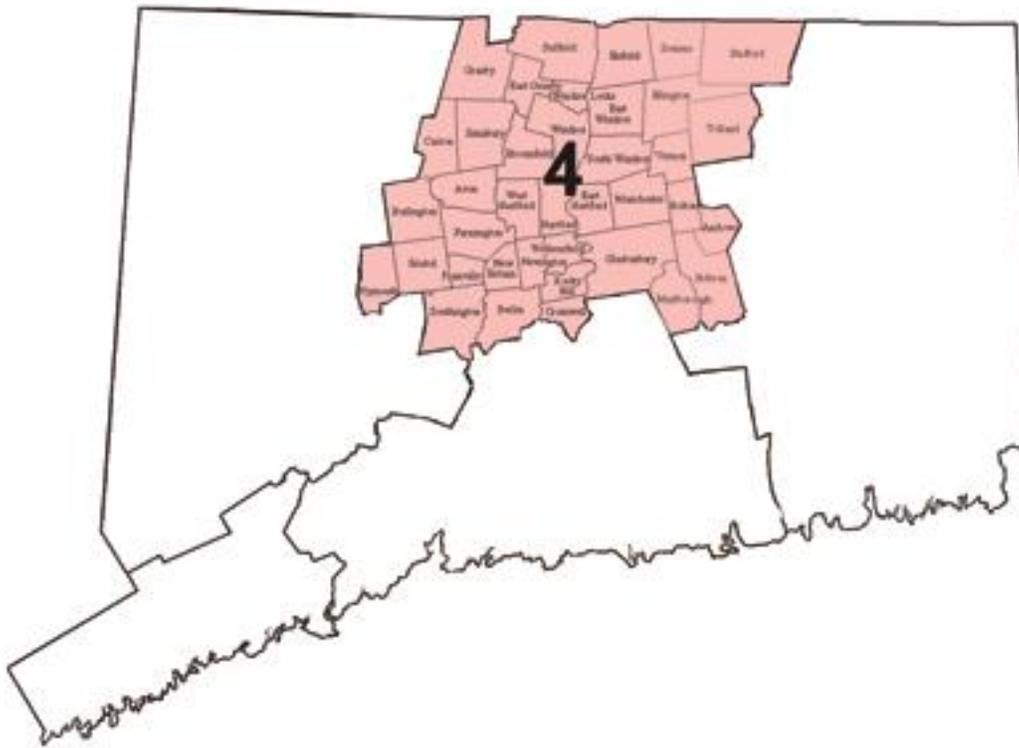


2016 REGION IV PRIORITIES AND RECOMMENDATIONS REPORT
2018 UPDATE



Submitted by the
North Central Regional Mental Health Board (NCRMHB)
East of the River Action for Substance Abuse Elimination (ERASE)

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TABLE OF CONTENTS

I. Introduction	2
II. Process and Data Sources	2
III. Key Priorities for Mental Health and Addiction.....	4
A. Overarching Issues Across Core Areas.....	4
B. Core Services	4
1. Outpatient Services.....	4
2. Recovery Supports Services	6
3. Residential, Crisis Response, and Respite Services.....	9
4. Inpatient Treatment	11
5. Education, Research and Prevention	12
IV. New Trends and Emerging Issues	14
V. Recommendations for Mental Health and Addiction Treatment.....	15
A. Outpatient Services.....	15
B. Recovery Supports Services	15
C. Residential, Crisis Response, and Respite Services.....	16
D. Inpatient Treatment.....	16
E. Education, Research, and Prevention	17
VI. Closing Comments	17

2016 REGION IV PRIORITIES AND RECOMMENDATIONS REPORT

I. Introduction

2018 UPDATE

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 to capture needs and trends on the local, regional, and statewide basis. DMHAS contracts with Regional Behavioral Health Action Organizations to conduct these assessments. In Region IV the North Central Regional Mental Health Board, Inc. (NCRMHB) and the East of the River Action for Substance Abuse Elimination, Inc. (ERASE) carry out 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 NCRMHB and ERASE.

This report provides an update to the Region IV priorities and recommendations report presented in 2016 and 2017.

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.

II. Process and Data Sources

Feedback for this report was obtained via dedicated NCRMHB Catchment Area Council (CAC) focus group discussions in May 2018 and well as responses to on-line survey distributed to Local Mental Health Authority CEOs (7 respondents). In addition, insights were incorporated from NCRMHB Inpatient Addiction Rehabilitation Services Evaluation and fidelity reviews, Region IV Community Conversations about Crisis Response (90 participants), the Alcohol and Drug Policy Council, North Central CT and Central CT Health District Opioid Task Forces, Beacon Health reports to the Behavioral Health Partnership Adult Quality and Access Committee, CT State Planning Council, and Older Adults Behavioral Health Task Force, CT Open Data information on Drug related deaths, Opioid related treatment admissions and drop boxes, DMHAS profiles, and the CT Coalition to End Homeless Coordinated Access Data.

Focus group participants and survey respondents were asked to rank five core areas of behavioral health 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 behavioral health provider 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 the Region’s perspective.

Chart 1: Core Service Area Rankings for Behavioral Health Services Among Surveyed Groups

Services That Need to Be Strengthened		
Core Service Areas	NCRMHB CAC Surveys and Focus Groups	Surveyed Behavioral Health Providers
Outpatient Services	1	3
Recovery Support Services	2	1
Residential, Crisis Response, and Respite Services	3	Not rated
Inpatient Treatment	4	2
Education, Research, and Prevention	5	Not rated

Chart 2: Core Service Area Rankings for Behavioral Health Services Among Surveyed Groups

Services That Need to Be Protected		
Core Service Areas	NCRMHB Focus Groups and surveys	Surveyed Behavioral Health Providers
Recovery Support Services	1	3
Residential, Crisis Response, and Respite Services	2	Not rated
Outpatient Services	3	1
Inpatient Treatment	4	2
Education, Research, and Prevention	5	Not rated

III. Mental Health and Addiction Treatment

A. 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. Cuts impact the entire safety net of care, not just DMHAS funded services. Demand for DMHAS funded services continues to increase while funding continues to decline. The number of Region IV unduplicated active DMHAS clients has increased from 35446 in FY 2015-6 to 41988 in 2017-8 (an 18% increase).

People and providers live in a climate of uncertainty due to CT's economic challenges and threats to the Affordable Care Act (ACA).

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

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

Coordination and continuity of care between systems and across communities is a major concern.

Across the board causes that need to be addressed: gridlock, long waiting lists, insurance barriers, navigation challenges, loss of hope, and adequacy of the workforce (language, staff shortages and turnover, skills, use of peers).

As a positive note, DMHAS was the recipient of a \$5.5 million per year 2-year grant to address the Opioid Crisis. Twenty-five projects are underway for improving prevention, treatment, and recovery support services. A second 2-year grant is anticipated with \$11million in funding for each of the two years. Many of the current projects will continue and community feedback has been sought for new and needed initiatives.

B. Core Services

1. Focus group participants rated Outpatient Services as the number 1 service that needed to be strengthened and the number 3 service that needed to be protected given CT's financial concerns. In contrast, behavioral health providers rated Outpatient Services as the number 1 service to be protected and the number 3 service to be strengthened.

For both groups, the status of outpatient services for mental health conditions was described as worse due to high turnover, unfilled vacancies, long wait for prescriber appointments and higher levels of care (i.e. Assertive Community Treatment [ACT]), and a growing concern among individuals and families about premature discharge to lower levels of care that is more related to provider capacity than the needs of individuals. The status of outpatient services for

addiction was described as improved due to the infusion of funding and technical assistance for addressing the Opioid epidemic.

Overall Strengths noted for Region IV were continuing strides since 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 a medical clinic on site. The fourth has established a close working relationship with a nearby hospital for medical services. Two providers are certified as Federally Qualified Health Centers (FQHC). One provider has clinical staff located in a neighboring outpatient clinic and two are providing services in local schools. Another has expanded their Assertive Community Treatment services to help people maintain in Board and Care housing. Another is providing services to 3 correctional settings including induction to medication assisted treatment and NARCAN upon release from prison or jail. LMHA providers are active participants in the efforts of Region IV Community Care Teams to better address the needs of individuals who are frequent users of emergency and inpatient services.

In response to the Opioid crisis, CT has a strong **Alcohol and Drug Policy Council** with active subcommittees who continue to make recommendations and improvements in prevention, treatment and recovery services. The availability of Medication Assisted Treatment has increased in all five LMHAs. Several hospitals are starting patients on Medication Assisted Treatment prior to leaving the hospital. Providers have access to a Learning Collaborative for help with updating their policies, standards of care and protocols for addiction treatment and tele-health support through Beacon Health Options for treatment of opioid use disorders. Training is ongoing and widely available, often at no-cost. SBIRT (Screening, Brief Intervention and Referral to Treatment) is being implemented across multiple settings for adolescents, adults, and older adults.

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

People seeking services are presenting with more serious and complicated issues than in the past (per both behavioral health providers and social services staff).

Pressure to discharge people prematurely from all levels of care due to insurance and capacity issues. “I have 15 minutes every 3 months with a psychiatrist. My therapist told me I don’t need a therapist anymore.”

Shortages, understaffing, and high turnover – especially prescribers and bilingual staff. Results: disruption to the therapeutic relationship, medication management concerns (too much, too many changes, cancelled appointments without renewals).

Although the Community Support Program (CSP) is identified as an outpatient service by DMHAS, most respondents view it as a critical recovery support. In 2016 the Residential

Services Coordination (RSC) program was closed and people in that program were moved to CSP services. “For some people that was like fitting a round peg in a square hole and for others a reduced level of care.” One provider reported they find themselves turning those “round pegs” away, because they don’t want or aren’t able to adhere to CSP criteria and the provider has no alternative to offer them.

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 effective strategies for transitioning people off medication.

Need to promote harm reduction (vs. abstinence) as an acceptable goal for some individuals in treatment (especially in NA support groups).

Need to start treating addiction as a chronic illness for which short term treatment is only phase one – the journey is along one with many things needed along the way.

Need Intensive outpatient and partial hospitalization programs offering during evening hours.

With the transition of funding from the Department of Children and Families to the Court Support Services Division, addiction treatment programs and support services for at-risk youth adolescents are in jeopardy (Juvenile Review Boards, Multidimensional Family Therapy).

Youth and individuals with commercial insurance encounter many obstacles to securing treatment.

Regulatory barriers limit access to care – requirements for multiple licenses, limited scope of practice for various licenses.

Members of a NAMI focus group expressed great frustration with the lack of communication and support to families. “They don’t call me back.” They also cite poor communication between home care, CSP, and clinical staff. They asked for greater transparency about their loved one’s treatment plan and how to access services. They also asked for more outreach and education to the judicial system and conservators.

- 2. Focus group participants rated Recovery Support Services as the number 2 service that needed to be strengthened and the number 1 service that needed to be protected given CT’s financial concerns. In contrast, behavioral health providers rated Recovery Support Services as the number 1 service to be protected and the number 3 service to be strengthened.**

Status is about the same as in 2016 due to the lack of resources for shelter and the lack of affordable supportive 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. There is a growing emphasis on non-clinical approaches such as yoga, meditation, mindfulness, and peer support. Peer support still an under-utilized but effective resource for engagement and long-term support. DMHAS is encouraged to continue its efforts to expand and strengthen its peer workforce.

DMHAS is in its third 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. The monolingual Latino program has had great success. Of concern is the number of clinicians who are reluctant to refer and the number of individuals and families reluctant to seek employment. Listening forums and surveys are in process to better understand concerns and development strategies to address them.

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. Recently the CT Coalition of Psychosocial Rehab Programs held a statewide forum, "Life Between Appointments," to highlight how the Clubhouse model complements and enhances traditional clinical care and improves outcomes for people.

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 2018 count, coordinated by the Connecticut Coalition to End Homelessness (CCEH), showed that overall homelessness in Connecticut is down 15% compared to 2017, and down by 69% since 2014.

CT's Youth Homeless Response System received a large federal grant to create a coordinated community plan to end youth and young adult homelessness. The project has 8.5 youth navigators, funds for shelter diversion or rapid exit, 23 crisis housing beds, and rapid re-housing units. They are working to infuse housing interventions into all systems that work with youth.

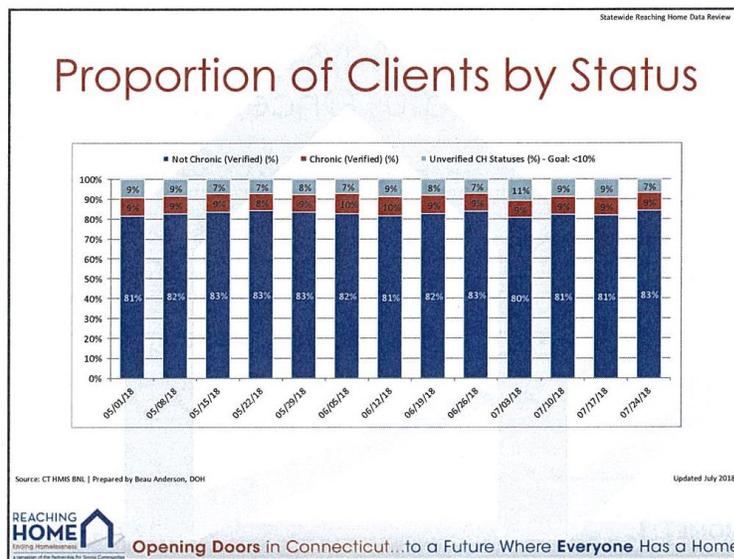
The following concerns were noted across focus and key stakeholder groups:

Clubhouse members and their families concerned about how budget cuts will affect them, loss of members, level of peer management, and the ability to meet a wide array of needs including socialization, advocacy, skill development, and vocational support.

Stable housing is 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. The chart below

shows the proportion of homeless individuals by status from May through July 2018: verified homeless but not chronic; verified chronic; unverified chronic. Over 80% of the people have the status of not chronic. These are the people coming from hospitals or to agencies or town social services who, if not able to be diverted from homelessness without additional resources, have nowhere else to turn. Unfortunately, this is the largest group of homeless individuals encountered by community members, and as a result, a tremendous source of frustration. One provider commented that 80% of people who walk through their doors are seeking housing. Outreach workers through CHR’s PATH Program spend much of their time finding people just to verify that they are indeed homeless.

Chart 3: Proportion of Homeless Clients by Chronicity Status



People with bad credit and criminal histories encounter additional barriers. Wait times for the appointment to be assessed for housing options have been significantly reduced for Greater Hartford (average of 1-2 days), but still high for Central CT (New Britain/Bristol/ Berlin (6-9 days)).

CT’s strategy for ending chronic homeless has not addressed homelessness for many of the people in Region IV served by DMHAS. In fact, the number of active DMHAS clients in Region IV who are homeless has increased (from 1079 in 2015 to 1147 in 2017). Prioritization for housing assistance is determined using a vulnerability index triage tool (VISPDAT). The tool is designed to help determine the level of support individuals need to secure and maintain housing. Unfortunately, people with high scores are given priority for housing subsidies, but due to lack of supportive housing resources, are offered housing with less support (Rapid Re-housing) instead the of level that matches their assessed need. Per providers, this often results in failure – a disheartening result for the person, the staff who are trying to help them, and the landlords who are taking a chance on them.

Much struggle is reported about non-emergency transportation. In January 2018 the non-emergency transportation was awarded to VEYO. Hope was expressed that, with a new state contractor, would come improved services, however the transition was abysmal and complaints re: late arrivals and no-shows continue. The VEYO contract is being monitored closely by the Behavioral Health and Medicaid Oversight Committees. Transportation is more problematic in more rural areas and for people who are older, homebound, physically challenged, or have serious medical issues.

Much concern is expressed about the safety and quality of 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. A bill was passed this session to create a voluntary certification process which, it is hoped, will help people identify homes that take seriously their responsibility to ensure the safety of residents or neighboring community.

3. Focus group participants rated Residential, Crisis Response, and Respite as the number 3 service that needed to be strengthened and the number 2 service that needed to be protected given CT's financial concerns. Behavioral health providers did not rate this service area

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 proposal, employing recovery coaches in hospital emergency departments, and developing health ministries within the faith community. DMHAS has been meeting quarterly with Mobile Crisis providers and a new vision and a 1-year learning collaborative curriculum has been established for roll out this fall.

As of this writing DMHAS is in the middle of a technical assistance visit from the Action Alliance for Suicide Prevention. Their "Crisis Now" model includes a centralized call center, residential crisis stabilization programs, and peer respite. We are hopeful that some of their recommendations will give fuel to the development of at least a few of these promising practices.

In addition to its provision of mobile crisis services, the state of CT continues its investment in specialized training in the Crisis Intervention (CIT) model for law enforcement and other first responders. As of this date all but 4 of the 37 towns in Region IV have the availability CIT trained officers.

The Manchester HOPE Program goes beyond CIT to offer diversion to treatment for anyone facing arrest or seeking help for addiction. Hartford is considering a similar initiative to be

piloted in 2 neighborhoods. Berlin PD, based on their understanding of the impact of Adverse Childhood Events (ACES), routinely notifies school personnel after any law enforcement encounter in which a child may have suffered trauma due to something they witnessed or experienced. The notice provides no detail but seeks to ensure that the child is not re-traumatized in the school setting..

In 2018 the South Park Inn Shelter received a contract with Hartford Hospital to provide respite for individuals with behavioral health concerns who were not ready or had no options for discharge to the community after their inpatient stay. The contract has already been expanded from 5 to 8 beds. Discussions for a similar contract are also in process with St. Francis hospital. Guests may stay in respite as long as the hospital determines is necessary for recovery. While a guest at South Park Inn, people are supported to continue treatment through intensive outpatient or partial hospitalization programs and with securing benefits and/or housing for return to the community.

InterCommunity, Inc. expanded its Recovery Center housing this year for people who are waiting for an intensive rehabilitation option after detox, an extended rehabilitation placement, or preparing for a safe return to the community. People who stay at the Recovery Center credit the program for helping them find peer mentors who provide encouragement, support, hope, and preparation for the next phase of their recovery.

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

The number of people served by DMHAS in Region IV has grown exponentially 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. 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 is expressed by nonprofit providers with lack of residential options at appropriate levels of care for people being discharged from inpatient hospitalization (including CVH) and with people discharged without benefits or income for housing. In 2017 DMHAS completed an inpatient services study with recommendations “aimed at improving use of appropriate and efficient utilization and bed flow at higher levels of care (including respite),” however, there has been no development of options since the report, and gridlock remains.

Over reliance on Department of Social Services licensed Residential Care Homes (also called Board-and-Care) due to lack of residential options for people who need more support than supportive housing. Staff lack training for dealing with behavioral health issues.

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.

- 4. Focus group participants rated Inpatient Services as the number 4 service that needed to be strengthened as well as protected given CT's financial concerns. In contrast, behavioral health providers rated Inpatient Services as the number 2 service to be strengthened and protected.**

Status is improved for addiction treatment due to DMHAS efforts to make information about the availability of inpatient addiction treatment readily available and understandable for individuals, families, and referral organizations.

Overall Strengths: Community Care Teams are in place in of the Region IV hospitals are helpful for addressing the needs of people who frequently rely on emergency or inpatient treatment. Currently three Region IV hospitals (Manchester, St. Francis, and Hartford) have CCAR Recovery Coaches working in the emergency department (ED) and following up with patients after discharge. As of their February 2018 report the connect to care rate for people seen in the ED by a Recovery Coach is 97%. Recovery Coaches are trained in active listening and offer information about multiple paths for recovery. Although much of the impetus and funding for this work is in response to the Opioid epidemic, people who struggle with problem alcohol use have been the largest group helped (59% for alcohol, 36% for heroin or other opiates). There has also been a positive impact on the ED culture in some hospitals. Alcohol is also reported as the drug most frequently used upon admission to DMHAS programs in Region IV (53.7% in 2017 vs. heroin or other opiates 50.5%), both have seen an increase seen 2015 (alcohol 47%, heroin or other opiate use has risen from 47.5%).

The 1-800-563-4086 number for treatment options is broadly marketed via websites, posters, billboards, and Facebook. Call-center services include information about a variety of treatment options as well as a warm hand-off and transportation assistance as necessary. The bed availability site <http://www.ctaddictionservices.com> offers up-to-date listings for detox, residential treatment, and recovery house openings. Both resources make navigation much easier and have been well received.

Several Region IV hospitals offer induction on medication assisted treatment along with referrals for continued treatment as a part of their discharge process.

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 from CAC members were based in large part on participants' personal experiences with inpatient psychiatric 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 a setting that does more than provide a room and medication. Although Recovery Coaches have had a positive impact on emergency or inpatient experience of patients with addiction issues, there is currently no comparable option for individuals with hospitalized for psychiatric concerns in Region IV.

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).

Providers described an increase in numbers of individuals they serve who are often 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.

Access to inpatient care is more problematic in rural areas.

Much concern expressed over several proposals to move Blue Hills detox and rehabilitation beds to Connecticut Valley Hospital or to convert from state-operated to private nonprofit (PNP). Maintaining a presence for the Blue Hills program in the heart of Region IV was seen as highly important given Hartford's high overdose and treatment admission rates (highest in the region and among the highest in CT). NCRMHB's 2018 evaluation of 28-day intensive rehabilitation addiction programs recognized strengths and benefits of offering rehabilitation services in both state-operated and PNP sites. Of significant concern was the report by both PNPs that their rehabilitation programs were operating at a significant loss. Also, inpatient rehabilitation is not covered by Medicare, Husky C and most commercial insurance plans. CT has very limited grant funding for hospital stays that are not covered by insurance.

- 5. Focus group participants rated Education, Research and Prevention as the number 5 service that needed to be strengthened as well as protected given CT's financial concerns . Behavioral health providers did not rate this service area.**

Overall Strengths: DMHAS has been the recipient of several federal grants 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 Drug Free Communities or Partnership for Success grants and are supported by Regional Behavioral Health Action Organizations (RBHAOs).

DMHAS and 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. Through a Federal “State Targeted Response (STR)” grant DMHAS shepherded a “Change the Script” statewide awareness campaign throughout 2017 to connect town leaders, healthcare professionals, treatment professionals and everyday people with the resources they need to address prescription opioid misuse. Ready-to-use materials are available for distribution that offer consistent messaging across CT about the risks of addiction to prescription opioids as well as treatment and recovery support options. DMHAS mini-grants were awarded to 14 Region IV Local Prevention Councils for hosting and advertising opioid awareness forums and NARCAN administration, promoting prescription drug disposal and safe storage strategies, and disseminating Change the Script materials. Another part of the grant was to increase awareness and use of CT Prescription Monitoring and Reporting System (CPMRS). CT is in its second year of the STR grant and anticipated additional funding for this purpose in 2019 and 2020. 24 Region IV Communities now have drop boxes.

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

The nonprofit Boards of ERASE and NCRMHB are in the process of merging their organizations and operations to carry out the work of an integrated mental health and addiction advisory service under contract with the Department of Mental Health and Addiction Services (DMHAS). This consolidation of two strong organizations increases the scope of our work to include evaluation, strategic planning, development, and coordination of prevention and behavioral health promotion activities across an individual’s lifespan. We are hopeful that, by combining our efforts in this way, we will strengthen the ability of our region to assess needs, develop plans, and advocate for strategies and resources to advance healthy and inclusive communities.

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.

For the past 3 years the Older Adult Behavioral Health Workgroup has worked steadily on increasing education, awareness, and access to behavioral health services for older adults. An on-line training tool has been developed and is embedded in the DMHAS Learning Management System and the Department of Social Services curriculum for community waiver providers. The universal assessment tool used by all Medicaid Waiver programs now

incorporates screening, brief intervention and referral to treatment (SBIRT). Grants were awarded to an organization in each CT region to provide Senior Outreach and Engagement services to isolated seniors.

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

Currently the most visible prevention efforts are related to the opioid epidemic, yet mental illness, alcohol, and marijuana misuse are also continuing issues. Furthermore, emerging issues such as increasing supply of purer, cheaper methamphetamine should be addressed.

Young people and their parents have low perception of harm from marijuana. National statistics, other state laws, and the current budget crisis point to the likelihood that the state of CT will legalize recreational marijuana in the near future. There is a need to educate the public and legislators about risk factors.

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.

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.

IV. New Trends and Emerging Issues

The most significant issue confronting us is several years of drastic budget reductions across all aspects of the CT human services system. Many of our constituents have co-occurring medical conditions and physical challenges that require resources and care from entities other than DMHAS. Many of those services continue to be 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 and legalization of sports betting is imminent. The Springfield, MA casino is opening soon. This is another major step toward expanding gambling and the accompanying problems that must be addressed.

While cigarette smoking rates among teens have dropped over the last few decades, the use of electronic cigarettes (e-cigarettes) -- also called vaping -- has risen in this age group. Surveys show that many teens don't know about the dangers of these products.

V. 2017 Recommendations for Mental health and Addiction treatment and Mental Health Promotion Going Forward.

A. 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 with supportive relationships responsive to individual needs.

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

B. Recovery Support Services

Protect fund and promote promising practices for social clubs, supported employment, peer supports, case management/community support, supportive housing, and warmlines.

Exercise greater influence at the state level to ensure CT's efforts to end homelessness include efforts address the needs of individuals with behavioral health challenges.

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 BIZ as alternatives to the Individual Placement and Support (IPS) model. Explore options to involve private industry in vocational training.

C. Residential, Crisis Response, and Respite Services

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. Explore models for crisis stabilization, intermediate care, and transitional 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.

D. 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.

E. Education, Research, and 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 for socio—emotional learning and utilizing the Strategic Prevention Framework (SPF).

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

Educate Local Prevention Councils, Schools and Law Enforcement about Adverse Childhood Experiences (ACES) and how trauma impact, cognitive and socioemotional development, and has long-term negative health consequences (including mental health and problem alcohol and substance use). Promote promising practices like Massachusetts’ “Helping Traumatized Children Learn”.

Promote youth involvement in prevention activities related to problem gambling. Utilize ERASE 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 programming with a special focus on youth. 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.

Provide community education is needed regarding the risks associated with vaping

VI. 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 RBHAOs 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.