**2016 REGION IV PRIORITIES AND RECOMMENDATIONS REPORT**

**2017 UPDATE**

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**Submitted by the**

North Central Regional Mental Health Board (NCRMHB)

East of the River Action for Substance Abuse Elimination (ERASE)

Capital Area Substance Abuse Council (CASAC)

**July 31, 2017**

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1. **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 provides an update to the Region IV priorities and recommendations report presented in 2016 based on feedback from North Central Regional Mental Health Board (NCRMHB) Catchment Area Council (CAC) and Regional Consumer Advisory Council (RCAC) members and other key informants and stakeholders in Region IV communities (see section II). New and emerging issues are discussed in section IV and recommendations in Section V.

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.

1. **Process and Data Sources**

Feedback for this report was obtained via dedicated NCRMHB Catchment Area Council (CAC) focus group discussions in May 2017 and well as responses to on-line survey distributed to Region IV Social/Human Services Directors and Local Mental Health Authority CEOs list (13 respondents). In addition, insights were incorporated from NCRMHB Outpatient Services Evaluation and fidelity reviews, Region IV Community Conversations about Crisis Response (56 participants), review of data and strategies from the Enfield Commission on Aging Strategies to Shape Livable Communities, United Way 2-1-1 Barometer, Alcohol and Drug Policy Council, North Central CT and Central CT Health District Opioid Taskforces, Beacon Health reports to the Behavioral Health Partnership Adult Quality and Access Committee, CT State Planning Council, and Older Adults Behavioral Health Task Force, as well as key accomplishments in the 2017 Legislative Session.

Focus group participants and survey respondents were asked to rank five core areas of Mental Health and Substance Abuse Services in priority order and provide comments and recommendations for improvement in each area. As detailed in the Charts 1 and 2 below, there were differences in the way focus group participants and survey respondents ranked services among the five core areas. For the purposes of this report, comments and recommendations are organized per focus group rankings. Because the focus groups were conducted during CAC meetings with CAC member representation from both town social services and the behavioral health provider system, we found it to be the most representative of NCRMHB’s perspective.

**Chart 1: Core Service Area Rankings for Mental Health Treatment Among Surveyed Groups**

|  |  |  |  |
| --- | --- | --- | --- |
| **Core Service Areas** | **NCRMHB CAC Focus Groups** | **Surveyed City/Town Social Services Directors** | **Surveyed Behavioral Health Providers** |
| **Outpatient Services** | **1** | **1** | **1** |
| **Recovery Support Services** | **2** | **3** | **4** |
| **Residential, Crisis Response, and Respite Services** | **3** | **2** | **3** |
| **Education, Research, and Prevention** | **4** | **5** | **5** |
| **Inpatient Treatment** | **5** | **4** | **2** |

**Chart 2: Core Service Area Rankings for Addiction Treatment Among Surveyed Groups**

|  |  |  |  |
| --- | --- | --- | --- |
| **Core Service Areas** | **NCRMHB CAC Focus Groups** | **Surveyed City/Town Social Services Directors** | **Surveyed Behavioral Health Providers** |
| **Outpatient Services** | **1** | **1** | **2** |
| **Recovery Support Services** | **2** | **3** | **4** |
| **Residential, Crisis Response, and Respite Services** | **3** | **4** | **3** |
| **Education, Research, and Prevention** | **4** | **5** | **5** |
| **Inpatient Treatment** | **5** | **2** | **1** |

1. **Key Priorities for Behavioral Health**
2. **Overarching Issues across Core Areas**

Budget and reimbursement system concerns were consistently brought up by all informants as an overarching and looming topic of concern. These cuts impact the entire safety net of care, not just DMHAS funded services.

When the 2016 Region IV Priorities and Recommendations report was submitted last year, funding reductions were anticipated, but had not yet occurred. A reduction of $14.2 million in

DMHAS funding has been carried over into the 2017-18 state budget proposals. In addition, we ended the fiscal year without an approved budget for 2017-18. We are currently operating under an Executive Order, with drastic cuts to many human services, but do not know the final impact of budget cuts that will take place.

People and providers live in a climate of uncertainty due to threats to the Affordable Care Act (ACA). Changes to the ACA may significantly reduce the number of individuals eligible for Medicaid and increase the number of people who are un-insured. Grant funds must be preserved to protect their access to care.

Many informants reported difficulty with ranking core areas of service in priority order. All of them are vital to recovery and access is problematic in each area.

Lack of safe, affordable, and supportive housing continues to be the top priority issues raised by all groups as a primary barrier to recovery.

Transportation is a major barrier, especially for people living in outlying communities.

Coordination between systems and across communities was also noted as a major concern.

Across the board causes that need to be addressed: desensitization, loss of hope, increase of people coming for services, loss of safety net places, and gridlock

As a positive note, DMHAS was the recipient of a $5.5 million grant to address the Opioid Crisis. Grants have been awarded and 25 projects underway for improving prevention, treatment, and recovery support services.

1. **Core Services**
2. **Outpatient Services remains the top priority service category for mental health and addiction services by focus group participants.**

**Overall Strengths** noted for Region IV were huge strides in 2016 with offerings of same day or next day access to an intake appointment, trauma-informed care, and a focus on whole health – integration of behavioral health with overall health and activities that promote wellness. Four out of the three Local Mental Health Authorities (LMHAs) have established a medical clinic on site. The fourth has established a close working relationship with a nearby hospital for medical services. Two providers have become certified as Federally Qualified Health Centers (FQHC). One provider has clinical staff located in a neighboring outpatient clinic.

In response to the Opioid crisis, CT has a re-constituted **Alcohol and Drug Policy Council** and a **CORE** plan with recommendations and a strategic plan. The availability of Medication Assisted Treatment has increased in all five LMHAs. It is anticipated that by October 2017 the Hartford Dispensary will be offering Intensive Outpatient services in all their sites. DMHAS has established a Learning Collaborative to help providers update their policies, standards of care and protocols for addiction treatment. As Co-Chair of the CT Alcohol and Drug Policy Council (ADPC) treatment subcommittee, CMHA’s Medical Director has been a strong support to his peers and proponent of growth in this area. At a 3-day conference sponsored by SAMHSA, DMHAS, and the Women’s Consortium in July 2017, 65 new practitioners received the training needed for certification as buprenorphine prescribers. Also, family members were pleased with a new protocol initiated by CHR to reach out to emergency contacts when a person they are serving goes missing from treatment.

**The following concerns were noted across focus and key stakeholder groups:**

Gridlock within outpatient programs due to lack of access to other levels of care (i.e. Community Support Program [CSP] serves as a holding place for Assertive Community Treatment [ACT] and Behavioral Health Home [BHH] programs.

Pressure to discharge people prematurely from inpatient to Partial or Intensive Outpatient services (without regard to patient readiness or immediate access). Similar pressure to step down prematurely from Partial or Intensive Outpatient services. Length of stay appears to be dictated by insurance vs. best interest of the person served.

Shortages, understaffing, and high turnover – especially prescribers, bilingual staff, and for youth and older adults. Concerns re: turnover because it results in constantly establishing new therapeutic relationships, starting from scratch, and retelling one’s story each time. Makes it harder for folks with trust issues. Concern that each new prescriber will make medication changes or transition medication management to primary care provider. Concern that prescriber doesn’t have enough time to know patient well. Concern on the part of some informants about increasing use of APRNs (vs. psychiatrists) as prescribers – without regard to individual choice. Concern re: lack of coordination between prescriber, clinical treatment and recovery supports.

Re: Intensive Outpatient Programs (IOPs)– respondents reported a desire for greater emphasis on accommodation of work schedule or support for return to work. Difficulties with mismatch of participants within support groups (age, culture, background, etc.) were reported as problematic.

Although the Community Support Program (CSP) is identified as an outpatient service by DMHAS, most respondents view it as a critical recovery support and expressed concern about a $200,000 funding cut across Region IV nonprofit providers. That reduction included the transition of individuals served in Residential Services Coordination (RSC) programs to CSP services. With the restructuring came an adjustment to fidelity standards, but much concern was expressed that the transition will result in reduced levels of care. Outcomes for individuals served (not just adherence to standards must be monitored.

Concern that we will go too far with Medication Assisted Treatment (MAT) without paying close enough attention to short and long-term side effects and plans for transitioning people off medication. Need to include harm reduction (vs. abstinence) as an acceptable goal for some individuals in treatment. Concern that current Health and Human Services secretary has spoken out against MAT and how this will affect funding.

1. **Recovery Support Services were ranked second in importance among core service categories for mental health and addiction services by focus group participants.**

**Status is worse than 2016 due to cuts in Supported Employment and diminishing resources for shelter and housing.**

**Overall Strengths:** DMHAS and DMHAS-funded providers have demonstrated a strong commitment to developing and maintaining recovery support services. Peer support programs like CCAR, Advocacy Unlimited’s TOIVO, Peer Bridger, Hearing Voices Network, and the TurningPointCT website are highly regarded. Several Region IV providers host Warm Lines staffed by individuals in recovery and several employ peer greeters in their waiting rooms. Through DMHAS and PRCH a Learning Collaborative has been established for agencies who have made a commitment to supporting & maximizing contributions of peer staff in their settings.

DMHAS is in its second year of a federal grant to study employment services and make needed adjustments to supported employment programs and address the needs of monolingual Latino clients and people with criminal backgrounds or involvement.

Members of Region IV Clubhouses are active participants in North Central Regional Mental Health Board Catchment Area Councils and the Keep the Promise Coalition. Clubhouse staff provide needed support for members to learn advocacy skills and testify for better mental health and addiction services. Several members commented about the use of Occupational Therapy interns as a great addition to Clubhouse programming.

CT’s efforts to end homelessness are focused on people who are assessed for vulnerability and meet the definition of chronically homeless. This is in line with new federal mandates, and CT has made progress in its efforts – having celebrated the end of chronic homelessness in the past year. The January 24th count, coordinated by the Connecticut Coalition to End Homelessness (CCEH), showed that overall homelessness in Connecticut is down 13 percent compared to 2016, and down by 24 percent since 2007, the first year the census was conducted statewide.

**The following concerns were noted across focus and key stakeholder groups:**

Despite widespread support for the notion that employment is integral to recovery AND overcoming homelessness, Region IV providers suffered $300,000 in cuts for Supported Employment services this year. Most providers are at capacity and have waiting lists for services. Cuts were doubly felt in those programs who also received funding from the Department of Corrections for vocational services. Some providers offer open hours for some level of timely support to individuals who are on the waiting list. Frustration expressed about the number of people who have graduated from Advocacy Unlimited’s Recovery University and have been unable to find employment as peer support staff.

Stable housing is even more central to recovery and the growing lack of affordable housing is a significant barrier. Despite reports that chronicle the end of chronic homelessness, most respondents expressed frustration about the lack of options for shelter, transitional housing, and permanent housing for people who do not meet the definition of “chronically homeless. People with bad credit and criminal histories encounter additional barriers. On a positive note, wait times for the appointment to be assessed for housing options have been significantly reduced, however once assessed, there is a further wait to be matched with housing and housing supports. Cuts to Department of Housing funding (state and federal) are a further threat.

Much struggle is reported about non-emergency transportation via Logisticare (no shows, late pickups, rude drivers). Hope expressed that, with a new state contractor, will come improved services. Transportation is more problematic in more rural areas and for people who are older, homebound, physically challenged, or have serious medical issues.

Respondents who view themselves as “high functioning” find themselves unable to access supports they need to become self-sufficient because those services are reserved for people with greater need.

Members of clubhouses express anxiety about how budget cuts will affect them. Concerns about clubhouse attendance, level of peer management, ability to meet a wide array of needs including socialization, advocacy, skill development, and vocational support.

Concern was expressed about the safety and quality of some sober housing. DMHAS has contracts with 14 Supported Recovery Housing Services Providers, but there many others operating in CT with no requirement that they be licensed or credentialed by DMHAS or DPH. Several bills were introduced this session as an attempt to impose greater oversight and ensure the safety of residents or neighboring community. This is difficult to accomplish without violating the privacy of tenants and subjecting them to “not in my back yard” community reactions.

1. **Residential, Crisis Response, and Respite Services were ranked a close third in importance among core service categories for mental health and addiction services by focus group participants. Status is worse than 2016 due to cuts to CRMHC Mobile Crisis and Residential Services Coordination, elimination of transitional housing, and diminishing resources for respite or shelter.**

**Overall Strengths:** DMHAS has continued to meet with mobile crisis staff as well as grant funded partners in a CT Wellness and Recovery Coalition as an effort to enhance and transforming CT’s crisis response system. Initiatives include development of a peer respite options, establishing recovery coaches in hospital emergency departments, and developing health ministries within the faith community. In addition to its provision of mobile crisis services, the state of CT continues its investment in specialized training in the Crisis Intervention Team (CIT) model for law enforcement and other first responders. As of this date all but 6 of the 37 towns in Region IV have the availability CIT trained officers. CIT promotes safety for all involved and links the person in crisis to services in the community whenever possible.

The Manchester HOPE Program goes beyond CIT to offer diversion to treatment for anyone facing arrest or seeking help for addiction. Hartford is considering an initiative like Manchester’s program to be piloted in 2 neighborhoods.

**The following concerns were noted across focus and key stakeholder groups:**

**T**he number of people served by DMHAS in Region IV has grown exponentially (20% in just the past 4 years) however staffing for Mobile Crisis has seen no increase in four of our catchment areas and has been reduced for Hartford, West Hartford, and the Farmington Valley. Also, a growing percentage of crisis calls are for people unknown to the services system adding to the complexity of assessing and addressing their needs. When Mobile Crisis is unavailable due to reduced hours or staff shortages, law enforcement is the first responder for behavioral health crises. Their intervention can go well or poorly depending on the level of training of the responding officer.

Respite is lacking across the region with a growing proportion of respite beds used for long-term “respite” due to the lack of shelter and supportive housing options.

Frustration among nonprofit providers with lack of residential options at appropriate levels of care for people being discharged from CVH and with people discharged without benefits or income for housing.

Over reliance on Department of Social Services licensed Residential Care Homes (also called Board-and-Care) due to lack of lack of residential options for people who need more support than supportive housing. High turnover among staff, staff often lack training for dealing with behavioral health issues leading to over reliance on law enforcement intervention

Federal funding for transitional housing has been eliminated, leading to the impending closure of a program in Region IV. With this closure comes the need to find alternate arrangements for displaced individuals in an already overtaxed system. As well, this is a **level of care that is now lost to our system**.

1. **Education, Research, and Prevention were ranked fourth in importance among core service categories for mental health and addiction services by focus group participants. Status is better than 2016 due to widespread effort and resources for education and prevention in response to the Opioid epidemic.**

**Overall Strengths:** DMHAS has been the recipient of several federal grants totaling over $400,000 targeted toward prevention this year. Educational forums have been held in almost every Region IV community with several having developed work plans for targeted initiatives. Some of these are funded by Federal Drug Free Communities grants and are supported by local Regional Action Councils (RACs). Forums have been led by RAC Directors, local health departments and school districts, legislators, etc. The CT Alcohol Drug and Policy Council has initiated many prevention initiatives to counter a rising tide of overdose deaths due to the Opioid crisis (including numerous training events for emergency responders, physicians, pharmacists, and the general public, a public service announcement/Facebook campaign, and safe drug disposal and remembrance quilt events).

The CT Clearinghouse is a great resource for informational events, posters, brochures, and flyers.

Through funding from a Garret Lee Smith grant, CT Departments of Mental Health and Addiction Services, Children and Families and Public Health in partnership with the CT Suicide Advisory Board (CTSAB) are currently implementing a Networks of Care for Suicide Prevention (NCSP) initiative. The overarching goal of the initiative is to enhance prevention, intervention and response services for youth and young adults ages 10 to 24 at risk for suicide.

Focus group respondents regard education/research/prevention as very important and something that should be integrated into all the other core services.

**The following concerns were noted across focus and key stakeholder groups:**

Concern by some respondents that focus on the Opioid epidemic has drawn attention away from mental health issues even though mental health and addiction issues often go hand in hand.

Police and emergency responders discouraged by people who don’t seem to care if they die, having to administer life-saving NARCAN multiple times for the same person, cost of NARCAN, and lack of timely access to treatment for people who want help.

Need to address the assumption that everyone who needs medical detox requires an inpatient setting. Need greater awareness and navigation assistance for outpatient detoxification options.

Participants of forums reported they were given conflicting interpretations of officer discretion over the “bystander law” which protects a witness from arrest or prosecution for minor drug or alcohol violations when they call for emergency assistance for a drug overdose

Need to understand the impact of trauma and intervene with children and young people before they start using or manifesting symptoms. Need to educate teachers about what to look for regarding ‘normal’ pre-adolescent development regarding Mental Health and Substance Abuse. Difficult to get into the school system because of limited time for teacher training and curriculum requirements.

Concern that prevention funding for Regional Action Councils, Local Prevention Councils and Drug Free Communities are all in jeopardy.

1. **Inpatient treatment was ranked a fifth in importance among core service categories for mental health and addiction services by focus group participants. Status about the same as in 2016. Waiting list for Connecticut Valley Hospital (CVH) is about the same as last year. Regional Mental Health Boards were scheduled to conduct a statewide evaluation of CVH services this year, but were asked to delay due to recent critical incidents that are under investigation by authorities.**

**Overall Strengths:** Community Care Teams have formed around most of the Region IV hospitals are helpful for addressing the needs of people who frequently rely on emergency or inpatient treatment. Currently one Region IV hospital (Manchester) has CCAR Recovery Coaches working in the emergency department and following up with patients after discharge.

**The following concerns were noted across focus and key stakeholder groups:**

Inpatient treatment was the area of greatest discrepancy between focus group participants and surveyed respondents to our on-line survey for prioritizing core service areas. All three groups expressed frustration about the lack of access to effective inpatient treatment. The low priority ranking by NCRMHB CAC members were based in large part on participants’ personal experiences with inpatient care and their frustration with poor access and unproductive, ineffective treatment. Several described the hospital as the last place they would want to go if they needed help. They saw hospitals and the pressures imposed by insurance reimbursement as a lost cause for further investment, and so preferred that resources be spent elsewhere.

Focus group participants described long stays in emergency rooms or hallways waiting for evaluation (even when they were there for suicidal ideation). Patients seen in emergency department for evaluation were quickly discharged. Hospitals were reluctant to admit people and often discharged patients in a state of psychiatric decompensation (even when sent with an order). Inpatient stay is focused on stabilization, not getting well or preparing for the next level of care. Desire for hospitals to do better than provide a room and medication.

Revolving door of patients in the Emergency Department and back into the community with substance abuse issues. Come in at night, cared for until morning, often they have nowhere to go, no services or supports in place to change this pattern. Often people refuse help. A disheartening situation for the staff who see them over and over.

Lack of coordination and continuity of care (from hospital to community and between hospital and family members). Pressure to discharge people prematurely from inpatient to Partial or Intensive Outpatient services (without regard to patient readiness or immediate access). Length of stay appears to be dictated by insurance vs. best interest of the person served.

Providers described an increase in numbers of individuals they serve who are more often than not unstable and unsafe even with community supports they are able provide. These individuals may be temporarily safe in the hospital, but are in and out of the hospital, because there are no other options for them.

Concerns over movement to provide Medication Assisted Treatment (MAT) for hospital patients without adequate follow-up after client is stabilized and discharged.

Access to inpatient care is more problematic in rural areas.

Much concern expressed over proposal to move Blue Hills detox beds to Connecticut Valley Hospital.

1. **New Trends and Emerging Issues**

Several focus group participants described discriminatory treatment because of their mental health diagnosis when taken to emergency for medical concerns (medical issue not taken seriously, records not consulted, put in seclusion or left alone with no one checking in on them).

The most significant issue confronting us is the drastic budget reduction anticipated across all aspects of the CT human services system. As of this writing, the CT Legislature has not passed a budget for the current fiscal year. The Governor has issued an executive order with extreme reductions that threaten the survival of important services organizations and the lives of vulnerable service recipients. Many of our constituents have co-occurring medical conditions and physical challenges that require resources and care from entities other than DMHAS. All those services are in jeopardy and the loss of some of those services are life threatening.

Efforts to legalize recreational marijuana (although not successful to date) have resulted in a change in perception of risk, especially for young people. This is despite evidence of a relationship with between cannabis use and psychotic disorders, increased risk of suicide, initiation of other illicit drug use, and learning and behavior problems especially among young and heavy users whose brains are still forming.

The use of heroin and deaths due to opiate overdose continue to rise at alarming rate despite efforts to stem the tide.

Establishment of a new satellite casino in East Windsor was approved by the CT Legislature this session. This is another major step toward expanding gambling and the accompanying problems that must be addressed.

1. **2017 Recommendations for Mental health and Addiction treatment and Mental Health Promotion Going Forward.**
2. **Outpatient Services**

Address license restrictions for treatment that can be provided by a Licensed Addiction Counselor (LADC) for individuals with co-occurring disorders (related to insurance reimbursement). Address license and certification burdens placed on providers (multiple licenses and certifications with multiple reports and audit requirements). Allow greater flexibility for billing services offered outside the four walls of a clinic. Explore scope of work and tele-psychiatry options to address workforce issues and mobile units to serve rural communities.

Develop partnerships between intensive outpatient detox treatment settings and sober housing as alternatives to inpatient care. Develop partnerships between behavioral health services, primary care and urgent care centers. Explore these and other partnership as avenues to enhance community responsiveness and a system of wrap around care that is more responsive to individual care needs. Support co-location. Pilot initiatives and use data to support decisions about how to enhance the system further.

Ensure that a significant portion of our attention and funding are focused on outreach, awareness/advocacy and access to care for new, emerging, and growing concerns caused by substance and gambling addictions. Continue efforts to expand access to medication assisted treatment.

Enforce standards regarding access to needed translation and interpretation services. Language Line isn’t always appropriate. Ensure organizations follow Culturally and Linguistically Appropriate Services (CLAS) Standards - staff must be culturally competent and organization should review staffing patterns to ensure they match community demographics. (Victor reported that CMHA does this). As staff are laid off, need to find ways (within union bumping rules) to keep non-English speaking staff in positions where needed to respond to patient demographics.

Monitor impact of transition from Residential Services Coordination to Community Support Program (focus outcomes for individuals served in addition to adherence to the program model). Use data to support decisions about adjustments needed to address individuals’ needs.

Continue to support ongoing Learning Collaboratives for equipping staff, such as for Medication Assisted Treatment, Peer support, Trauma Informed Care, etc.

Given funding challenges and a system that is at capacity, greater privatization regionalization of services must be considered as strategies going forward

1. **Recovery Support Services**

Recovery Support services are extremely vulnerable to further budget cuts. We must promote on-going funding for social clubs, supported employment, peer supports, case management/community support, supportive housing, and warmlines. New funding for Behavioral Health Home and expansion of Medication Assisted Treatment has allowed us to invest more resources in peer and recovery support roles. Continued investment in peer training, peer supports, holistic and wellness initiatives will be critical to our success. Need to focus on the whole person and their environment, not just their diagnosis.

Learn from DMHAS/SAMHSA Supported Employment grant initiative working with special populations, i.e. individuals with criminal justice involvement (New Haven) or Latino and monolingual (Hartford) about adjustments that are needed and effective. Support initiatives like Chrysalis vocational training programs and Street Smart Ventures YAS BIZas alternatives to the Individual Placement and Support (IPS) model. Explore options to involve private industry in vocational training.

1. **Residential, Crisis Response, and Respite Services**

Test and track the effectiveness of new 1-800 system for access and transport to detox treatment. Ensure there is a warm handoff. Ensure all parts of the state (including rural), ages, and co-morbidities have access to care.

Continue efforts to enhance and transform crisis response system such that people in distress have quick access to the types of care and/or support of their choice (clinical services, peer services, community supports) that will foster optimal post-traumatic healing and growth wherever they may be in the recovery process. Continue to support initiatives underway with funding from the CT Wellness and Recovery Coalition (CWRC), i.e. peer respite options, establishing recovery coaches in hospital emergency departments, and developing health ministries within the faith community. Explore models used successfully in other states.

We must reduce gridlock and over reliance on inpatient or emergency room care by protecting (and developing) residential options and related support services across the full continuum of care. In response to statewide concerns regarding lack of respite and residential options, DMHAS reported in January 2017 that they were about to conclude an inpatient services study that would include recommendations for addressing the need for higher intensity mental health residential treatment beds. Results of this study should be disseminated and resources and strategies developed to address findings. Explore models for congregate housing and options used successfully in other states. Provide training to better equip staff in Board and Care settings where individuals served by DMHAS reside.

1. **Education, Research, and Prevention**

Maintain support for Regional Action Councils and Regional Mental Health Boards who do important education and prevention work such as drug take backs, opioid forums, MHFA, and suicide prevention.

Promote awareness of alternatives to medication as solutions for pain management. Collaborate with coaching associations to educate athletes and their families about the dangers of narcotic pain medications and alternatives for treating pain and sports injuries. Work with Local Prevention Councils to promote and provide funding for evidence-based programs like “Teen Influencer” curriculum.

Address the inaccurate assumption that everyone who needs detoxification for an addictive disorder requires treatment an inpatient setting. Promote awareness and navigation assistance for outpatient detoxification options.

Partner with local universities and community colleges for researching best practices and training to address workforce shortages. Offer training and internship programs in schools for students in health professions who wish to work as Recovery Coaches. Re-invigorate the Project for Addictions Cultural Competency Training (PACCTT) program.

Educate Local Prevention Councils, Schools and Law Enforcement about Adverse Childhood Experiences (ACES) and how trauma leads to substance abuse. Duplicate and implement an initiative from Massachusetts and the publication titled “Helping Traumatized Children Learn”. Using the text to guide their implementation of a trauma sensitive framework. These safe and supportive environments bolster children in four domains for success: 1) developing caring relationships with adults and peers; 2) self-regulating emotions, behaviors and attention; 3) achieving academic and non-academic success; and 4) being physically and emotionally healthy.

Promote youth involvement in prevention activities related to problem gambling. Utilize RAC sponsored Annual Youth Leadership Conference to provide youth training in advocacy, media campaigns, presentation skills and building their capacity for an increase in youth led events and trainings.

Continue support for suicide prevention programing with a special focus on youth suicide as this group has seen an increase in the past year. Enhance and strengthen our partnerships with the Zero Suicide Program, Connecticut Suicide Advisory Board, American Foundation for Suicide Prevention State Chapters and the Garret Lee Smith Suicide Prevention program with DHMAS.

1. **Inpatient treatment**

Expand use of recovery coaches in inpatient settings for engagement and follow-up in the community. Ensure recovery coaches are trained to address co-occurring mental health and addiction issues and that with the development and growth of this important resource, DMHAS-funded providers are not permitted to create new silos between mental health and addiction.

See recommendation above in Residential, Crisis Care, and Respite care section. The answer is not necessarily more hospital beds, but more options at higher levels and across the continuum of care. In the words of one of our focus group participants, “we need to overcome our aversion to the hard work it takes to support people in lieu of hospitalization.”

Maintain Community Care Teams for people who cycle through hospitals and emergency rooms. Take advantage of lessons learned with these patients to improve discharge and step-down referral protocols for all patients. Improve communication and collaboration with family and community resources.

1. **Closing Comments**

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 RMHBs and RACs to ensure that this process provides the needed information to DMHAS that will help set priorities and inform the budget and federal block grant application. 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 to clarify and promote the recommendations in this report.