) age-appropriate services for young adults who are newly diagnosed and new to the state mental health and addiction service system; 2) integration of medical care and medical issues for adults with serious mental illness, particularly older adults who, as they are aging, are experiencing more and more complicated primary health care issues; and 3) gaps and barriers to accessing care from several specific entry/discharge points -- inpatient, emergency departments, incarceration, and shelters.**

Please note, however, that that transportation, housing, and employment are reflected as chronic and priority needs in all of the targeted areas listed above and continue to be areas where additional resources and fundamental reform are needed across the service system.

In the spring of 2012, local perspectives from all the towns in Region IV were gathered by NCRMHB and the East of the River Action for Substance Abuse Elimination (ERASE). Information was gathered utilizing a "360" approach from both within and outside of the DMHAS services system (i.e. on-line surveys, evaluations, CAC meetings and Review and Evaluation Committee meetings, focus groups, interviews with key informants (such as town social service, shelters, health departments, local colleges and universities), and parents and individuals in recovery who are new to the system or in the private sector.

A. On-line Provider Survey

The DMHAS Office of Program Analysis and Support developed a web-based survey to capture the perspectives of DMHAS funded and operated mental health and addiction providers regarding access and barriers to mental health and addiction services. Providers were asked to rate selected items based on their direct knowledge of providing a service or referring clients to other services not delivered through their agency. Questions focused on the availability of DMHAS funded services at specific levels of care, estimated wait times for each service, and the degree to which certain factors hinder access to care. Surveys were sent online to the chief administrators of mental health and/or substance abuse service providers throughout Connecticut. Surveys were completed by 25 agencies in Region IV.

B. Evaluations

Members of the NCRMHB Review and Evaluation (R & E) Committee participated in 12 fidelity reviews of the Community Support/Recovery Pathway program (CSP/RP) throughout 2011-12. R & E members conducted all of the focus groups with recipients of CSP/RP services. Information solicited in those focus groups and the fidelity reviews was considered in the writing of this report. Issues gleaned from those reviews as well as reviews of young adult services and psycho-rehabilitation programs from previous years were considered in choosing the emergent issues of focus for the 2012 priority setting process.

C. CAC, All-CAC, and R & E Committee meetings

In preparation for the conducting focus groups several meetings were held with the CACs and the R & E Committee to identify questions and key informants who should be invited to participate in focus groups. Information solicited in those meetings was documented and considered in this report. Issues gleaned from discussions at monthly CAC meetings were considered in choosing the emergent issues of focus for the 2012 priority setting process. In addition, a special All-CAC forum was held on the topic of "Innovative and Promising Practices in Integrated Health Care. The forum featured presentations by Region IV providers of MH/SA services and a representative of ValueOptions. This was followed by a town hall discussion forum with 72 registered participants. Their comments and concerns considered in the writing of this report.

D. Focus Groups

Nine focus groups were held, one at each of NCRMHB's six Catchment Area Councils (CACs), one with a group of young adults at InterCommunity, Inc., the DMHAS-funded provider serving East Hartford and five surrounding communities, and one with key informants to ERASE from the Vernon Social Services Community serving youth and young adults Focus groups held at CACs were attended by town appointees from the towns in each of the Catchment Areas, including people in recovery, family members, community referral organizations, and providers. In addition to regular CAC members, other key informants representing those same constituencies were invited to attend. There were a total of 92 participants – 33 people in recovery, 22 MH/SA providers, 36 community referral organizations, and 7 family members.

Participants were asked to respond to the following questions based on their own direct experience or perceived experience of people in their sphere of influence:

- What are the most important problems for which people seek or need MH/SA services in your community?

- How accessible are mental health/substance abuse services in your communities (how easy to locate, referral process, wait time, insurance issues, convenience for getting there, hours of operation)?

- How appropriate are available services to meet the needs of people in your community (age, culture, gender, language, treatment modality, how well are people's physical health needs being met, how well coordinated)?

- How would you rate the quality or effectiveness of available MH/SA services (what are you looking for vs. what you are getting, have services helped you get better or have a better life, are service settings welcoming and comfortable, are you satisfied with service received)?

- What do you think are the strengths of the MH/SA service system in your area?

- What are the barriers to receiving adequate-appropriate care in this region?

- What kind of changes do you think could be made to improve MH/SA services in your community (resources/services/relationships between providers that could help make things better, changes in policy that could help make things better, emerging practices that look promising)?

Responses were documented on flip charts and also recorded by an observer/note taker hired by DMHAS to assist with priority setting process. Once all responses were recorded, participants were asked to identify issues they considered to be of highest priority. Participants given 6 colored dots (blue for persons in recovery, yellow for family members, green for MH/SA providers, and red for concerned citizen or professionals working for referral agencies) and were instructed to put 2 dots on those items they considered most pertinent in the area of important problems for which people seek or need MH/SA services in your community; 2 dots on those items that created the greatest obstacles/barriers to receiving adequate-appropriate care; and 2 dots on any other items they thought most important for consideration in priority setting. Three of the focus groups centered their discussion around young adult issues, 2 on older adults with medical concerns, 1 on access to services from various discharge points, and 2 discussed all the emergent issues in reaction to summaries already generated from the previous 6 groups.

E. Interviews with Key Informants

As a follow-up to the focus groups a number of additional meetings and interviews were conducted with key informants who could provide further detail about the needs, nature and extent of obstacles, and existing or emerging programs and practices that might address some of the recommendations for improvement elicited during the focus groups. The following were contacted for follow-up information: Members of the Hartford Collaborative, Manchester Continuum of Care, Vernon Multi-

Disciplinary Group (focused primarily on older adults), Bristol Main Street Resources Group (focused primarily on homeless adults), participants in the Canton United Way Community Conversation, Faces and Voices of Recovery Listening Forum (focused primarily on young people recovery from substance abuse), staff from the Chrysalis and CRMHC Forensic and FUSE programs, Alicia Woodsby, Partnership for Strong Communities, Liz Aseveda, Easter Seals Supported Education program, Lila Coddington, Central Connecticut State University (CCSU), Sharon Wall, DMHAS Supported Education, Greg Williams, CT Turning to Youth and Families, Lisa McEacharn, DCF/ New Britain transition pilot with Community Mental Health Affiliates, Amy Marracino, DMHAS Young Adult Services, Tom King, Manchester Memorial Hospital, Laurel Reagan, Jennifer Glick, and Megan Goodfield (DMHAS staff with a focus on older adult services), Ruth Howell, (DMHAS/Bureau of Rehabilitation Services (BRS) staff focused on supported employment), and Melissa Camacho, United Way. Results of these conversations were documented and considered in the writing of this report.

III: Key Findings

B. Age-appropriate services for young adults who are newly diagnosed and new to the state mental health and addiction service system

1. Priority Areas/Problems (in order of priority)

Transitional, affordable, supportive housing (landlords are often not willing to rent to young adults due to lack of credit history, may be less successful with following rules & curfews, may be less willing to participate in treatment, may not qualify for social security benefits if newly diagnosed, not seen as unable to work, often lack independent living skills)

Vocational and educational Supports (tangible work experience for building skills and resume, finding & maintaining employment, guidance for career exploration, pursuing GED or continuing education, admissions and financial aid process, tutoring, support, and recovery housing in the college settings)

Services and insurance coverage for psychiatric, clinical, healthcare, co-occurring, dental services, and recovery supports (access and system navigation are especially difficult for young adults who do not meet the criteria for the DMHAS Young Adult Service program or live in a catchment area not funded for DMHAS Young Adult Services. Young adults with substance abuse disorders need more access to preventive care, detox, and supports for recovery from substance abuse disorders. Several young adults at the Faces of Recovery Listening Forum described instances when they were turned down from detox programs, because they weren't "high" enough. One went out and "scored" some more of his drug of choice so he could go back and meet the criteria for admittance.)

Training and support for developing basic life skills (budgeting, use of a checkbook, maintaining living situation, cooking, shopping, finding a job, etc)

Opportunities for socialization, recreation, building a support system, connections to peers (peer support, mentoring, psycho-social rehabilitation geared to young adults, "many have suffered trauma as youth and need a safe place with understanding staff and peers to figure out who they are and when and where they can express themselves. Many are coming out of schools that did not want them. They are looking for a sense of worth and connection to peers")

2. Access to Services

Need prompt and easier access to services (encounter "endless waiting lists for treatment and recovery supports,' "when coming out of the hospital they need everything at once and need it really fast. System is not friendly to new entrants," singular entry point, flow chart/navigation maps for DMHAS system – "where are the points of entry," doors to young adult services ebb and flow, but often only available via the Office of the Commissioner for people coming out of DCF. Participants in several groups indicated that services were good once a person could get in, but getting in felt almost impossible.)

Provide outreach to families and referral organizations (how to access services and navigate the system, preventative vs. crisis response, better partnership with schools, town social services, and

youth services bureaus to identify youth and young adults, make aware of services available and promote better transitions)

Utilize engagement strategies (address stigma, lack of trust, unwillingness to follow-through with treatment by offering up front the services most appealing to young adults – supported employment for people at various levels of engagement [i.e. competitive, programs like Gould Farm, entrepreneurial opportunities, work crews] and education, psycho-social rehabilitation, trauma-informed, respite. Use lessons learned from YAS programs, etc., as means of engagement. Some providers are of the mindset that vocational services are only available secondary to outpatient clinical treatment – won't offer vocational services without clinical services, because person "cannot succeed without being in treatment")

3. Quality/Effectiveness/Appropriateness of Services

Must be aware of the range of unique needs within the broad category of adults age 19- 26 ("YAs fall into different subsets with very different needs – 18-19 year olds, 23-26 year olds, experiencing first break, known to the MH system, vs. not known. Programs that serve youth have licensing issues about serving people over 18, but 18-19 year olds are often very immature, lack external and internal resources. "No one designated to take overall responsibility for this group," locations where services are provided tend to look like a kid's place or an older adult place – décor, kinds of magazines, etc)

Personalize services and supports (honor clinician preferences, requirements around getting services are not personalized – clinical care via groups vs. individual, requirement to get psychiatric, clinical and recovery supports from same agency, "attending groups on sensitive subjects with older adults just adds to trauma," availability of recovery supports, i.e. clubhouse and vocational up front as means of engagement, work experience opportunities via BRS, treatment plans with concrete goals and focused on strengths, transparency of documentation)

Address specialized needs of young adults who need pregnancy and parenting supports (legal issues – "children taken away by DCF just because young adult has diagnosis," barriers – staff can't transport child; housing options, childcare, scheduling appointments for clinical treatment around childcare issues).

Address specialized needs of Lesbian, Gay, Bi-sexual and Transgender (LBGT) youths/young adults (need to feel accepted and safe, may have been kicked out of family home, may not have birth certificate, higher rates of substance abuse, fewer resources)

Address shortage of resources youth/young adults with substance use or co-occurring disorders

4. Strengths

There are examples of good communication and transition planning (When need is identified early and treatment provided, it is effective, InterCommunity, Inc. has marketed services well so people know where to refer, DMHAS and LMHAs need better connections with school personnel, Youth Services Bureaus YSBs), school and town social services where youths are being identified and young adults turn up when they have nowhere else to go. Towns and YSBs have a good pulse and do good work. Some towns are not restricted from following a young person into adulthood, may have more flexibility – not funded by insurance, transition pilot between DCF and DMHAS for YAS

program in New Britain area working well, Adult Education/Asnuntuck Community College partnership)

There is a strong national and regional focus on wellness and recovery vs. solely on treatment ("more roads to wellness opening rather than just diagnosis," insurance coverage for 19-26 year olds, CMHA offers clubhouse young adult night as a front door service, then integrates clinical services with clubhouse, "my young adult group is my second family" "togetherness is important – seeing peers have success," DMHAS emphasis on trauma-informed care is essential as almost all young adults who participated in focus groups reported a history of trauma)

There are examples of supported employment and supported education services that are working well ("First experiences are so important," InterCommunity, Inc. use of "Street Smart Ventures" for vocational services geared to young adults, vocational services used as a means of engagement – front door to services, work skills programs offered in intensive outpatient programs i.e. Institute of Living (IOL), supports at CCSU including Wellness Recovery Action Plan (WRAP) groups, availability of Supported Education services via Easter Seals but needs to reach a larger, broader audience. One person who gave his testimony at the Faces and Voices of Recovery Listening Forum described the life-saving value of Recovery Housing at Rutgers University.

Programs are in place to promote Self Advocacy, raise awareness and address stigma (SuperAdvocacy, In Your Own Voice, NAMI, also provide meaning by providing opportunities for people to help others)

Intensive outpatient programs are helpful (a hospital stay that transitions from inpatient to intensive outpatient program more likely to meet with success (IOP and SRP at IOL). InterCommunity SECURE program in the middle of clubhouse eases transition.

5. Barriers

Very complex underfunded system (long waiting lists – so lose people, "difficult to know where to go for resources – typically if situation is complex, person or party referring is just left hanging," "once aged out of services for children, person feels like they are in limbo, in transit from here to there, don't know how to access services, how to make insurance cover services,")

Lack of transportation

Lack of influence on legislation and policy issues

Lack of awareness (family denial and fear of the mental health system, discriminatory treatment, confusion at onset of illness between illness and behavioral issues – person just looked at as a problem, often end up in trouble and incarcerated, young people don't understand that services will help them get the things they want, "these are young people who have been unwanted in to many of the places they have been.")

Turnover of treatment staff

Communication breakdown (issues of consent to communicate with family, alarming suicide rates for young adults in college, colleges don't maintain contact with family)

B. **Integration of medical care and medical issues for adults with serious mental illness, particularly older adults who, as they are aging, are experiencing more and more complicated primary health care issues**

1. Priority Areas/Problems (in order of priority)

Increased level, complexity, and coordination of care for people with long term mental illness currently served in the mental health system (significant increase in need due to an aging population in general and exasperated by circumstances associated with serious mental illness (SMI), co-morbid medical conditions, general functioning loss due to aging, risk of falling – safety and accessibility issues, nutrition, early dementia, more support needed for medical follow-up).

Services to older adults with long-term mental illness and/or substance use disorders that have been untreated (falling through the cracks due to difficulty engaging, difficulty navigating the system, lack of outreach, decrease in caregiver support, isolation, alienation, fear of being put away/loss of home, trust/suspicion re: home based services, progression of hoarding issues, coordination with protective services re: safety issues)

Intervention for older adults at risk due to abuse, neglect, mental health or substance abuse issues of caregivers (protection and support for person and property, education and support to overstrained caregivers, isolation, coordination with domestic violence and protective services)

*Homelessness, home insecurity, and poverty (*shortage of affordable housing with appropriate supports, (including assisted living) to maintain people in their homes and communities, Manchester Area Council of Churches (MACC) shelter reported at least weekly referrals from inpatient settings for people who they cannot safely serve in a shelter setting due to medical conditions. Others have refused care for so long that they are not capable of getting out of the shelter).

2. Access to Services

People with SMI often unwelcome in senior and adult day care centers (comfort level of other seniors, lack of behavioral support and expertise, many will not accept people with unstable diabetes or cardiac issues)

Income and insurance and past history issues limit eligibility and options for needed services (eligibility, time limits, cost of care - need to sign over assets for Medicaid funded services, limited options for people with past issues of fire setting, assault, or sex offense, individuals with developmental disabilities and SMI)

Workforce issues limit availability of services (3 month wait for geriatric psychiatrist, not enough programs with expertise and training in behavioral health)

Transportation issues impede people's ability to access necessary medical care (visiting nurse service needs doctor's order within 30 days for home care - which requires person to go see doctor. Ambulance transport is not covered by Medicare).

People who are medically compromised or have SMI often turned away by detox facilities (facilities indicate they are not equipped to handle the medical risks or medication interactions posed by this group).

3. Quality/Effectiveness/Appropriateness of Services

There are knowledgeable professionals and services within DMHAS and the community designed for seniors, but there are too many obstacles to getting good, coordinated care for those with behavioral health concerns (family education, nutrition education, coordination between behavioral, primary, dental, and specialty care, funding issues prevent agencies from working together – duplicative billing issues [see increased level, complexity, and coordination of care for people with long term mental illness on page 9])

Behavioral Health services are not specialized to older age group. (Different engagement and treatment strategies needed, different life issues - end of life/aging in place issues, may require more time and patience from providers, desire for individual therapy or groups with same age peers, compromised medical condition may preclude them from traditional substance abuse treatment – especially detox, need for homemaker and companion services, specialized inpatient and partial hospital programs for older adults)

Workforce issues affect quality of care available (need for nursing expertise for residential and supportive housing teams, specialized training for behavioral health providers re: co-morbid conditions, differential diagnosis, medication interactions, side-effects and difference is metabolism, safety issues, outreach, engagement, and treatment strategies, interaction between mental and physical health, complications of long term mental illness with dementia, co-occurring mental health and substance abuse issues, specialized training for nursing and community re: behavioral health issues)

Time limitations and productivity requirements for home health and behavioral health services limit effectiveness for people who are resistant, suspicious, or just take more time.

4. Strengths

Services via the Home Care Program for Elders, Mental Health Waiver, and Money Follows the Person are excellent for those who qualify

Outreach programs are helping us reach seniors and identify services needed and sources of referral (Gatekeeper via CRT, Senior Outreach and Engagement Programs for Substance Abuse via Wheeler, Alcohol and Drug Recovery Centers [ADRC], and Community Health Services [CHS])

Homecare agencies that have a psychiatric nursing specialty are excellent resources.

Some of the hospitals are equipped to provide care necessary stabilize patients medically while on psychiatric inpatient unit

Mobile crisis units provide good emergency assessment and intervention

Innovative programs emerging on a regional and state level for intensive care management and coordination with primary and specialty healthcare (Options2 Health – CMHA, Healthcare Liaison – CHR, Wellness and Care Coordination – ValueOptions, Co-location of medical, dental, and behavioral health services – Hartford Dispensary, Manchester Memorial Hospital initiative, collaboration with Community Health Centers – region-wide)

State and Federal re-examination of data, policies and service packages to better understand issues that impact health outcomes and address healthcare needs (Affordable Care Act upheld – development of Health Homes and Neighborhoods, Re-evaluation of Medicare 3-day inpatient rule for admission to a Nursing Facility [NF], amendment to Mental Health Waiver to include assisted living services, research studies re: equity and social determinants of health by UConn and CT Association of Health Directors)

5. Barriers

Discrimination/perception of mental health service prevents older adults from seeking needed care (They say, "I'm not one of them, I don't need that." Often will accept a medical diagnosis not a mental health diagnosis, resistant to teaching skills to manage MH/SA issues, often minimize symptoms)

Numerous funding issues present obstacles for people to receive needed services in their homes (Insurance that doesn't cover needed services, reductions in grants from towns for reduced payment services, delayed processing issues with Medicaid benefits, anticipated cuts in Medicare, situations in which family finances are bundled or other family members may be dependent on income or assets, payment issues for co-occurring treatment and coordination of services between agencies, insurance restrictions prevent LMHA clinicians from being reimbursed for services delivered in unlicensed settings i.e. senior centers).

Training and expertise is lacking among professionals who work with the elderly (see Quality/Effectiveness/Appropriateness on page 10).

High staff turnover interferes with comfort level with staff that provide needed services

Protective services are very conservative in their assessment of competency (Visiting nurse staff report that they assess and find that people are not safe in their homes, but resistant to care, so nothing happens until there is a crisis. Hospitals become the stop-gap when crisis occurs and person cannot safely return home, if a conservator is needed, hospital discharge is delayed).

Difficulties with diagnosis complicate treatment planning (interaction of mental illness, substance abuse, dementia, and memory impairment mask symptoms, and contribute to or interfere with treatment one of another, also see increased level, complexity, and coordination of care for people with long term mental illness on page 9 and workforce issues on page 10).

C. Gaps and barriers to accessing care from several specific entry/discharge points -- inpatient, emergency departments, incarceration, and shelters.

1. Priority Areas/Problems (in order of priority)

People are often discharged/released without diagnosis or insurance benefits, can't get needed medication (discharged/released with a 7-14 day supply and told to go find a provider or go to ER, easier to access medical care and medication than behavioral health care and medication, sometimes released from prison with no benefits, no identification, no address, no belongings - can be released straight from court – unanticipated, may enter jail with diagnosis and medication, are untreated in jail, released with no medication or referral for follow-up)

Limited step-down options for Transition/Middle Ground Housing Options for people to get on their feet (Housing First is a good model, but doesn't fit everyone. Some people are ill-prepared for living on their own and fail at Housing First – some states have more fall-back options if a person loses their housing. In Connecticut person tends to end up homeless. Lack middle ground options for people to get established, gain skills, income, benefits, supports to be able to afford and succeed in apartment setting)

More intensive and longer length of inpatient hospital stay for people who need it

For people accessing care from any of these entry points – extreme difficulty getting housing, employment, income and medical benefits

Limited employment options for people coming out of incarceration who need more structure and supervision than available in competitive employment

Some people are barred from shelters and have no place to go (people may be very symptomatic, but not enough to be hospitalized, barred from shelters due to current or past behavioral issues)

People need education and training so can earn income (one supported employment program focused on providing technical training in field where person can make a decent living (i.e. welding) so person would be less likely to return to selling drugs in order to have enough to live on)

Sources of treatment for those who go through jail diversion and do not meet DMHAS criteria

2. Access to Services

Consumers, families, and providers report that they don't know where to go for services or how to navigate the system (Need good resource guidance with criteria and intake process for each program distributed at hospitals, prisons, libraries, etc. 2-1-1 is difficult for people to use – always busy, don't have access to a computer, if don't have identification can't even use a library computer. New 2-1-1 Re-Entry Directory addresses some of these issues for people coming out of incarceration but does not provide detailed information about criteria and intake process).

*Some agency policies complicate and impede access (*each agency has a different intake policy – i.e. for CRT must have a history and physical prior to intake – people get lost in the meantime, Hartford

Behavioral Health [HBH] and Charter Oak have an orientation day, then must come back for intake – helps them screen out people who are not motivated to follow-through, strategies for reducing number of no-shows may actually cause system to lose people, CVH policy not to admit someone for detox if have a court hearing pending – instead of approaching court to have date extended)

Transportation issues impede people's ability to access services (staff who provide intensive case management report need for agency vehicles for transport)

*Wait for outpatient psychiatric appointment after incarceration is 8-10 weeks. (*Wait for initial intake can be 8-10 weeks, initial intake is not with a prescriber, can take a few months to be assigned to a treatment team)

Some catchment areas [i.e. CA 17] have no respite, shelters, transitional housing, or board and cares, so lose touch with people who have to go to a different catchment area

Lack of housing support options for people who don't meet Frequent User Service Enhancement [FUSE] criteria (# of incarcerations, shelter days) *or rapid re-housing (*income)

3. Quality/Effectiveness/Appropriateness of Services

Housing and transitional options for people with varying needs and backgrounds ("can't even talk about quality when a person has no place to live," people who are symptomatic or actively using can't go back to detox, need locations that accommodate people with physical disabilities, age appropriate, new parents, people with families, LGBT orientation, non-English speaking, wet housing, history of sex offense, fire-setting, etc.)

Treatment and support services that address the following: (integration of behavioral and physical health, co-occurring issues especially in the corrections system, quality of life training and support services geared to age, culture, gender, and family issues).

*Issues of coordination, continuity of care, and provider sensitivity limit quality and effectiveness (*All too often people are sent home from an inpatient psychiatric hospitalization without an exit meeting and a plan. Released and back within a week. No coordination of care once person leaves hospital. No options for recovery oriented services for someone who has private insurance).

4. Strengths

*There are a number of DMHAS funded forensic programs designed to assist with diversion and end of sentence release. Data is evaluated to see what model and programs work well (*ASIST – court ordered intensive Case Management, Connecticut Offender Re-entry Program – group treatment, psycho-education and planning for discharge, outreach/engagement services go into the jail/prison to help plan for end of sentence release, OOC/DOC Interagency Referral Program for Case Management and linkage to services after release; forensic outpatient services including psychiatrist who can assess while person is still incarcerated. Pilot collaboration with ADRC at arraignment at community court for individuals with substance use disorders - would benefit from expanding to include people with co-occurring disorders. CRMHC Jail Diversion staff are housed in the court, so even if a person is released without medication, can usually go back and get an order for 14 days.

May take a couple days, and then have to find the person. Person may have to go back to court to fill the order).

There is good communication between DMHAS, DOC and Community Courts (at State Office and provider level, the issue is resources, not communication, community courts really do try to divert people from incarceration)

There are a limited number of transitional "slots" for diversion and post-release (30 days ASIST housing at Open Hearth, 90 days with CRT. These work well, just need more. Need to assess level of motivation when offering these slots. Support comes with rules – need to make sure person understands the expectations and is willing to work with them. More likely to work if person has previously been served by DMHAS and can get back into service in a timely manner.

*There are a limited number Rental Assistance Program certificates (*30) *are used by CRMHC forensic unit that come with support services from Chrysalis*. (Vocational services via the Chrysalis EARN Program are also effective)

Level of commitment among community providers for the hard work that people in these situations require (homeless outreach, forensic, shelter providers)

Possibility of collecting data about discharge and access issues from inpatient hospitalization via ValueOptions

Possibility that Connecticut's investment in "Reaching Home/Opening Doors supportive housing strategies to end homelessness will address some of these issues (i.e. central intake process for homeless shelters, healthcare patient navigators targeting people who are repeatedly homeless, medical respite, expansion of SOAR program – expedite access to Social Security disability, job placement, benefits counseling)

National and local initiatives and funding to promote same day access to services

Recent expansion (via Connecticut legislature) *of providers who can make tax incentives available to employers who hire individuals with disabilities*

5. Barriers

Delays in processing applications for entitlements (Can start when person is in the hospital, but person often lacks the support system to supply necessary documentation, back-log in DSS processing and lack of access to caseworkers to resolve problems, people coming out of incarceration can't apply until released, 3-6 month process for new applications, not everyone qualifies for Social Security – especially young people)

People lack housing, income, are typically educationally disadvantaged and often illiterate (Majority of people who come into shelters have no income. All shelter has is petty cash to help obtain medication. When Connecticut made the change from SAGA to Medicaid LIA, lost the cash benefit that used to come with SAGA)

Some agency policies complicate and impede access (see Access to Services on pages 12-13).

Difficult to find employment options for people with legal issues

Difficult to find any discharge options for people coming out of inpatient hospitalization who are undocumented

Many communities have zoning restrictions that limit affordable housing

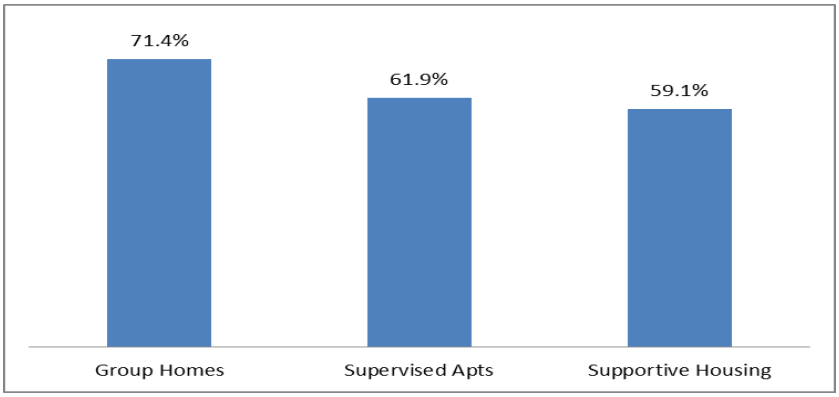
System barriers are constantly changing, so it's hard to develop strategies to address them (also difficult to plan, put in new programs when don't know what subsidy will be from year to year)

IV. Mental Health Treatment and Promotion Recommendations

A. Service Domain: Age-appropriate services for young adults who are newly diagnosed and new to the state mental health and addiction service system

Recommendation 1: Increase access to transitional, affordable, supportive housing for those young adults, ages 18-25 who are not eligible for Young Adult Services

Rationale for recommendation: Survey results as well as feedback from the focus groups indicated that housing continues to be the primary service need for young adults living with mental illness. **The chart below reflects survey results from Region IV providers who rank supportive housing, supervised apartments, and group homes as not available or only sometimes available between 59%-71% of the time for all of their service recipients.**



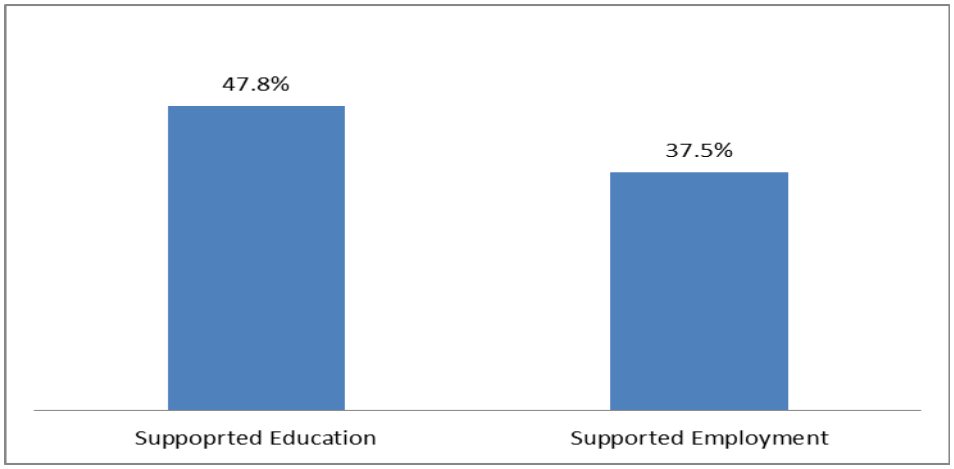
Young adults encounter even more significant challenges in this area. They experience more difficulty qualifying for benefits and therefore have limited or no income to support living in the community. In addition they often lack independent living skills and resources, are often unsuccessful with following rules and curfews, may be less willing to participate in treatment.

Strategies and Interagency Collaboration Required:

- Offer a range of housing options including respite, transitional, family, supported and supervised apartments, and step down options for people whose behavior results in eviction
- Ensure that services and supports address the special needs of young adults with various sexual orientations and those who are pregnant or young parents
- Provide outreach, education and support to families as they may continue to be relied upon by young adults as a support system
- Work with Journey Home/Reaching Home to establish young adults as a priority for affordable and supportive housing or to develop an approach/model to address their needs.
- Improve relationships between local LMHAs and housing authorities for addressing skill and behavioral issues that threaten independent living success

Recommendation 2: Provide outreach and expansion of supported employment and supported education options geared to young adults

Rationale for recommendation: Employment is recognized as a very important part of recovery, in fact, a centerpiece for a recovery-oriented system. Employment should be a basic component of services offered to every person in the system. **Yet, the chart below reflects survey results from Region IV providers who rank supported employment and education as not available or only sometimes available between 38% - 48% of the time for all of their service recipients.**



Vocational and educational supports are even more critical for young adults as these are the peak years when major mental illnesses develop and affect their future prospects for healthy, productive lives. These are also the times when challenges are great for completing education and preparing for the workforce and family life. These are the years when the right kind of services can change the course of a lifetime. Issues raised in our focus groups identified the need for tangible work experiences including volunteer, entrepreneurial opportunities, and work skills programs for building skills and a resume. Also supported employment and education are seen as effective engagement tools and a front door to services for young adults who are reluctant to become involved with treatment and the mental health system.

Strategies and Interagency Collaboration Required:

- Offer a range of vocational supports: entrepreneurial, volunteer, work skills training, and use of curriculum like "Street Smart Ventures." Given that supported employment programs must focus only on competitive employment in order to meet DMHAS fidelity standards, identify alternative options and expectations for other programs within the service array to offer other options such as pre-employment, volunteer, work skills training (i.e. psychosocial rehabilitation programs).
- Include supported education as a component in every supported employment program and embed both supported employment and education as integral components of all community mental health treatment services
- Improve connections and partnerships with school personnel, school based behavioral health clinics, youth services bureaus, school and town social services where youths are being identified and young adults turn up when they have nowhere else to go
- Expand outreach by DMHAS funded Supported Education programs to schools and town social services departments
- Work with local colleges and universities for expansion of disability supports i.e. depression screenings, WRAP groups, and recovery housing

Recommendation 3: Streamline access to needed mental and physical health care services

Rationale for recommendation: Participants in Region IV focus groups described a full range of needed clinical and health care services as well as a long list of barriers that exist and work against their access to those services. Services identified included psychiatric and clinical care, recovery supports, and health, dental, co-occurring and preventive care. Recovery supports needed include training and support for developing basic life skills and opportunities for socialization, recreation, and building a support system. As of December 2011, there were 5962 young adults being served by DMHAS funded agencies – only 782 of them were enrolled in specialized young adult services (YAS) programs. Most of the 782 entered the DMHAS system through what is called the "front door" – as a transition from DCF funded services and authorized by the Office of the Commissioner. Those who were attempting to enter the system through other means (the other 5180 –via self, parent, community agency, or school system referral) found the mental health system too complex, underfunded, and unfriendly to new entrants. They described great difficulty knowing where to go for resources, finding a point of entry, establishing eligibility, and endless waiting lists. In the words of one referral source, "typically if a situation is complex, the person or party is just left hanging. Once a person ages out of youth services, the person is just in limbo, in transit from here to there." Young adults may be experiencing their first break or in the early stages of adjustment to their illness. "They are coming out of the hospital and needing everything all at once and really fast." They also experience greater difficulty qualifying for health care coverage and health care services they need. Frequently their illness is accompanied or exasperated by addiction to alcohol or substances.

Strategies:

- Create and distribute clear-cut, straightforward flow charts (including web-based) detailing points of entry and criteria for accessing and navigating the MH/SA service system
- Establish peer mentors in inpatient settings to help with awareness and navigation of mental health system and services available
- Continue focus on wellness and recovery vs. solely on treatment (expansion of recreational opportunities for young adults, SuperAdvocacy, Young Adult ACT Teams, trauma-informed care, more integration of therapy into alternative activities)
- Extend funding for YAS program to all LMHAs in Region IV
- Share lessons learned from YAS programs and DCF/DMHAS transition pilot in New Britain to better tailor services to the needs of young adults throughout Region IV
- Expand prevention and recovery supports for substance abuse and co-occurring disorders

B. **Service Domain: Integration of medical care and medical issues for adults with serious mental illness, particularly older adults who, as they are aging, are experiencing more and more complicated primary health care issues**

Recommendation 1: Spearhead Mental Health and Aging Coalition/Intersystem Collaboration to improve policy and practices in the system of care for older adults

Rationale for recommendation: Adults age 60 and older are the fastest-growing segment of the U.S. population. Currently 14% of Connecticut residents are over 65. This number is expected to double by 2030. Add to this the problem that adults living with serious mental illness are dying 25 year earlier than the rest of the population, in large part due to unmanaged physical health conditions, therefore the age at which many individuals with serious mental illness (SMI) begin to experience to effects of aging is closer to 45 or 50. The result is a significant increase in need due to an aging population in general and exasperated by circumstances associated with SMI. Although, there are knowledgeable professionals and services within DMHAS and the community designed for seniors, there are too many obstacles to getting good, coordinated care for those with behavioral health concerns. Behavioral health services are not specialized to this age group or co-morbid health conditions. Home-care, senior, and adult day programs are not welcoming to people with behavioral health disorders or equipped to provide specialized care needed. There a numerous funding issues that present obstacles for people to receive services in their homes and community settings, and many older adults are reluctant to seek treatment due to cultural norms and prejudices associated with mental illness or fears about losing independence and being put away.

Strategies and Interagency Collaboration Required:

- Spearhead interagency coalition to improve collaboration/connections/communications between providers and agencies that work with elders, explore and address policy and practice issues that are barriers to health equity and coordinated and effective care
- Explore options for providing therapy in natural settings that seniors frequent (i.e. licensing, funding, additional supports)
- Address scheduling, training, time constraints, and compliance issues of staff providing in-home care or medication administration and co-occurring treatment,
- Explore options for developing supports necessary for people with SMI to participate in senior centers and adult day centers - explore use of volunteers or Recovery Assistants as supports.

Recommendation 2: Conduct training and workforce development to increase the numbers, clinical skills, and cultural competencies of professionals who work with older adults

Rationale for recommendation: People living with SMI have significantly higher prevalence of major medical conditions that are in large part preventable such as diabetes, metabolic syndrome, lung and liver diseases, hypertension, cardiovascular disease, infectious diseases, and dental disorders. DMHAS and other systems that serve adults who are medically compromised must better equip themselves to address the increased complexity, level and coordination of care issues that go along fragile health, aging, mental illness, and chronic substance abuse. Issues described in our focus groups included: co-morbid medical conditions, general functioning loss, risk of falling – safety and accessibility, nutrition, better support for medical follow-up, differential diagnosis, medication interactions, side-effects and differences in metabolism, outreach, engagement, and treatment strategies, and the interaction between mental and physical health. In addition, diagnosis is more difficult and complicated because of the interaction of mental illness, substance abuse, dementia, and

memory impairment masking symptoms, and contributing to or interfering with treatment one of another.

Strategies and Interagency Collaboration Required:

- Recruit and train for the development of a cadre of professionals trained in geriatric behavioral health care
- Provide basic and cross training to staff within hospitals, primary care, psychiatry, senior and adult day care centers, senior housing, home health, protective services, mental health, and substance abuse settings on topics such as those listed above

Recommendation 3: Continue to explore and develop innovative programs for intensive care management, coordination with primary and specialty healthcare, and follow-up care for older adults coming out of the hospital

Rationale for recommendation: With the advent of health care reform, innovative programs are emerging at the regional and state level for intensive care management and coordination with primary and specialty healthcare (see strengths section on page 11). Programs such as these ensure better quality and coordination of care, and reduce the need for costly re-hospitalization or premature nursing home care.

Strategies and Interagency Collaboration Required:

- Explore possibilities for collaborative relationships between hospitals, ValueOptions, Community Health Centers, and LMHAs for intensive case management and coordination of care within the model design for Health Homes and Health Neighborhoods
- Continue to explore means to ensure prompt access to community mental services upon discharge from hospital

Recommendation 4: Provide training and support to families who are caring for older adults with SMI

Rationale for recommendation: Families are a primary source of care for older adults that allow them to remain safely in the community. The provision of caregiver support comes with many challenges above and beyond dealing with the emotional, medical, and care needs of the person. They experience difficulties with navigating the system, encouraging their loved ones to engage in treatment, dealing with legal and benefit issues, the alienation, isolation, and fears of their loved ones, unbundling family assets, and alleviating their own strain and burnout and thus mitigating potential for abuse or neglect of their loved one.

Strategies and Interagency Collaboration Required:

- Organize outreach, training, and support to families through a Mental Health and Aging Coalition/Intersystem Collaboration

Recommendation 5: Promote expansion of Money Follows the Person, Elder Home Care, and Mental Health Waiver programs and affordable assisted living to meet growing demand.

Rationale for recommendation: Participants of our focus groups were very complimentary about the services and support available through Money Follows the Person, the Elder Home Care, and Mental

Health Waiver programs for those who qualify and can be maintained safely during the eligibility process. These are critically needed programs. For those who qualify and have long standing behavioral health concerns, life includes poverty and risk of homelessness. One of our focus group participants reported that she turns away referrals weekly for people coming out the hospital who cannot be served safely in a homeless shelter due to their medical conditions. The addition of assisted living services to the amended application for the DMHAS Mental Health Waiver provides some additional resources to address this issue, especially since DMHAS is reaching out to assisted living settings that are affordable for people with low income. This outreach and expansion is a critical step to address the lack of affordable housing available for adults with SMI who require a higher level of care than traditional supportive housing is equipped to provide.

Strategies and Interagency Collaboration Required:

- Continue to promote collaboration and expansion of Waivers that allow individuals to remain safely in community settings as alternatives to nursing home care.

Recommendation 6: Continue and expand outreach and engagement efforts for older adults with SMI and Substance Use Disorders

Rational for recommendation: Participants in our focus groups were very complimentary about the outreach efforts and design of the Gatekeeper program funded by DMHAS. They identified as a top priority need services to older adults with long-term mental illness and substance use disorders that have gone untreated. Continued funding for outreach programs such as Gatekeeper and Senior Outreach and Engagement programs for Substance Abuse are of critical importance.

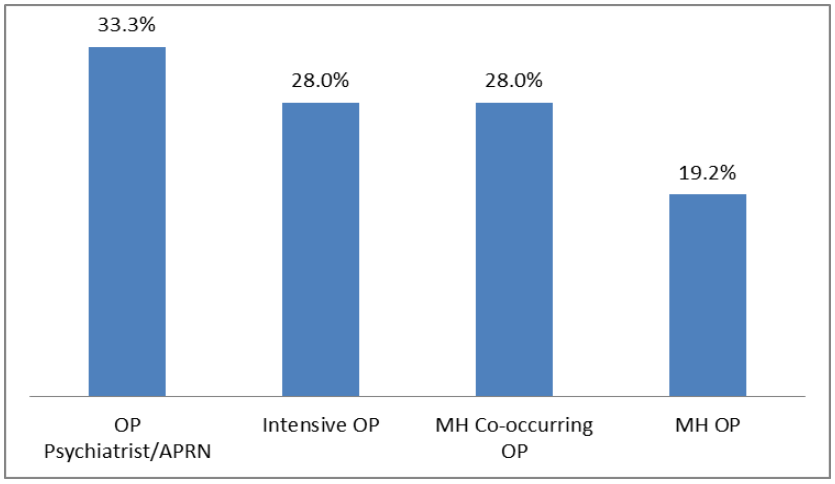
Strategies and Interagency Collaboration Required:

- Continue funding and support for outreach programs such as Gatekeeper and Senior Outreach and Engagement programs for Substance Abuse
- Use information gathered via outreach efforts to identify services, supports, and strategies that are most helpful for engaging older adults and improving health outcomes

C. Gaps and barriers to accessing care from several specific entry/discharge points -- inpatient, emergency departments, incarceration, and shelters.

Recommendation 1: Promote collaboration between state agencies, hospitals, Community Health Centers, LMHAs, and ValueOptions to create vehicles for same day access to outpatient, prescriber and intensive case management follow-up when needed after discharge from inpatient hospitalization.

Rational for recommendation: Survey results as well as feedback from the focus groups indicated that access to mental health (especially prescriber) services is a primary service need for people coming out of inpatient, jail, or prison settings. **The chart below reflects survey results from Region IV providers who rank outpatient mental health and psychiatric services as not available or only sometimes available between 19-33% of the time for all of their service recipients.**



Although Region IV providers reported average wait times for these services to be from 15-27 days, participants in our focus groups described wait times of at least 8-10 weeks. Only 12 of the 24 Region IV providers gave information about wait times for prescriber services – those ranged from 10 to 60 days.

Focus group participants described many occurrences when a person was released from inpatient, jail, or prison settings with no more than a 7-14 day supply of medication. They were told to find a provider or go to a hospital emergency department if they needed a refill. Given the trend to shorter lengths of stay for inpatient hospitalization, the lack of prompt access to outpatient and prescriber services impedes their chances for recovery and frequently results in re-hospitalization. Consumers, families, and providers all reported difficulty with using Infoline 2-1-1, knowing where to go for services, how to access, and how to navigate eligibility criteria and intake procedures for various agencies (see access to services on page 12). Too often people are sent home from an inpatient psychiatric hospitalization without an exit meeting that includes a receiving community mental health provider and a discharge plan. All of this is exasperated by the current backlog at DSS for processing Medicaid applications (reportedly a 3-6 month wait for new applicants).

Strategies and Interagency Collaboration Required:

- Establish and promote collaborative effort with organizations above to gather and analyze data re: people who are frequently hospitalized, people leaving hospital and unable to access needed medication or services, and social, economic, and policy issues that impact health outcomes
- Identify resources to replicate the transition nurse model being used by local hospitals for patients with chronic and severe medical conditions to be used for patients with psychiatric conditions
- Continue to explore means to ensure prompt access to community mental services upon discharge from hospital or incarceration (and address policies that impede same day access – see access to services on page 12-13)
- Promote co-location of physical and behavioral health services
- Collaborate with DSS for streamlining the eligibility process for Medicaid entitlements including dedicated DSS outreach staff at LMHAs, expedited/ presumptive Medicaid eligibility at least for medication to stabilize while everything else is being worked on
- Create and distribute clear-cut, straightforward flow charts (including web-based) detailing points of entry and criteria for accessing and navigating the MH/SA service system

Recommendation 2: Expand cross funded programs between Department of Corrections (DOC) and DMHAS

Rational for recommendation: Issues described above re: access to services upon release from inpatient settings also apply to incarceration. For some individuals this situation is worsened because they may have been undiagnosed and untreated while in jail or prison or they may be released straight from court with no belongings, identification, address, or benefits. Application for benefits cannot begin until the person is released from incarceration. Lack of transportation impedes their ability to access services even when receiving services from a DMHAS funded forensic program. Fortunately there is good communication between DMHAS, DOC, and the Community Courts and there are a number of DMHAS/DOC funded forensic programs designed to assist with diversion and end of sentence release. Data is collected and evaluated to see what models and programs work well. Still, there are a limited number of "transitional slots" for diversion and post release. Some people are barred from shelters and have no place to go due to their current behavior or past history.

Strategies and Interagency Collaboration Required:

- Work with Journey Home/Reaching Home to establish diversion and transition from incarceration as a priority for affordable and supportive housing and expand the number and lengths of stay for transitional housing "slots" or additional housing options along a continuum for those who are not appropriate for or without access to housing first options access
- Provide transportation assistance and/or bus pass for the first month out of prison
- Improve relationships between local LMHAs and housing authorities to identify housing options for people with a criminal history and people who are starting out with no income.
- Ensure support for addressing skill and behavioral issues that threaten independent living success
- Provide training for people coming out of incarceration and those who work with them re; topics such as anger management, what's bad or mad, and symptoms vs. self-serving survival behaviors

Recommendation 3: Develop a range of housing transitional, vocational, case management options for people with varying needs and backgrounds

Rational for recommendation: People coming from any of the entry points listed above (hospital, shelter, incarceration) have extreme difficulty accessing housing, employment, income and medical benefits. Lack of affordable supportive housing continues to be a top priority need. As discussed in the section for young adults, Region IV providers rank supportive housing, supervised apartments, and group homes as not available or only sometimes available between 59%-71% of the time for all of their service recipients (see chart on page 16). We are fortunate that CT recognizes this issue and continues to appropriate funding for the development of new supported housing and rapid re-housing options. However, there are relatively few options available for people who are ill-prepared for living on their own, even with that level of support. CT is lacking in the availability and support for middle ground options for people who fail at independent living or need a higher level of support to get established, and gain skills, income, benefits, and supports for succeeding in apartment life. Some of the catchment areas in Region IV have no respite, shelters, transitional housing or board and cares, therefore tend to lose touch with people they are serving who have to go to a different catchment area for housing. People also need education, training, and employment so they can afford to live. Many are educationally disadvantaged or illiterate, and some need more structure and support than is offered in competitive employment settings.

Strategies and Interagency Collaboration Required:

- Work with Reaching Home/Opening Doors to develop housing supports that address some of the issues listed above (see strengths on page 14)
- Expand availability of transition/middle ground/step-down housing options for people with varying levels of need and backgrounds to get on their feet (see priority areas/problems section on page 12 and quality/effectiveness/appropriateness section on page 13) and resources for people not appropriate for shelters
- Ensure the availability of outreach programs throughout Region IV to offer a more loosely structured level of service for people who are resistant to treatment (focus on engagement and maintaining contact)
- Develop employment options for people coming out of incarceration who need more structure, mentoring, and/or supervision than available in competitive employment settings
- Strengthen/repair relationships between LMHAs and housing authorities so that LMHAs are more responsive and can intervene when person living there is having problems that might lead to eviction

We thank DMHAS for this opportunity to involve recipients of mental health and addiction services, family members, providers, referral organizations and concerned citizens in this priority setting process. There is a strong desire on the part of Regional Mental Health Boards and Regional Substance Abuse Action Councils to ensure that this process provides the needed information to DMHAS that will help set priorities and inform the budget. There was much time contributed and earnest caring among survey and focus group participants and key informants that their participation would make a difference. We look forward to working with DMHAS going forward in order to clarify and promote the recommendations contained in this report.