# Report on Region IV Outpatient & Co-Occurring Services

Site visits conducted July 2015-16

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# Table of Contents


I. Executive Summary

a. Methodology ..... 3
b. Selected Outpatient Programs ..... 4
c. Survey Results ..... 5
d. Overall Strengths ..... 7
e. Outpatient Record Review Summary ..... 7
f. Overall Recommendations ..... 9
g. Conclusions ..... 11

II. Report by Catchment Area

a. Catchment Area 15 ..... 14
    i. CHR – Manchester focus groups . 19
b. Catchment Area 16 ..... 23
    i. InterCommunity focus groups .... 28
c. Catchment Area 17 ..... 32
    i. CHR-Enfield focus groups ..... 36
d. Catchment Area 18 ..... 39
    i. IOL focus groups ..... 41
e. Catchment Area 19 ..... 44
    i. CMHA focus groups ..... 49
f. Catchment Area 23 ..... 53
    i. CRMHC focus groups ..... 55
    ii. CRMHC-YAS focus groups ..... 62
    iii. HBH focus groups ..... 68
    iv. Wheeler focus groups ..... 75

# Executive Summary

# Executive Summary

*Members of North Central Regional Mental Health Board wish to thank its six Catchment Area Councils (CACs), the Local Mental Health Authorities (LMHAs) in Region IV, agencies providing mobile crisis services, their staff, and persons in recovery who participated in the discussions held during this review. We hope that all the participants see this report as their opportunity to convey to the Department of Mental Health and Addiction Services their perceptions and recommendations.*

In FY 2015-16, the North Central Regional Mental Health Board (NCRMHB) conducted a review of DMHAS funded outpatient and co-occurring programs in Region IV to achieve the following objectives:

1. Understand the particular outpatient and co-occurring care models currently available in the region;
2. Document how outpatient and co-occurring care has been implemented;
3. Assess the effectiveness of outpatient and co-occurring care programs in creating recovery pathways for people in recovery.

In Region IV, outpatient and co-occurring services are available under DMHAS contract to offer services outside hospitals, in community agency settings, for adults (18 and over) experiencing long-term and acute behavioral health issues. Outpatient services consist of therapy, case management, groups, and medication management, as needed. Co-occurring services are outpatient services that address both mental health and addiction concurrently, with the idea that one issue affects the other. Co-occurring services involve integrated treatment that requires collaboration and a person-centered treatment plan.

This report focuses on issues that arose from outpatient and co-occurring program visits and interviews with persons in recovery, families, and key stakeholders as indicated above in each of the CACs in our region throughout FY 2015-16.

We hope that our review efforts will stimulate further discussion among the region's mobile crisis programs, the agencies that provide inpatient and outpatient services, DMHAS, and our various community partners, so that system-wide and cross sector improvements can be made to broaden the impact and increase the effectiveness of crisis response and care in our region.

# Methodology

To do this work, NCRMHB conducted a series of focus groups, surveys, and key informant interviews with agencies in Region IV that offer outpatient and co-occurring support programs. We were interested in the system of care (including some special populations of concern) through the lenses that we chose. We looked at these programs with an eye for **cultural competency, co-occurring programming, and trauma-informed work.**

A total of **15 NCRMHB volunteers participated in the reviews as interviewers**. Review teams were comprised of NCRMHB staff, NCRMHB Review and Evaluation Committee members, and CAC members that included persons in recovery, family members, provider members, and concerned citizens.

The review team surveyed individuals in recovery, staff of outpatient and co-occurring programs, and leadership. The review team also conducted staff and (separately) people in recovery focus groups for nine outpatient and co-occurring programs. Finally, a DMHAS official helped NCRMHB conduct a record review. These methods helped NCRMHB gain a broad and detailed understanding of how outpatient and co-occurring programs operate in Region IV. The notes drawn from these focus groups, surveys, and record review inform the analysis of outpatient services for the sections that follow and help us highlight some best practices.

# Selected Region IV Outpatient Programs

**CAC 15:**

- **Community Health Resources (CHR):** 587 Middle Turnpike E., Manchester, CT
  - *Manchester Adult Outpatient Program (AOP) & Intensive Outpatient Program (IOP)*

**CAC 16:**

- **InterCommunity (IC):** 281 Main St., East Hartford, CT
  - *Standard Outpatient Program (SOP) Mental Health & SOP Addiction Services*

**CAC 17:**

- **Community Health Resources (CHR):** 153 Hazard Rd., Enfield, CT
  - *Enfield Adult Outpatient Program (AOP) & Intensive Outpatient Program (IOP)*

**CAC 18:**

- **Hartford Hospital's Institute of Living (IOL):** 200 Retreat Ave., Hartford, CT (+ serves CAC 23)
  - *Standard Outpatient Program (SOP) Mental Health Services*

**CAC 19:**

- **Community Health Affiliates (CMHA):** 270 John Downey Dr., New Britain, CT
  - *Forensics*

**CAC 23:**

- **Capital Region Mental Health Center (CRMHC):** 500 Vine St., Hartford, CT 06112 (+ serves CAC 18)
  - *Adult Co-Occurring Services*
  - *Young Adult Services*

- **Hartford Behavioral Health (HBH):** 2550 Main St., Hartford, CT
  - *Standard Outpatient Program (SOP) Mental Health Services*

- **Wheeler Clinic:** 999 Asylum Ave., Hartford, CT
  - *Standard Outpatient Program (SOP) Addiction Services*

# Survey Results

These are the results of the surveys administered to staff and people in recovery in Spring 2016. (To see a full set of results from the surveys, see the Appendix).

**Survey for People in Recovery:**
The Survey for People in Recovery had feedback from people who received services from 11 outpatient programs. Respondents were 23% Black (which represents more than the state percentage of Black people), 25% Latino (which represents more than the state percentage of Latinos), 48% White (which represents less than the state percentage of White people), 4% Native American, and none identified as Asian. The survey respondents are not representative of DMHAS clients[1]. DMHAS figures from 2015 are as follows: White/Caucasian 64%; Black/African American 16%; Other 14%; Latino/Hispanic Identity 20%. People's level of education was a bell curve centered around "high school graduation." Most individuals surveyed have a high school diploma and some college; few graduated from college or had their graduate degrees. The largest group of respondents are 45-54 year olds (middle-aged folks). The second largest group were 25-34 year olds (young adults). There were few older adult respondents past retirement age in our survey sample. Respondents were 45% female and 55% male. Of the individuals surveyed, there were more males even though there were more female staff.

Half of all respondents felt that they were in charge of their own recovery, while the other half cited a combination of staff, programs, court/probation, and God. Respondents had been in recovery for anywhere from 1 day to 17 years. Most individuals surveyed felt recovery is important – on a scale of 1 to 10 (1 is "not important" and 10 is "very important"), people rated recovery at 8.9. Most individuals surveyed also felt that outpatient services are addressing their needs, rating this measure at 7.7 out of 10. Many individuals surveyed felt outpatient programs taught them about the experience of trauma, also rating this at 7.7 out of 10.

The most important part of treatment for individuals surveyed is "learning coping skills for dealing with triggers and avoiding relapse." This response is different than what staff thought was most important for individuals surveyed. Individuals surveyed felt that their treatment offered culturally appropriate care – rating this at 7.9 out of 10. Respondents rated the most important part of cultural standards in treatment as the idea that people's "cultural beliefs are valued and respected." This is reflected in what the staff believe. However, respondents also valued the idea that the staff speaks their language (2$^{nd}$ most important to cultural standards in treatment), and that the staff come from a similar culture as them (3$^{rd}$ most important). Five percent of respondents know nothing about co-occurring treatment, but overall, individuals surveyed felt that their knowledge is a little better than average, at 6.9 out of 10. While 70% of respondents felt it is important to treat co-occurring issues, 11.5% did not know whether co-occurring treatment was important. Of the people who felt co-occurring treatment was effective, 48% individuals surveyed cited seeing their own health improve as a result of this treatment, and 17% cited seeing co-occurring treatment work for their friends or family.

While 61% of respondents believed treatment for co-occurring disorders helps solve physical health problems, almost 32% did not know whether this treatment helps their physical health. Many individuals surveyed (72%) believe that treatment for co-occurring disorders helps with mental health and addiction issues, but over 26% did not know. Individuals surveyed wanted to know most how co-occurring treatment could help with mental health issues. For the most part, individuals surveyed felt that outpatient services helped increase their understanding of most measures regarding recovery – but almost 44% felt that there was no change for them in regards to getting access to stable housing and employment. Over 40% of individuals surveyed felt that there was no change regarding their ideas and beliefs about others' recovery. The overwhelming majority of individuals surveyed (65%) said that outpatient services could be improved if there were more programs. Over 26% of individuals surveyed stated services could be improved with shorter waitlists, and almost 9% wanted services in more languages.

[1] http://www.ct.gov/dmhas/lib/dmhas/eqmi/annualreportsfy2015.pdf

More individuals surveyed knew "nothing" about alternative (holistic, yoga, etc.) programs to recovery than "anything." Individuals surveyed rated their knowledge of alternative programs at 4.7, with almost 22% of people admitting they know nothing and over 67% saying they have an average to poor knowledge of these types of programs.

When describing what they liked least about outpatient programs, an equal number of individuals surveyed cited programs were too long (probably stemming from court-mandated respondents) or they couldn't understand what was going on. A full 16.7% disliked the lack of discharge planning, and another 16.7% felt outpatient treatment did not feel useful to their recovery. In terms of what individuals surveyed liked most about their outpatient treatment program, the number one choice cited was meeting new people. Overall, respondents rated their outpatient treatment programs highly, at 7.6 out of 10.

**Survey for Staff:**
Over 95 staff members from all participating agencies completed our surveys. Staff rated their knowledge of co-occurring programs at 8 out of 10. Most (95%) of staff identified their program as a co-occurring program. Most (99%) staff felt it was important to treat co-occurring issues. A majority (67%) felt this is important because they have seen people's health improve from this kind of treatment. To integrate treatment for mental health and addiction, staff shared a variety of strategies. This ranged from discussing how symptoms of one influence the other, to how coping skills can be developed, to meeting people where they are at. Despite the emphasis on co-occurring treatment and the belief that this works, about a quarter of the staff surveyed (26%) felt like they were not receiving enough training to treat co-occurring issues. More than a fifth of the staff (22%) felt that they were not receiving enough supervision to treat co-occurring issues.

In terms of cultural sensitivity, almost a quarter of staff (24%) shared they knew nothing about Culturally and Linguistically Appropriate Services (CLAS) standards, while only 6% felt they knew a lot. The majority of the staff (68%) felt they knew less than average (4.3 out of 10) about CLAS standards. Staff need training on this topic! Very few individuals surveyed thought what's most important for promoting cultural standards in outpatient treatment is having translation or interpretation available. Nobody thought it was most important for staff to come from a similar culture as individuals surveyed.

Staff felt the most important element for program success was ensuring people feel safe in the program environment. Staff seem to know about and value co-occurring treatment in a larger health context, as 93% of them believe treatment for co-occurring disorders helps solve physical health problems. When asked about alternative (holistic, yoga, etc.) programs to recovery, staff rated themselves 6 out of 10. Individuals surveyed seemed to know a little more than average about these programs.

Most staff (75%) identified as White/Caucasian. Of the staff surveyed, only 2% were Asian/Pacific Islander (which is less than the CT Asian population of 4%), and 4.7% were Black/African American (which is less than the CT Black population of 11.6%). Over 16% identified as Hispanic/Latino (which is more than the CT Latino population of 14%). If our survey sampling of staff accurately represents our region, we should consider hiring more Asians and Blacks to reflect the diversity in CT. Most staff (91%) have attended graduate school, while only 2% have graduated from high school and have had some college. Staff survey respondents are mostly in the 25-34 age group, which suggests that millennials are more interested in working in outpatient behavioral health services than their predecessors, or that people move up, or burn out and leave the field as they approach their late thirties into middle age. Staff surveyed were predominantly (76%) female, while individuals surveyed are predominantly male. Staff respondent earnings are a bell curve with most earning in the $50K-$75K range. The staff educational requirements and staff demographics do not reflect the communities they serve. This is a reason to consider engaging Community Health Workers or Peer Specialists, to bridge the cultural divide between staff and people in recovery.

# Overall Strengths

Region IV's outpatient and co-occurring programs are strong in their integration of mental health and addiction services, and in their integration of behavioral health and physical health services. Most outpatient and co-occurring programs in Region IV integrated their mental health programs with addiction, asking about co-occurring issues in intake and acknowledging the role of addiction in mental health issues and vice versa. Moreover, many outpatient and co-occurring programs are moving towards an integrated health model where people can get primary care services and other physical health issues treated alongside mental health and addiction issues. This gives people with complex medical issues a way to address the needs of their mind and body all at once. This approach also enables people and cultural groups who stigmatize mental health and addiction issues to have access to behavioral health services while seeking primary care; and it gives people with mental health and addiction issues access to primary care.

# Outpatient Record Review Summary

At the Board's request, the DMHAS record review focused on each program's delivery of services to individuals with co-occurring mental health and substance use disorders. This included a review of documentation of the initial assessment and ongoing monitoring of each disorder as well as any interaction; assessment of Stage of Change for substance use and mental health; treatment planning; education about each disorder and their interactions; availability of addiction medications; use of Evidence Based Practices; information about and/or referral to peer support groups such as AA, NA, or specialized groups for individuals with co-occurring disorders such as Double Trouble in Recovery (DTR) and Dual Recovery Anonymous (DRA); engagement and use of a harm reduction approach; and overdose prevention education for individuals with a history of opiate use.

A sample of two active and two discharged client charts from the following mental health outpatient programs were reviewed: CHR (Enfield and Manchester); CRMHC (Co-Occurring Outpatient Program and Young Adult Services Program); Hartford Behavioral Health; Institute of Living (Adult Psychiatric Outpatient Program); InterCommunity; CMHA; Wheeler Clinic (Hartford and Plainville). The DMHAS reviewer also met with the outpatient Program Director(s) and/or Clinical Director at each agency to obtain a brief overview of the outpatient services.

**Site Visit Findings**

- Each program treats individuals with a wide range of co-occurring substance use disorders, with the exception of the Institute of Living Adult Outpatient Psychiatric Clinic whose clients have less severe substance use disorders. The Program Director stated that the program doesn't see itself as a "co-occurring program"; depending on the level of care needed, individuals with more significant substance use problems such as opiate use are referred to the IOL's Co-Occurring Disorders Day Program or Professionals Program, as well as to other substance use programs in the Hartford Hospital system such as Rushford or Natchaug Hospital.

- Each program's initial assessment collects information on the individual's substance use and mental health history and treatment history to varying degrees. The level of detail and exploration of any chronological relationship between co-occurring disorders often depended upon the clinician. InterCommunity's assessment most consistently captured a more detailed integrated chronology of the course of both disorders and any interaction between them.

- Ongoing monitoring of both disorders was documented by all programs in progress notes and/or recovery plan reviews. InterCommunity consistently asked individuals to rate their substance use urges/cravings on a 1-10 scale to try to quantify and track improvement, for example. All programs except the IOL use urinalysis to varying degrees in addition to self-reporting in order to monitor substance use. Urinalysis can be used with individuals a program may be concerned about, although regular urinalysis primarily occurs only for

individuals in Intensive Outpatient services, those receiving Suboxone (CHR, CRMHC and CMHA), or those who have legal or DCF involvement; CRMHC is an exception in that it does not relate urinalysis testing specifically to legal involvement because the program wants individuals to see urinalysis as a clinical resource. HBH's practice is to require urinalysis at least every 90 days for those individuals with more acute substance use histories, e.g., PCP, cocaine, etc. HBH has also applied for a grant for carbon monoxide monitors to use with those individuals in the clinic's smoking cessation program.

- Stage of Change is not consistently assessed and documented so it was difficult to determine if some programs use it to guide treatment interventions for both disorders. Only CHR, CMHA and Wheeler Clinic assess an individual's Stage of Change separately for substance use and mental health, with CHR and CMHA consistently documenting it for each treatment plan goal or objective. InterCommunity has been assessing an overall (combined) Stage of Change, but is also training staff to document it separately for treatment plan goals and objectives. HBH currently documents Stage of Change for substance use only. CRMHC and IOL don't use it consistently, although CRMHC does offer a Persuasion Group for individuals in Pre-Contemplation in its Co-Occurring Outpatient Program.

- Each program addresses both mental health and substance use disorders in treatment planning, including interactions/relationships between the two as appropriate.

- It was evident that each program provides education to individuals about their mental health and substance use disorders and/or their interactions.

- Each program prescribes various addiction medications, e.g., Acamprosate, Naltrexone. CHR, CMHA and CRMHC prescribe Suboxone as well, and HBH is exploring this.

- Use of Evidence Based Practices was evident. Each agency documented use of Cognitive Behavioral Therapy and Motivational Interviewing. In addition, most programs use specific curricula for topic groups such as anger management, relapse prevention, co-occurring disorders education, and/or trauma. Charts reviewed also documented use of Dialectical Behavioral Therapy (CHR, InterCommunity, IOL), and Eye Movement Desensitization and Reprocessing (InterCommunity).

- All the programs encourage the use of mutual support groups such as AA, NA, etc. Some programs included the use of support groups on recovery plans, and/or documented in progress notes the exploration of support group use or follow-up with individuals regarding their attendance/experience. Both CRMHC and CMHA host weekly Double Trouble in Recovery meetings.

- Each program clearly employs a "harm reduction" philosophy. The charts sampled included those for clients with a wide variety of individual experiences/preferences, e.g., individuals who were struggling with substance use relapse, were interested in stopping use of one substance but not another, or who needed a higher level of care but were only interested in attending outpatient services. It was evident that all the programs consistently work to engage each individual using a recovery-oriented and non-judgmental approach.

- With the exception of IOL's Adult Psychiatric Outpatient Program, each program provides some type of specific overdose prevention education related to opiate use, e.g., how tolerance changes, overdose risk in early recovery, etc. It may be provided on an individual basis or as part of a group curriculum. At CMHA, a prescriber who has a specialty in addiction attends group counseling sessions to provide information on Narcan and overdose prevention, and is available outside of group to answer individual questions. Pharmacists at the Genoa pharmacy on site at both CHR clinics have trained clients on the use of Narcan.

- CHR, CMHA, CRMHC and Wheeler Clinic all offer the option of Narcan to individuals who have opiate use histories or who have disclosed use/relapse while in treatment, as well as to their family members. In an effort to make Narcan as accessible as possible, Wheeler Clinic clients or their loved ones are able to access Narcan through their prescribers without a medication management session; the clinician documents the need, provides education on safe use, and the prescriber writes a prescription that can be filled at the pharmacy of their choice, including the Plainville clinic's on-site Genoa pharmacy. CHR's on-site Genoa pharmacists have taken the training required to prescribe Narcan; this enables CHR clinicians to walk clients directly to the pharmacy to obtain the Narcan, precluding them from walking out of the clinic with an unfilled prescription in their hand.

- One trend seemed worth noting even though it is not specifically related to co-occurring disorders. CHR, InterCommunity and Wheeler Clinic all have full open access, i.e., an appointment is not required for an intake, and HBH offers open access two mornings a week. It appears that the ease of access to services has resulted in these programs seeing more individuals who perhaps would have presented to a crisis program before the advent of open access. Often these individuals feel better after the initial crisis or urgency has passed, making it more challenging to keep them engaged in services; many do not follow through after the intake or may attend only an outpatient session or two. In response, HBH tries to quickly schedule therapy and medication management appointments. CHR routinely reaches out by phone and letter and keeps clients "open" for an extended period, and also refers some individuals as appropriate to CHR's Community Support Program to assist with engagement. Wheeler Clinic has implemented additional Intensive Outpatient Program (IOP) groups, and started an Illness Management and Recovery group. InterCommunity agreed that in general individuals are presenting with higher acuity for a variety of reasons; however, the program has had open access for a very long period of time, so does not find the change as noticeable at this point. The program pointed out that these individuals likely wouldn't have kept intake appointments in the past; they are now being seen and provided some initial engagement, and tend to re-engage over time.

# Overall Recommendations

1. **Prioritize housing first:** Lack of safe, affordable and supportive housing continues to be the top priority issue raised by all groups as a primary barrier to recovery. "Emergency shelter placement is near to impossible these days and even more difficult for folks with behavioral health needs." Homelessness has been repeatedly shown in national research studies and cited by people served by outpatient programs as being the number one cause of decompensation and Emergency Room visits. Super utilizers of the healthcare system struggle with follow-up and outpatient care when they lack stable housing. Preventive outpatient and co-occurring programs fail if clients are not stably housed. For all our outpatient services to be effective and cost-efficient, housing must be secured for chronically homeless people served by outpatient programs. DMHAS and DMHAS-funded providers have demonstrated a strong commitment to developing and maintaining recovery support services. The two Supportive Housing options settings recently developed in Manchester are stellar. 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 Veteran homelessness last year. While this effort has not been without its challenges, the two Coordinated Access Networks (CANs) serving region IV, Journey Home, and Central CT CAN (CCAN) all report progress toward their goals of ending chronic homelessness by the end of 2016 (at 55% and 30% respectively as of July 2016). DMHAS should continue as a leading partner with other state and federal government agencies to promote access to safe, affordable, and Supportive Housing to its constituents.

2. **Implement more comprehensive follow up after discharge:** Follow up with a phone call as well as a letter, in case people do not regularly get mail. Offer opportunities for people in recovery to check back with therapists or with the agency if needed. Figure out how to determine the success of discharge. Connect people with community supports rather than only medication. Some agencies are incentivized to discharge people served by outpatient programs quickly and efficiently, but this practice may not be effective. Once discharged, many people served by outpatient programs feel alone and lack resources to continue recovery, and some feel they are rejected from services

because they do not fit the "level of care" or lack a sufficient crisis to come back to their outpatient program. People should have a range of services available in the community, so that they can get help when they are in crisis, as well as in recovery mode.

3. **Set aside funding for dedicated interpreters and translated materials:** Behavioral health is a service for which it is especially important to have dedicated interpreters and translated materials. Without these essential services, many people who can benefit from therapy or outpatient services cannot and will not use preventive behavioral healthcare. About 400 refugees are graciously welcomed into Connecticut every year; most have trauma histories, PTSD, and lack language skills to address these issues. Without dedicated interpreters and translated materials in behavioral health settings, the state is doing a poor job of helping these refugees transition. Without a dedicated interpreter on staff, agencies may rely on family members, untrained staff, or community health workers to do this essential work. However, relying on family members or friends to translate about subject matter that is personal and stigmatized in many communities can be detrimental to treatment. Relying on community health workers to do this work is untenable because they will have to juggle interpretation in clinical settings with the many other healthcare advocacy and support work they do in the community. To do a better job of addressing behavioral issues before they become emergency problems, interpretation and translation services must be prioritized. Since the state of Connecticut welcomes these refugees, the commitment to offer interpretation and translation services should not only come from DMHAS, but from other state agencies as well.

4. **Promote cultural competency in agency settings:** Creating an atmosphere of inclusion and offering culturally competent care is key to increasing people's access to outpatient services. In this turbulent financial period, it may be difficult to hire qualified bilingual staff or recruit more diverse clinicians. Lack of reliable interpretation services prevent many minorities and immigrants from accessing behavioral health care, and since interpretation services are often not reimbursable with health insurance, it is important to consider how else to address "soft" cultural barriers to healthcare access. One way to do this is to make sure all staff are trained in cultural competency. Almost a quarter of staff (24%) we surveyed shared they knew nothing about Culturally and Linguistically Appropriate Services (CLAS) standards, while only 6% felt they knew a lot. Staff need training on this topic!

Additionally, while having diverse staff at the agency can help attract a diversity of people served by outpatient programs and ease people's concerns, we should not assume that someone from the same ethnic background as a person struggling with behavioral health can adequately represent that person. Given the big minority and immigrant populations in certain communities, it is important that clinicians are trained to be more culturally sensitive. Also consider offering the services of peer bridgers or community health workers to help clinicians provide culturally competent care for our diverse communities.

5. **Make grievance policy more accessible:** Make it easy for people to know about and find the grievance policy. Given the diversity of the people served by outpatient programs, consider sharing the policy in Spanish and/or in other appropriate languages. Ensure that all people served by outpatient programs are well informed about the grievance policy in verbal and written forms.

6. **Provide and pay for better training:** Staff value professional development. However, there is a concern about the availability of training due to the budget cuts that eliminated the DMHAS training division. Paucity of training and professional development opportunities in some agencies may contribute to high staff turnover and leads to worse health outcomes. Help staff work more effectively by offering free training and/or compensation to pursue professional development. Some staff felt that training opportunities allowed them to get on the same page and reinvigorated their work. Invest in staff professional development to save money and prevent escalating behavioral health crises.

7. **Develop agency surveys:** Give feedback to staff and help people served by outpatient programs feel their opinion is valued. Currently it seems that few feedback mechanisms exist outside of the DMHAS Annual Satisfaction Survey. Staff talked about how organizations that fund agencies administer surveys, but staff admit these programs want to look good so the results may not reflect what is going on.

8. **Help people served by outpatient programs with transportation:** Consider working with Regional Mobility Managers (such as Way To Go CT: www.waytogoct.org) to help people served by outpatient programs navigate transportation options. Partner with the Department of Transportation (DOT) to develop more options for people served by outpatient programs to access free or low cost transportation. This is especially important as LogistiCare may suffer budget cuts due to the state crisis.

9. **Develop Young Adult Services (YAS):** Of the young people (14,849 people between the ages of 18-34) in the Region IV DMHAS system, fewer than 300 are served in Region IV YAS programs. Most referrals come from the Department of Children and Families (DCF) for youths who are aging out of their services. It is very difficult for someone without DCF referral to access YAS services regardless of level of need. There is also need for other DMHAS-funded services to be more sensitive and responsive to the unique needs of young adults. Young people getting clinical services from outside the DMHAS system are often not told about all the supports available to them. There is also need for more awareness at college campuses. For many years Central Connecticut State University (CCSU) offered a model program – the Central Access and Student Development program that was described as "lifesaving" by some of the students we interviewed. Unfortunately, in the wake of budget cuts, the program has been discontinued. For the majority of young adults who are not involved in YAS programs, outpatient services must be geared to their developmental and lifestyle needs. They may be uncomfortable in group settings, perhaps because they are not comfortable in the groupings. Young adult life struggles are different than in other life stages.

10. **Continue Workforce Development efforts for qualified prescribers**: DMHAS should continue efforts to address barriers to medication assisted treatment and to attract professionals who are qualified to evaluate and provide medication management for both psychiatric and substance abuse disorders. This was cited in all of the focus groups as a significant area of workforce shortage among Region IV providers.

11. **At outpatient program discharge, offer a stepdown; no more discharges to nothing:** Some people talked about lack of services when they were discharged from outpatient programs. This left many people feeling adrift. Certain agencies require people to make follow-up appointments if they need additional or ongoing services, which is a barrier to getting healthcare. The agencies that offer a stable level of recovery support after discharge from outpatient programs provide a useful example of what may work. For example, CT Community on Addiction and Recovery (CCAR) offers daily phone call check ins – which is a level of recovery support that doesn't require ongoing appointments, and meets people where they are at.

# Conclusions

The Review and Evaluation Committee came up with a few general observations from our numerous focus groups and surveys. First, the Committee noticed that the integration of mental health and addiction is strong in most outpatient programs; the idea of "co-occurring" treatment was familiar to and made sense to many staff and people in recovery, and lacking in just a couple of programs. Furthermore, trauma was a well-known topic among almost all the individuals surveyed; most people were either asked about trauma in their intake evaluations, or felt that trauma was openly discussed in therapy sessions and/or groups. The Committee was also interested in cultural competency of outpatient programs in North Central Connecticut, and our review helped us understand that there are some strides being made in this arena. While some agencies struggled to find and retain culturally appropriate staff, many agencies were aware of the importance of addressing cultural competency. More training on cultural sensitivity for agency staff will help address some of the "soft" barriers to accessing behavioral healthcare. The paucity of interpretation and translation services means that many people are not accessing outpatient programs, so a dedicated interpreter or an interpretation telephone line can help address these issues. Beyond these three issues, the Committee was heartened to note that same-day access for outpatient services increased across agencies in our region. This means people can get access to outpatient services when they need it, within the day. Finally, the integration of physical and mental health was another shift that we appreciated noting. People can get primary care and behavioral

health services in the same place, at local mental health agencies and in outpatient settings. This integration of care means that people can work on physical and mental health issues concurrently.

Some areas of concern are noted above, under "Our Recommendations" – but another concern is that agencies are pushing to organize more groups and offer fewer one-on-one appointments. While this priority can seem positive because groups help foster a sense of community, engender social trust, and cultivate group therapy, this shift may also turn away people who can benefit from outpatient services. Increased emphasis on group therapy may be a result of rising caseloads and overloaded therapists. This means that people see their therapists fewer times per week or per month, and may hinder some people's recovery. In certain cultures, it is not appropriate to share one's personal issues in a group setting. Additionally, individuals surveyed have reported that they do not feel safe sharing everything in a group setting – that there is a vulnerability component in groups that is difficult for them and so they prefer to talk through issues with a clinician before group or concurrently with group therapy. Other people who benefited from group therapy have reported that some agency staff explicitly instructed them to abstain from sharing parts of their story that may be traumatizing to others. For some people, holding back on sharing their complete stories inhibits them from processing their experiences and from accessing the tools to a rich and full recovery from their peers. Groups are a space that can be valuable only if peers are encouraged to share and learn from other peers, and if groups are not a replacement for individual therapy.

This report aims to provide an opportunity for a rich exchange of ideas among all the people in outpatient and co-occurring care management, families, and people in recovery. Throughout the review and evaluation process, all the outpatient programs provided evidence of thoughtful program management efforts, continuing efforts to improve practices, and a committed dedication to support recovery.

# Report by Catchment Area

## Community Health Resources (CHR) – Manchester Adult Outpatient Program (AOP)

***AGENCY QUESTIONNAIRE***

Program Description and Services

- **Staff: (share numbers)**
  - Agency Administrative staff: Two Clinical Program Directors, Service Director who oversees most agency clinics
  - Peer Support Staff: 0
  - People in Recovery as Staff: unknown
  - Agency Direct Program staff: 22 FTE
- **Location:** 587 East Middle Turnpike, Manchester
- **Total Program Funding:** 2,376,236 budgeted
  - DMHAS funding: 938,513
  - Last Fiscal Year: 1,135,221
- **Program Capacity:**
  - Active Clients at time of review: 3,161 clients (includes CSSD referred clients)
  - Hours of operation per week: M-Th 8-8, F 8-5, Sat 9-11
- **Number of training hours for staff:** Varies by staff. In addition to CHR sponsored training, staff are eligible to attend DMHAS and other trainings. CHR sponsored training is 9-12 hours annually plus supervision._____
  - Types of training offered: In addition to required annual trainings (e.g., fire safety etc.,), CHR provides training annually. This training year (Sept to Aug, 2015-2016), training topics include Integrated Care, Risk Assessment, Self-care, Vicarious trauma, Substance Abuse, and Cultural Diversity. These are required trainings. All new staff at CHR are introduced to the concepts of Trauma-sensitive and Gender-responsive principles, and Integrated Dual Disorder Treatment.
- **Number of Peer-Run activities:** Hearing Voices Self-Help Group, Dual Recovery Anonymous. Many clients also use the CHR Clubhouse as well. Identified individuals also utilize BHH Wellness groups.
- **Mission Statement:** The mission of the Adult Outpatient Program of Community Health Resources is to provide a range of outpatient counseling, psychiatric and substance abuse services in a timely manner to residents north and east of Hartford, Connecticut who are experiencing mental disorders, substance abuse disorders and life adjustment difficulties. The purpose of the service is to assist clients in reducing symptoms and distress; help clients to understand, manage and cope with their illness and distress; to promote productive life choices and ways to manage stresses. It is the goal of the program to facilitate the client's highest possible level of functioning in the least restrictive environment possible, in each aspect of their life – with self/family and friends/work/school/community. Staff works with clients to assist them in utilizing and becoming involved with natural community supports and their recovery

**SERVICES FOR SPECIALIZED POPULATIONS**

- Persons with a co-occurring disorder: 1,940 identified individuals. CHR assesses both mental health and substance use disorders at each intake. Clients with Co-Occurring Disorders can participate in Intensive Outpatient Program (IOP), individual, family, and group therapy. All substance use and co-occurring therapy groups are stage-based and available for people from Pre-contemplative/Contemplative (New Beginnings Group) to Action (Relapse Prevention) stages of change. There is a specific relapse prevention group in the Manchester Clinic for people with severe mental illness and substance abuse. All other treatments are Co-occurring Competent and use the Living In Balance Co-Occurring Curriculum to supplement the substance focused Living in Balance. No clients are declined services due to substance use in the Outpatient Program. Clients whose mental illness symptoms prohibit benefitting from standard IOP SA programming can participate in the newly developed IOP Plus program that is more flexible and relies upon therapies geared toward the needs of the individuals in the program. Clients actively using continue to receive medication

management for mental illness in the Manchester Clinic. The Manchester Clinic has initiated Suboxone treatment this past month and the treatment of our first client is underway.

- Persons of different cultural backgrounds: 1,106 identified individuals. The Manchester Adult Outpatient Program (AOP) employs bicultural and bilingual Spanish speaking staff, including a Program Director and two therapists. Staff members are receiving training this year on cultural diversity, in addition to the annual training on this topic. We have one staff member who speaks Farsi and has worked with Indian American clients.
- Young Adults (18-25): 462 identified individuals. While we treat clients in this age group in the outpatient clinic, we do not have specialized programming. There is a need for this and we have spoken about it. We do make referrals from the outpatient clinic to specialized Young Adult Teams at the agency. Among young adults, we have noticed an increase in referrals of people diagnosed with autism spectrum disorders who have greater needs than can be addressed on DMHAS programming and who do not have the functional and documented impairment to DDS care.
- Elderly (55+): 721 identified individuals. We do not have specialized programs to treat the elderly. We have, however, developed a close working relationship with CCCI who provides care coordination for elderly clients.
- Persons with a trauma history: 572 identified individuals. Over the past two years, CHR has dedicated considerable focus on being a trauma-sensitive agency for clients and staff alike. In the Manchester Adult Outpatient Program (AOP), we have trauma sensitive treatment for men and women, specialized group programming, gender specific IOPs and group therapy. We use the Seeking Safety Curriculum, DBT, and Helping Women/Men Recover. Trauma and its aftermath is assessed at every intake and is routinely considered in interventions with clients.
- Persons with co-morbid health problems: 1131 identified individuals. CHR Manchester Adult Outpatient Program (AOP) has a close working relationship with the behavioral health home at CHR which provides intensive care coordination for people with mental illness and medical conditions. CHR Manchester has a center for Health and Wellness with primary care and wellness programming embedded in the outpatient clinic. We have recently developed a consultation relationship with Dr. Golar, the physician attached to the Behavioral Health Home and provided training last month on symptoms of acute medical conditions. We are in the beginning stages of integrated care, but efforts are underway.

**UTILIZATION**

- Number of persons served, both duplicated and unduplicated in FY 2015: **3,776** Unduplicated or **4,041** Duplicated
- Average length of stay for FY 2015 *(as calculated by averaging the length of stay for those who have received long-term clinical support and those who have received short-term episodic treatment):* **2.37 Years**
- How does the location of this program affect the clients? The Manchester Adult Outpatient Program (AOP) is directly on the bus line and very close to the Department of Children and Families and Department of Social Services and we share a building with the local Probation Office all contributing to good access to multiple services commonly used by our clients. CHR does serve towns in surrounding communities that are not accessible by bus. Unfortunately, the increase in services provided has caused the parking area to be overwhelmed and this is a struggle for clients and staff.

**PROGRAM ACTIVITIES:** (program goals, defining features of program, and description of model)

CHR Adult Outpatient Program (AOP) programs use a number of evidence-based practices in treatment for trauma, substance use, mood disorders, gender-responsive care, and anger management. Treatment is provided in varying levels of intensity dependent upon client needs. We have 5 Intensive Outpatient Program (IOP) programs, multiple group therapies, individual, and family therapy. We offer a bi weekly Family Matters support group open to any family member of persons with mental illness and/or substance use. We offer medication management and psychiatric evaluations. CHR provides open access, same-day intake assessments and urgent care for existing clients who need to be seen immediately.

- **Role in agency**

The outpatient clinic provides initial assessments and triage for the vast majority of clients who are admitted to the agency. The Adult Outpatient Program (AOP) clinic staffs hosts service-wide treatment team meetings, case conferences, and performs client evaluations for all other adult division programs as needed. Most clients in all CHR programs receive at least medication management at the outpatient clinic. The outpatient clinics coordinate closely with all other funded LMHA services including Community Support Programs (CSP)[2], Employment Services, Mobile Crisis Response Team (MCRT)[3], Clubhouses, Respite, Residential programs etc. Together these make up an integrated service system.

- **Recovery focus, health & wellness activities**

In the outpatient clinic, recovery treatment plans are completed with the client and are focused on the goals of the client. Staff members are versed in the recovery model, person-centered care, and the stages of change. Within the clinic, staffed by the center for health and wellness and behavioral health home, are group education programs addressing smoking cessation, nutrition, exercise, and engagement in primary and medical care. The focus of Adult Outpatient Program (AOP) treatment is recovery and healthy living

- **Utilization of Culturally and Linguistically Appropriate Services (CLAS) standards and/or co-occurring program models**

The Adult Outpatient Program (AOP) at CHR use the Integrated Dual Disorder Treatment (IDDT)[4] model of care providing stage-based groups and harm reduction, including not limiting services or discontinuing services in response to a client's substance use. We use motivational interviewing and persuasion groups. The Manchester Adult Outpatient Program (AOP) clinic provides services that are culturally and linguistically appropriate for Latino community. We have therapists, care coordinator staff, reception staff, and medical records staff who are bilingual and bicultural. CHR provides a language line to permit interpretation in nearly all languages on the spot. However, we are limited to individual therapy for monolingual Spanish speaking clients, which is a limitation for those needing Intensive Outpatient Program (IOP) or group treatment.

- **Outcome measures employed**

The adult outpatient program uses the Brief Psychiatric Rating Scale as its outcome measure. This has been in place over the last 6 months. Per DMHAS we also use the modified Global Assessment of Functioning (mGAF)[5]. We

[2] CSP/RP (Community Support /Recovery Pathways) program consists of mental health and substance use rehabilitation services and supports necessary to assist an individual in achieving and maintaining the highest degree of independent functioning. The service utilizes a team approach to provide intensive, rehabilitative community support, crisis intervention, individual, and group psycho-education and skill building for activities of daily living, peer support and self-management. CSP/RP includes a comprehensive array of rehabilitation services most of which are provided in non-office settings by a mobile staff. Services are focused on skill building with a goal of maximizing self-management skills and independence. Community-based treatment enables the team to become intimately familiar with the individual's surroundings, strengths and challenges, and to assist the individual in learning skills applicable to his/her living environment. The team services and interventions are highly individualized and tailored to the needs and preferences of the individual.

[3] The Mobile Crisis Response Team provides a number of integrated services including: • Evaluation of immediate need for crisis/emergency services (telephone triage) • Crisis intervention and/or assistance in de-escalating the situation • Risk assessment and evaluation for more intensive services • Short-term crisis management until other supports/services are in place, or the crisis is resolved • Liaison between individual, families, health care providers and emergency services • Coordination of appropriate community-based services for ongoing treatment and follow up

[4] The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice that improves the quality of life for people with co-occurring severe mental illness and substance use disorders by combining substance abuse services with mental health services. It helps people address both disorders at the same time—in the same service organization by the same team of treatment providers. IDDT emphasizes that individuals achieve big changes like sobriety, symptom management, and an increase in independent living via a series of small, overlapping, incremental changes that occur over time. Therefore, IDDT takes a stages-of-change approach to treatment, which is individualized to address the unique circumstances of each person's life. IDDT is multidisciplinary and combines pharmacological (medication), psychological, educational, and social interventions to address the needs of consumers and their family members. IDDT also promotes consumer and family involvement in service delivery, stable housing as a necessary condition for recovery, and employment as an expectation for many.

[5] The Global Assessment of Functioning (GAF) assigns a clinical judgment in numerical fashion to the individual's overall functioning level. Impairments in psychological, social and occupational/school functioning are considered, but those related to physical or environmental limitations are not. The scale ranges from 0 (inadequate information) to 100 (superior functioning). Starting at either the top

also collect outcome data on employment, housing status, substances used in the last 30 days, self-help used in last 30 days and other indicators

**PROGRAM ACCESS & DISCHARGE**

- Criteria for outpatient program referral and for discharge: The Adult Outpatient Program treats all individuals with the exception of clients in DDS group homes or skilled nursing facilities. We do not decline to service clients based on severity of illness or substance dependency. The outpatient program is a time-unlimited treatment and most discharges occur when clients themselves disengage.
- The average length of time elapsing between receipt of referral and admission to the program is:
    - The clinic invites people to intake same day or next day. On average individuals attend an intake appointment within 3.4 business days.
    - Barriers to admission include: Barriers to admission include transportation, homelessness, and people in pre-engaged stage of treatment who do not come for a first appointment. Periodically, clients need to wait at the clinic to be seen for intake or first psychiatric evaluation as part of the open access model and this can be hard for some people.
- Describe any community integration of the program: Staff from CHR Manchester Adult Outpatient Program (AOP) attend regular meetings with the Department of Children and Families (DCF), Probation, and other CHR staff who provide rehabilitation on the community. The Manchester clinic provides community groups for families of the mentally ill and a support group, Hearing Voices. The outpatient clinic houses a pharmacy. We have periodic meetings with the police department and department of social services to coordinate services. We have close working relationship with the local hospital and attend meetings regularly there to coordinate care and have invited the local community health center, First Choice, to provide primary care in the outpatient clinic. This service has been implemented.

**PLANS FOR CHANGE OR CHANGES ANTICIPATED:**

- Please describe changes you implemented or plan to implement in response to DMHAS goals for a recovery-oriented system.

CHR outpatient program uses collaborative documentation and person-centered care. We have implemented an open access and urgent care clinic so that clients can use the service as needed. Outpatient therapists regularly make referrals for employment services, transportation assistance, housing assistance, and outpatient rehabilitation programming to assist clients to meet their goals. Outpatient treatment is time-unlimited and offers a diversity of programming to address client choice. The outpatient clinic has been utilizing peers in the waiting area as greeters to assist and support clients.

- Please describe barriers, challenges, tensions, differences in philosophy, system issues, or obstacles that need to be addressed.
    - Transportation
    - There are significant limitations related to strict rules limiting the credentials of individuals who can assess and write commitment papers for clients at risk. In the clinic, that is psychologists and psychiatrists only.
    - It is a serious issue that there are no identified providers for young adults with developmental disabilities who are not eligible for DDS services or DMHAS grant-funded services because autism spectrum disorders are not classified as severe and persistent mental illnesses. Consequently, there is insufficient training of staff and resources for rehabilitation.
    - Access to intermediate and longer term hospitalization is problematic.
    - Lack of homeless shelter space and affordable housing.
    - Problems with recruiting bilingual and/or bicultural clinic providers.

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or the bottom of the scale, go up/down the list until the most accurate description of functioning for the individual is reached. Assess either the symptom severity or the level of functioning, whichever is the worse of the two. Check the category above and below to ensure the most accurate one has been chosen. Within that category there will be a range of 10. Choose the number that is most descriptive of the overall functioning of the individual. The modified Global Assessment of Functioning (mGAF) scale provides a more detailed criteria and scoring system than the original GAF.

- Lack of residential treatment programs for clients with very serious symptoms.
- There is a big gap in services for middle-aged, severely ill clients who have lived with their parents all their lives when the parents reach an age that they are no longer able to adequately respond to the clients' needs.
- Increase in opiate addiction and overdoses.
- Increase in suicides and its impact on staff members who are exposed to these losses. It would be nice if there was an initiative to address this and support the staff.
- Cuts to DMHAS funding

## CHR – MANCHESTER FOCUS GROUP HIGHLIGHTS:

The staff focus group was full of smiling, talkative staff who were comfortable expressing their criticism of the agency while extolling its strengths. The staff group was one of the larger ones we met with, and their passion and enthusiasm were apparent.

The staff shared that CHR will be moving on July 1st, 2016 into a new building on Center Street in Manchester. This building will be on a bus line and will be closer to a lot of community members. However, they acknowledged this transition may be difficult on some people.

### FEEDBACK FROM PEOPLE IN RECOVERY:

- **Ways this program has been helpful to people served by the program:**
  - There are a lot of groups and programs that help people served by the program recover
    - "The program got me to come out of my shell"
  - The materials given out are helpful for coping – helped people served by the program understand mental health issues in the context of addiction
  - Learned about seeking safety, using "WISE" mind, breathing, grounding, and stress-relieving activities
  - People served by the program feel their perspectives are valued and they are regularly solicited for feedback

- **Client concerns about program:**
  - The program is too short – 15 sessions, 3 days a week; some people served by the program say it lasts only 2 hours when it's supposed to be from 9am-noon. People wish therapy was longer, or that there's more therapy rather than groups or medical visits
  - Wish there was job or housing help – there's no discussion of this

- **Cultural awareness of program:**
  - People served by the program feel respected by staff in regards to their culture

- **Grievance Policy:**
  - People served by the program are not aware of the grievance policy and stated they would talk to their APRN or staff if there are any grievances

### FEEDBACK FROM STAFF:

- **Special aspects about program:**
  - Open Access clinicians allow for one-on-one meetings and resources for acute and symptomatic people served by the program in the group. During a group meeting, if someone starts to decompensate, the group leader can call a break and bring the person to the Open Access office to meet with a therapist right away. This is a great resource to ensure groups can move forward and helps prevent triggering group members, while people in crisis can have immediate one-on-one access to a therapist. Staff wishes there is Open Access for evening groups.
  - Behavioral Health Home (BHH) for people with Husky D (Medicaid) is focused on whole health. These places have primary care, wellness groups, nutrition classes, and workout groups.
  - Assertive Community Treatment[6] (ACT) Team and case management services
  - There's a walk-in evaluation, a clinic, wraparound services, and not a long wait list compared to other agencies (someone can see a clinician within 3 weeks)

[6] Assertive Community Treatment (ACT) is an evidenced-based practice that offers treatment, rehabilitation, and support services, using a person-centered, recovery-based approach, to individuals that have been diagnosed with a severe and persistent mental illness by a mobile, multi-disciplinary team in community settings. .

- Intensive Outpatient Program (IOP) Plus program is valued by people served by the program
- The CHR pharmacy provides and prescribes Narcan[7] so that family and friends can get it for emergencies
- CHR has a food pantry
- There is a new Soboxone[8] program

- **Staff concerns about program:**
  - Some surveys administered are not consumer-friendly; staff must sit with people to help them complete these surveys
  - Some staff expressed that it would be helpful to have navigation help as new staff, or an orientation program. They shared that the caseload is high but they need time to acclimate, and that it would be helpful for new staff to shadow another therapist to learn on the job.

- **Work with special populations:**
  - 2 bilingual therapists; the supervisor is bilingual
  - There's a Young Adult ACT team: YACT – offers wraparound services

- **Staff Professional Development:**
  - Training is useful for some and not others;
  - Training on therapy techniques is not consistent;
  - Staff don't get training on Cognitive Behavioral Therapy (CBT)[9], Dialectical Behavior Therapy (DBT)[10], or the Wellness Recovery Action Plan (WRAP)[11] – staff expressed that it would be helpful to do more training on these topics from outside agencies that specialize in these trainings rather than in-house at CHR.
  - People want more practice and in-depth trainings – they only get 2 hours at CHR, or 2 non-CHR trainings that they need to pay for.

- **Grievance Policy:**
  - Staff shared that people served by the program are given the grievance policy at intake

### *RECOMMENDATIONS:*

- Post a grievance policy in office clearly visible to clients and give a copy to those first-timers.
- Implement a Young Adult Services Program which includes autism spectrum disorders.
- Assist surrounding towns in providing transportation for clients.
- Work to provide access to intermediate and longer-term hospitalization.
- Continue to work on homelessness, shelter space and affordable housing.
- Recruit bilingual/bicultural clinic providers.

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[7] Narcan™ (naloxone) is an opiate antidote. Opioids include heroin and prescription pain pills like morphine, codeine, oxycodone, methadone and Vicodin. When a person is overdosing on an opioid, breathing can slow down or stop and it can very hard to wake them from this state. Narcan™ (naloxone) is a prescription medicine that blocks the effects of opioids and reverses an overdose. It cannot be used to get a person high. If given to a person who has not taken opioids, it will not have any effect on him or her, since there is no opioid overdose to reverse.

[3] Suboxone is used to treat narcotic (opiate) addiction.

[9] CBT is a type of talking treatment that focuses on how your thoughts, beliefs and attitudes affect your feelings and behavior, and teaches you coping skills for dealing with different problems. It combines cognitive therapy (examining the things you think) and behavior therapy (examining the things you do).

[10] Dialectical behavior therapy (DBT) is a specific type of cognitive-behavioral psychotherapy developed in the late 1980s by psychologist Marsha M. Linehan to help better treat borderline personality disorder. Since its development, it has also been used for the treatment of other kinds of mental health disorders.

[11] The Wellness Recovery Action Plan® or *WRAP*®, is a self-designed prevention and wellness process that anyone can use to get well, stay well and make their life the way they want it to be.

- Address services for home-bound middle-aged clients who are severely ill.
- Implement services to support staff impacted by client suicides.
- Implement access to community services such a jobs program or housing program available in the community.
- More and better training for staff, such as: CBT, DBT, and WRAP. Training should be free and more frequent and in-depth.
- Continue work to improve prompt access to care, especially for persons referred to CHR upon discharge from a hospital setting (3 week wait time from intake to clinician appointment).

### *PROVIDER COMMENT:*

- **Client concerns about program:**
  - *"The program is too short…"* - This is in reference to IOP. Generally, Husky will only approve 15 sessions unless the person continues to be highly symptomatic. There should be 3 hours of treatment in IOP. We will ensure that this standard is met.
  - *"Wish there was job or housing help – there's no discussion of this."* - We are not sure what program this comment pertains to. CHR contracts with WorkSource at ECHN to provide Supported Employment. Any individual who is in our services may access this service simply by expressing the desire to participate in competitive employment. Also, CHR is a leader in providing housing services. Most of those services, however, require that the person be homeless at the time they are accessing the services.

- **Staff concerns about program:**
  - *"Some surveys administered are not consumer-friendly; staff must sit with people to help them complete these surveys."* - CHR uses a consumer survey form that is required by our funder, DMHAS. We agree that many of the questions on this form, particularly in regards to recovery are not consumer friendly and very unclear. Consequently, CHR has gone to administering the survey with staff and peer counselors.

- **Staff Professional Development:**
  - *"Training is useful for some and not others. Training on therapy techniques is not consistent."* - CHR provides three half day trainings per year for adult staff. In addition, we provide supervision and various trainings to AOP staff. Due to turnover, some staff are always behind and we need to be better at repeating trainings to make sure new staff are trained.
  - *"Staff don't get training on CBT, DBT, WRAP… said it would be helpful to do more training on these topics from outside agencies that specialize in these trainings rather than in-house at CHR."* - CHR provided certification training in ART (Accelerated Resolution Therapy), a state-of-the-art, evidence-based trauma approach in June of this year. This training was provided by the developers of this approach. This was a three-day training.
  - *"People want more practice and in-depth trainings – they only get 2 hours at CHR, or 2 non-CHR trainings that they need to pay for."* - In addition to the above, staff are able to access outside trainings at outside agencies on a case by case basis at agency cost assuming the training is relevant to and needed for their work. CHR provides much more than 2 hours of training.

### *RECOMMENDATIONS:*

- *"Implement a Young Adult Services Program which includes autism spectrum disorders."*
  - Note that YAS funded programs specifically do not include funding for autism spectrum disorders. However, CHR does have many clients with autism spectrum disorders seeking services.
- *"Work to provide access to intermediate and longer-term hospitalization."*
  - Our clients who are in need of hospitalization frequently are in need of longer stays and are discharged before they are stable. It is extremely difficult to access intermediate and longer term

hospitalizations at this time. Because of this, community hospitals are reluctant to hold clients in their facilities while awaiting longer term beds. CHR does not control hospital beds.

- *"Recruit bilingual/bicultural clinic providers."*
    - CHR actively recruits bilingual/bicultural providers. We have created bonus incentives for new hires, rewards for staff who refer successful candidates, advertised in alternative media. We welcome any suggestions to increase our recruitment efforts.
- *"Implement access to community services such a jobs program or housing program available in the community."*
    - As noted above, Supported Employment services are readily available through WorkSource. CHR has multiple housing programs most of which are reserved for people experiencing homelessness.
- *"More and better training for staff, such as: CBT, DBT, and WRAP. Training should be free and more frequent and in-depth."*
    - See above comments about training.
- *"Continue work to improve prompt access to care, especially for persons referred to CHR upon discharge from a hospital setting (3 week wait time from intake to clinician appointment)."*
    - CHR's target for people referred from a hospitalization is same-day intake, 1 week to psychiatric evaluation.

## InterCommunity (IC) – Standard Outpatient Program for Mental Health and Addiction

***AGENCY QUESTIONNAIRE***

Program Description and Services

- **Staff: (share numbers)**
  - **Agency Administrative staff**: 7 including BHH (Behavioral Health Home) administrative assistant
  - **Peer Support Staff:** 5 peer positions (all in rehab services)
  - **People in Recovery as Staff**: While we certainly have staff who have chosen to share that they are in recovery, we do not currently keep statistics on this or identify staff as such. Given the statistics regarding trauma in the general population as well as the likelihood of people working in this field being in recovery we assume the percentage is high.
  - Agency Direct Program staff: 85
- **Location:** Outpatient Services are located at 281 and 287 Main Street East Harford, CT
- **Total Program Funding:** InterCommunity total DMHAS funding FY '16: $6,048,024
  - DMHAS funding: InterCommunity Outpatient funding FY '16: $1,530,267
  - Last Fiscal Year: InterCommunity Total DMHAS funding FY '15: $5,732,386
  - InterCommunity Outpatient funding FY'15 $1,530,267
- **Program Capacity:** The *Outpatient Psychiatric and Substance* Abuse Treatment Services (OPAS) never has a waiting list and never closes its doors. We made a commitment years ago that our mission is to serve clients in need to the best of our ability. We have created programs to support clients in active treatment while they may be waiting for assignment to a therapist as well as to meet clients where they are in terms of need for services and ability to attend consistently. Our walk-in therapy (4 days a week) in addition to our walk-in housing, entitlements and community support groups (available in English and Spanish) have supported clients in rapid access to services and in using therapy as needed when they are unable to make a commitment to weekly treatment.
  - **Active Clients** at time of review: 1199 total clients in Adult Outpatient Services, 777 clinical, 422 medication management only
  - **Hours of operation per week**: M W 8-5:30, T TH 8am -8 pm, F 8-6, and when clinical staff are available: S 8-4.
- **Number of training hours for staff:** Staff are encouraged to take 2 training days per year in the areas that are most needed to support their particular areas of focus. In addition, we periodically support staff in building particular skill sets by financially supporting them in paying for additional training and offering additional training days. In the past 8 months for example we supported 2 clinicians in obtaining intensive training in Eye Movement Desensitization and Reprocessing (EMDR)[12].
  - **Types of training offered**: Our agency meets fidelity for the evidenced-based practice of Integrated Dual Disorders Treatment and as a Trauma Informed and Gender Responsive agency. While these initiatives were active, the entire staff of InterCommunity, including non-direct care staff, was trained in these areas. We offer annual training to support new staff in understanding these important approaches to our entire environment of care. We also will offer additional trainings as needed in

[12] Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories (Shapiro, 1989a, 1989b). After successful treatment with EMDR therapy, affective distress is relieved, negative beliefs are reformulated, and physiological arousal is reduced. During EMDR therapy the client attends to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus. Therapist directed lateral eye movements are the most commonly used external stimulus but a variety of other stimuli including hand-tapping and audio stimulation are often used (Shapiro, 1991). Shapiro (1995, 2001) hypothesizes that EMDR therapy facilitates the accessing of the traumatic memory network, so that information processing is enhanced, with new associations forged between the traumatic memory and more adaptive memories or information. These new associations are thought to result in complete information processing, new learning, elimination of emotional distress, and development of cognitive insights.

clinical areas that seem pertinent to the work (examples include, DCF presentations, Motivational Interviewing, DMS5)

- **Number of Peer-Run activities:** Via our Social Rehab services we currently have 6 peer run weekly groups (i.e. women's support group, Art expression, Mental health Discussion groups) and 14 peer run activities (i.e. Community garden, Clerical Unit, Event planning, Video Productions, Grant writing)
- **Mission Statement:** "To help people improve their quality of life by providing physical and mental health services for optimum health and recovery"

## SERVICES FOR SPECIALIZED POPULATIONS

- **Persons with a co-occurring disorder**: estimate 75% of our consumers have a dual disorder.
- **Persons of different cultural backgrounds**: 50% White, 50% other ethnicities
- **Young Adults** (18-25): 11% of our consumers are young adults
- **Elderly** (55+): estimate 24 % of our client are over 55
- **Persons with a trauma history**: Given the statistics on trauma nationwide on those struggling with mental health and Alcohol and Other Drug (AOD) issues we assume that 90% of our clients have a trauma history
- **Persons with co-morbid health problems** estimate 80%

## UTILIZATION

- **Number of persons served, both duplicated and unduplicated in FY 2015**: Total services provided in adult outpatient services: 35,796 (intake assessments, medication management, individual and group therapy sessions); unduplicated clients: 3,301
- Average length of stay for FY 2015 *(as calculated by averaging the length of stay for those who have received long-term clinical support and those who have received short-term episodic treatment):*
- **How does the location of this program affect the clients?** Intercommunity is across the street from a bus line and just of the exit from Route 2. Our central location in East Hartford allows for ease of access to our services.

**PROGRAM ACTIVITIES:** (program goals, defining features of program, and description of model)
With adherence to InterCommunity's Mission, the Adult Clinical Services Department provides clinical services to consumers aged 18 and over who meet the admission criteria for the agency. Working in collaboration with our prescribers of psychiatric medications and our Assessment Center, we embrace all individuals in need of services, including special populations, providing reasonable accommodations on an individualized basis.

As an agency, Intercommunity is committed to approaching our work with each other and with our consumers from a culturally competent, trauma-informed and gender-responsive perspective which includes incorporating the core values of safety, trustworthiness, choice, collaboration and empowerment in all aspects of our care delivery system. The *Outpatient Psychiatric and Substance* Abuse Treatment Services (OPAS) strives to support the agency effort to meet the quadruple aim of improved consumer experience, better health outcomes, cost reduction, and staff wellbeing. Services are offered in Spanish and English.

We approach our clinical work with consumers from both a strengths-based and stage-based perspective. We support clients obtaining the particular services they are currently motivated to participate in, based on interest, stated wants and needs as well as strengths and abilities. We offer individualized service plans to support client growth and healing. Assessment and treatment planning in OPAS is a continuous and collaborative process between client, clinician and other InterCommunity providers (i.e. community support staff, employment specialists, prescribers, and primary care).

In an effort to meet our "quadruple aim" we offer treatment modalities and approaches when at all possible that are evidence based, gender specific and include: assessment, individual therapy, group and family therapy, Intensive Outpatient Program (IOP) and medication management. We have a strong commitment to support the professional development of the clinical staff in order to facilitate provision of a progressive system of care. Our agency

incorporates Integrated Dual Disorders Treatment (which is an Evidenced Based Practice) approach which includes a respect for clients stage of change, and which utilizes motivational enhancement therapy, and a holistic approach to the work with clients who struggle with Co-Occurring disorders. In addition, we offer other evidenced based approaches including the trauma based groups of Seeking Safety, and Men's Trauma Recovery and Empowerment Model (M-TREM)[13], EMDR, and Dialectical Behavior Therapy for the treatment of those living with Borderline Personality Disorder. Our work with clients is provided by APRNS, MDs, and masters trained clinicians (MFT, LMSW, LCSW). We also provide a learning sight for graduate students. We offer assessment, medication management, individual and group psychotherapy. Currently we are offering 28 therapy groups and 2 intensive outpatient group programs. (these are in addition to the peer run and social rehab groups noted above)

**Criteria for outpatient program referral and for discharge:**

**Admission:**

Individuals meeting all of the following criteria are eligible for admission to InterCommunity's behavioral health services:

1. Have a psychiatric disorder, substance use, or a co-occurring disorder (psychiatric and substance abuse disorder)
2. Be willing to receive services.
3. Have identified needs that can be addressed within the organization's service delivery system.

Clients are eligible for therapy and medication management regardless of their age (for OPAS must be over the age of 18) and where they reside. Their age and geographic residence may limit some of the community-based services they are eligible for, however, all our PRN walk in services are offered to anyone who is active with the agency.

**Discharge:**

Intercommunity has several kinds of discharge and outreach processes. In general, clients are discharged from a program when they have met the objectives and goals of their treatment plans. Clients are able to be open in one program and closed in another. If not active in Adult Clinical services, clients are able to have additional support via the walk in therapy groups noted above. When clients are for a variety of reasons, unable to come to therapy consistently, we make every effort to outreach/engage; however, we employ a strict policy re lack of attendance. When clients are discharged due to lack of attendance, they are encouraged to attend the walk-in therapy groups to re-engage. Routinely if clients are discharged from clinical services and have no other services in which they are engaged, we keep them open with the agency for 60 days to allow client time to re-engage via walk-in group before we discharge.

**Role in agency:** See above

**Recovery focus, health & wellness activities:** The Adult Outpatient Services works in close collaboration with Intercommunity's other programs and departments to support health and wellness activities and a focus on recovery. Common Ground, our social rehab service, offers a wide variety of recovery activities, peer run groups and activities

[13] TREM and M-TREM are fully manualized group interventions for women (TREM) and men (M-TREM) who are trauma survivors. These groups, developed with and for members of the target population at Community Connections, are interventions that address a broad range of trauma sequelae among people with severe mental disorders and/or substance abuse problems. Both use cognitive restructuring, psychoeducation, and coping skills training, weaving each of these techniques throughout the intervention, which incorporates a specific recovery topic in each weekly 75-minute session. The current version of TREM is 29 sessions long while M-TREM comprises 24 sessions. TREM groups are for women only with female co-leaders; M-TREM groups are for men and routinely have male co-leaders. Both groups are designed for 8-10 members. TREM is organized into three major parts: empowerment, trauma education, and skill-building. In the empowerment section topics focus on helping women to learn strategies for self-comfort and accurate self-monitoring as well as how to establish safe emotional and physical boundaries. In the education part, women address issues of abuse directly. Discussions cover topics of sexual, physical, emotional, and institutional abuse, and women explore and reframe the connection between abuse experiences and other current difficulties. In the skill-building part, the focus shifts more explicitly to problem-solving and skills training, as group members address communication style, decision-making, managing out-of-control feelings, and developing safer relationships. M-TREM is similarly organized but differs in the content of the three major parts. In M-TREM, the first section focuses on emotions and relationships, helping men to develop a shared emotional vocabulary and increased capacities to address relationship dynamics. The second section is similar to that of TREM, addressing emotional, physical, and sexual abuse directly. The third part of M-TREM, like TREM, centers most directly on skill-building and problem-solving but addresses different content issues in a different order than the TREM group.

and also wellness programs (including a wellness group in Spanish). We in Adult Outpatient Services incorporate the concepts of recovery and wellness into our many groups as well as our individual treatment. We also support client wellness via coordination with our behavioral health home care coordinators as well as the Community Support Team and employment services. Finally, we offer a range of "as needed" or Part-time Recovery Nurse (PRN) groups. These are groups clients can access as needed to support periodic need without having to re-engage in assigned treatment or case management. Examples include weekly walk-in therapy 4 times a week, walk-in entitlement, employment and case management group as well as both Latino walk-in therapy and Latino walk-in rehab group.

**Utilization of Culturally and Linguistically Appropriate Services (CLAS) standards and/or co-occurring program models:** See above for Co-Occurring models. Intercommunity has a cultural competency committee and policies addressing cultural competence. We have always met client needs for preferred language either with bilingual staff we have employed and/or with use of the language line. Based on the number of Spanish speaking clients who come to InterCommunity, we have always employed some Spanish Speaking clinical staff. Recently we were able to create an actual Latino Program to better support culturally appropriate service to this population. The Latino program, part of our Adult Clinical Services offers specific assessment times for our Latino clients, in addition to the aforementioned Spanish Speaking walk in group, and a group to support those living with anxiety and depression. In March we will add a Spanish Speaking group for Co-Occurring Disorders. We are excited to be expanding our services to our Spanish Speaking clients as we are able. We currently have 28 Spanish Speaking staff agency wide (Billing, ACT, OPAS, CST, BHH, Primary Care, Children's Clinic and administrative supports).

**Outcome measures employed:** We have used various outcome measures for groups and individual treatment such as Beck Depression Inventory (BDI)[14] scores, PTSD screens, and updates of the Mini Mental Health and CAGE scoring tools. We also use the DMHAS Client Satisfaction. We also have used the Trauma and Gender (TAG) fidelity scoring tools to look at client and staff assessment of the TAG core values. We do not at this time employ a universal outcome measure as our Electronic Care Record (ECR) does not allow for a useful tool.

## PROGRAM ACCESS & DISCHARGE

- **Criteria for outpatient program referral and for discharge**: please see below
- **The average length of time elapsing between receipt of referral and admission to the program**: We employ same day access so clients are offered an assessment and assigned to the appropriate service the same day they call or walk in. Clients are able to access clinical services within a week of the intake if entering a group or using the walk-in group; individual therapy may take 2-3 weeks. However the walk-in group is available within a week for support while awaiting the first individual therapy appointment,
- **Barriers to admission include:** There really are no barriers.
- **Describe any community integration of the program**: Intercommunity is strongly engaged in the greater East Hartford and surrounding towns' services. Our assessment center has developed extremely effective relationships with all area police departments and first responders as well as local towns' services and medical practices. We have regular meetings with the local hospital Emergency Departments and the other local crisis services to coordinate care.

## PLANS FOR CHANGE OR CHANGES ANTICIPATED:

- **Please describe changes you implemented or plan to implement in response to DMHAS goals for a recovery-oriented system**. (see above summary)

[14] The **Beck Depression Inventory** (**BDI**, **BDI-1A**, **BDI-II**), created by Aaron T. Beck, is a 21-question multiple-choice self-report inventory, one of the most widely used psychometric tests for measuring the severity of depression. Its development marked a shift among mental health professionals, who had until then, viewed depression from a psychodynamic perspective, instead of it being rooted in the patient's own thoughts. In its current version, the BDI-II is designed for individuals aged 13 and over, and is composed of items relating to symptoms of depression such as hopelessness and irritability, cognitions such as guilt or feelings of being punished, as well as physical symptoms such as fatigue, weight loss, and lack of interest in sex.

- **Please describe barriers, challenges, tensions, differences in philosophy, system issues, or obstacles that need to be addressed.**
    - An ongoing obstacle is our lack of space and the challenges involved in our ever expanding locations. We are a growing agency and continuously add programs to support consumer recovery and need. Space evaluation and adjustment is an ongoing discussion and the impact of the changes is addressed in our management team and TAG committees regularly. We listen intently to the feedback of consumers and staff re the impact of the change and diligently work hard to make improvements, if we are able. If there are negative consequences to a change we make, we will work to rectify it. We are a nimble agency. This also helps us respond quickly to the continuing issue of DMHAS budget challenges. Our attention to the quadruple aim mentioned earlier has us always focused on balancing quality client care and staff satisfaction with work practices that are effective and efficient. We employ dedicated staff who work hard, and we employ systems that support effective use of time, high productivity standards, and ability to bill for the majority of our services. Some examples of this are: long-standing use of concurrent documentation, strict attendance policy and outreach practices to reduce the no-show rate, and creative staffing practices.

## INTERCOMMUNITY FOCUS GROUP HIGHLIGHTS:

InterCommunity (IC) was a place with a clear integration of physical and behavioral healthcare. The holistic approach was noted and appreciated by the review team. The staff seemed to have a compassionate approach and the agency seemed client directed and person-centered.

The grievance policy was posted but many on the review team could not find it.

Some Review and Evaluation (R&E) members noted that the chairs in the waiting room were stuck together, and wondered whether that fit into the "trauma-informed" model that IC espoused. Others noted that IC recently merged with Alcohol and Drug Recovery Center (ADRC) and wondered how the process was going. Finally, the review team thought the discharge plan seemed vague. The current plan seemed to be sending a letter to people served by the program and leaving it up to the person in recovery to follow up. Some reviewers wondered whether this follow-up is sufficient.

How much individual vs. group therapy is offered? Where are outpatient services in the continuum of care?

### FEEDBACK FROM PEOPLE IN RECOVERY:

- **Ways this program has been helpful to people served by the program:**
  - It is convenient to get meds and all doctors' appointments in one place – "one stop shop": one client said "I get my meds, therapist, and caseworker here – they helped me get my own apartment; they are so responsive and great listeners."
  - People served by the program feel an affinity with staff and each other: "I found a place to belong"; "it's reaffirming to hear everyone has the same experiences"; "this is a lifeline!"; "staff in this program really care"
    - During the client focus group, people were helping each other by sharing resources about transportation. Great community focus and positive helping tone set by program
  - The groups and programs discuss trauma, co-occurring issues, and are "grounding" – Common Ground, the clubhouse, is helpful to recovery outside of groups: "I come here to breathe"
  - People feel that therapists respect their wishes: "they were like angels to me!"; "without IC I wouldn't be alive." People served by the program agree that therapists go above and beyond to help them – being flexible with schedules and accommodating to needs and offering help with transportation
  - People loved the Intensive Outpatient Program (IOP) – agreement that they learned a lot and want to continue the program
  - Length of stay in therapy or groups is unlimited and people feel they can always come back – some people expressed that other programs may discharge them before they are ready, but InterCommunity lets them stay for as long as they need
  - Location is convenient and on the bus routes

- **Client concerns about program:**
  - When the clubhouse Common Ground was in the same building, it was easier to welcome new people served by the program into the clubhouse; there were more movies and more evening activities in the past at the clubhouse but now those activities are limited. It was also easier to go from the clubhouse to therapy
  - Some people wanted the Intensive Outpatient Program (IOP) to be longer; others wanted more groups and more open hours
  - People served by the program wish IC had a van to pick them up to go to the clubhouse, or to help with transportation from home

- **Cultural awareness of program:**
  - People feel that their cultural differences are respected

- **Grievance Policy:**
    - Shared at intake; the Intensive Outpatient Program (IOP) program has clear instructions about where to go and what to do for grievance procedures; most people agree there are no program problems so no need to complain

FEEDBACK FROM STAFF:

- **Special aspects about program:**
    - With primary care offered at the main location, IC is a "one stop shop"
    - Assessment center supports other departments; IC is expanding to provide more services
    - Open Hours allow people to use IC services until case manager becomes available
    - There are bilingual and Spanish case managers; staff who helps integrate people into the community, and a care coordinator
    - Flexible and responsive curriculum, caters to population of people served by the program
    - Can accommodate patients with Medicare even though some IC services are not covered

- **Staff concerns about program:**
    - Medicare doesn't pay for Intensive Outpatient level of care that is needed; no Intensive Outpatient Program (IOP) in Spanish
    - People who are discharged from individual therapy can come back for programs, but being discharged from the program means they have to complete the entire intake again
    - People served by the program have to take initiative to follow up after discharge; current staff follow-up is a letter

- **Work with special populations:**
    - IC has a young adult group; Spanish speaking people served by the program; over 50% people served by the program have co-occurring issues

- **Staff Professional Development:**
    - Can ask for whatever training is needed; all training is voluntary and suggested by supervisors; agency requires general online training (OSHA, safety, emergency preparation); once a month all-providers' meeting
    - Supervision is weekly; helpful to Latino staff – it's a time to discuss difficult cases; there is an open door policy if staff want more supervision; new employees find supervisors helpful
    - Administration seems to support professional development – will always give permission to staff who ask for more training

- **Grievance Policy:**
    - Policy is in the handbook and is reviewed briefly at intake; supposedly it's on everyone's door (the review team had trouble finding it); staff reassures people served by the program it's okay to have grievances

### *RECOMMENDATIONS:*

- **Help people served by the program with transportation between clubhouse and main building:** Since the clubhouse moved to a separate building, there has been a drop in people served by the program utilizing the clubhouse. People in recovery report that it is an extra journey to get from the main clinic to the clubhouse and vice versa. Many do not get free bus passes, and some cannot walk over a mile down Main Street to access the clubhouse. People want better accessibility to the clubhouse.
- **Implement more comprehensive follow up after discharge:** Perhaps follow up with a phone call as well as a letter, in case people do not regularly get mail. Offer opportunities for people in recovery to check back with therapists or with the agency if needed.

- **Make grievance policy more accessible:** Make it easy for people to find the grievance policy. Given the diversity of the people served by the program, consider sharing the policy in Spanish and/or in other appropriate languages. Ensure that all people served by the program are well informed about the grievance policy in verbal and written forms.

### *PROVIDER COMMENT:*

Reviews and audits always offer a wonderful opportunity to both look at our accomplishments and successes as well as to see areas where there is need for adjustment and improvement. The recent RMBH review offered us a good opportunity to again hear client and staff feedback, as well as the comments and suggestions from the review board members and representatives. We appreciate the detailed nature of the report and will incorporate this feedback into our future planning as we are able.

Clarification regarding group vs. individual treatment in Adult Outpatient service:

There was a question regarding how much individual vs. group therapy is offered. Clients are assessed for services at intake and an outpatient treatment disposition is based on matching the appropriate kind of treatment given the individual client presentation of problem and need as well as client preferences, stage of change, and availability with present service options. We offer individual (includes family) and group treatment. Client may be seen in group therapy, individual therapy or both. In FY 2016, 57% of our services were individually-based and 43% were group. The scope of groups includes on average 30 outpatient groups running weekly and 2 gender responsive IOP programs. 80% of our outpatient groups are gender specific and responsive. Groups are in held in Spanish and English. The focus of groups include DBT, Trauma, Anger Management, Anxiety and Depression, Severe and Prolonged Mental Illness, and stage-based COD (co-occurring disorders) groups including psycho-education and motivation group (for those who are pre- contemplative), Early Recovery, and Active Recovery.

Recommendation Comments:

1. Discharge Process: While we will continue to review the impact of our discharge practices on client care and well-being, we offer the following clarification regarding our discharge and outreach policy and process. There appears to have been some confusion regarding our discharge process (specifically: clients are not simply sent a one-time letter, and once discharged from the program, clients do not require a full intake to come back). We actually offer significant opportunities for outreach and engagement.

    a. Clients engaged in services in InterComunity's Adult Outpatient Clinic can be in multiple programs within the agency, or can be engaged in one program (i.e. OP, CSP, Vocational, Medication Management, Social Rehab, etc.) Clients who meet their goals and objectives in any of these programs are discharged from the program (which is a planned process with the client input), but the client's case can remain open in any other InterCommunity program. Clients who have completed all their goals in all programs will be discharged from the agency with information offered regarding how to re-engage via our open access intake process should the need arise in the future for additionally needed services.
    b. For those clients who do not engage or drop out mid-treatment, the following efforts are made to support engagement and re-engagement:
        a. Client signs a letter of understanding of our attendance policy at first outpatient session to be sure they are informed of our policy and also how to access services again *without the need for a new intake.*
        b. Clients who do not show for appointments are called by clinician during that appointment and are called for groups by clinician or designees to support outreach and engagement and another appointment. (letter is sent if client has no phone)
        c. If outreach noted above is not successful and client does not engage (having not shown for > 2 appointments and or having had no contact or response to outreach in > 30 days), client is

sent a letter offering our walk-in therapy groups (which meet 5x a week) to support re-engagement.

i. This offer is available as long the client is engaged in some are of our broad offerings of services (i.e.: Rehab, Vocational, Medication Management, etc.). The providers in these other departments offer support to client to re-engage in therapy.
ii. If the client is not engaged in other services than OP, the client's case is held open for 60 days to allow time for engagement before all agency discharge is completed. This discharge, unlike the others noted above, does require the client complete an intake on return, but it is the exception rather than the rule that clients have no other connection to Intercommunity Services and have an all-agency discharge.
    1. Letter is sent with information regarding how to access services via same day open access.

d. Given the above clarification, it is noted that client is often offered at least 2-4 phone outreach calls, in addition to letters, and may also receive verbal encouragement from other providers (such as case managers or prescribers), before we would move to an all-agency discharge.

2. Grievance Policy: We are reposting the grievance policy and process in multiple locations in both Spanish and English.

## Community Health Resources (CHR): Enfield

***AGENCY QUESTIONNAIRE***

Program Description and Services

- **Staff: (share numbers)**
  - Agency Administrative staff: Two Clinical Program Directors, Service Director who oversees most agency clinics
  - Peer Support Staff: 0
  - People in Recovery as Staff: unknown
  - Agency Direct Program staff: 23.4 FTE
- **Location:** 587 East Middle Turnpike, Enfield/Bloomfield
- **Total Program Funding:** 3,385,155 budgeted
  - DMHAS funding: 1,209,403
  - Last Fiscal Year: 1,434,004
- **Program Capacity:**
  - Active Clients at time of review: 2992 clients
  - Hours of operation per week: M – Th 8AM-8PM, F 8AM-5PM, Sat 9AM-11PM
- **Number of training hours for staff:** Varies by staff. In addition to CHR sponsored training, staff are eligible to attend DMHAS and other trainings. CHR sponsored training is 9-12 hours annually plus supervision.
  - Types of training offered: In addition to required annual trainings (e.g., fire safety etc.,), CHR provides training annually. This training year (Sept to Aug, 2015-2016), training topics include Integrated Care, Risk Assessment, Self-care, Vicarious trauma, Substance Abuse, and Cultural Diversity. These are required trainings. All new staff at CHR are introduced to the concepts of Trauma-sensitive and Gender-responsive Principles, and Integrated Dual Disorder Treatment.
- **Number of Peer-Run activities:** Hearing Voices Self-Help Group, Dual Recovery Anonymous. Many clients also use the CHR Clubhouse as well. Identified individuals also utilize BHH Wellness groups.
- **Mission Statement:** The mission of the Adult Outpatient Program of Community Health Resources is to provide a range of outpatient counseling, psychiatric and substance abuse services in a timely manner to residents north and east of Hartford, Connecticut who are experiencing mental disorders, substance abuse disorders and life adjustment difficulties. The purpose of the service is to assist clients in reducing symptoms and distress; help clients to understand, manage and cope with their illness and distress; to promote productive life choices and ways to manage stresses. It is the goal of the program to facilitate the client's highest possible level of functioning in the least restrictive environment possible, in each aspect of their life – with self/family, friends/work/school/community. Staff works with clients to assist them in utilizing and becoming involved with natural community supports and their recovery.

**SERVICES FOR SPECIALIZED POPULATIONS:**

- Persons with a co-occurring disorder: 1165 identified individuals. CHR assesses both mental health and substance use disorders at each intake. Clients with Co-Occurring Disorders can participate in Intensive Outpatient Program (IOP), individual, family, and group therapy. All substance use and co-occurring therapy groups are stage-based and available for people from Pre-contemplative/Contemplative (New Beginnings Group) to Action (Relapse Prevention) stages of change. There is a specific relapse prevention group in the Enfield/Bloomfield Clinic for people with severe mental illness and substance abuse. All other treatments are Co-occurring Competent and use the Living In Balance Co-Occurring Curriculum to supplement the substance focused Living in Balance. No clients are declined services due to substance use in the Outpatient Program. Clients whose mental illness symptoms prohibit benefitting from standard IOP SA programming can participate in the newly developed IOP Plus program that is more flexible and relies upon therapies geared toward the needs of the individuals in the program. Clients actively using continue to receive medication

management for mental illness in the Enfield/Bloomfield Clinic. The Enfield/Bloomfield Clinic has initiated Suboxone treatment over the past year and currently serves 24 people in this program.

- Persons of different cultural backgrounds: 686 identified individuals. The Enfield/Bloomfield Adult Outpatient Program (AOP) employs one bicultural and bilingual Spanish speaking staff at this time. Staff members are receiving training this year on cultural diversity, in addition to the annual training on this topic.
- Young Adults (18-25): 546 identified individuals. While we treat clients in this age group in the outpatient clinic, we do not have specialized programming. There is a need for this and we have spoken about it. We do make referrals from the outpatient clinic to specialized Young Adult Teams at the agency. Among young adults, we have noticed an increase in referrals of people diagnosed with autism spectrum disorders who have greater needs than can be addressed on DMHAS programming and who do not have the functional and documented impairment to DDS care.
- Elderly (55+): 767 identified individuals. We do not have specialized programs to treat the elderly. We have, however, developed a close working relationship with CCCI who provides care coordination for elderly clients.
- Persons with a trauma history: 602 identified individuals. Over the past two years, CHR has dedicated considerable focus on being a trauma-sensitive agency for clients and staff alike. In the Manchester Adult Outpatient Program (AOP), we have trauma sensitive treatment for men and women, specialized group programming, gender specific Intensive Outpatient Program (IOP), and group therapy. We use the Seeking Safety Curriculum, DBT, and Helping Women/Men Recover. Trauma and its aftermath is assessed at every intake and is routinely considered in interventions with clients.
- Persons with co-morbid health problems: 974 identified individuals. The AOP has a close working relationship with the behavioral health home at CHR which provides intensive care coordination for people with mental illness and medical conditions. We are in the beginning stages of integrated care, but efforts are underway.

**UTILIZATION:**

- Number of persons served, both duplicated and unduplicated in FY 2015: 3,502 Unduplicated / 3,837 Duplicated
- Average length of stay for FY 2015 *(as calculated by averaging the length of stay for those who have received long-term clinical support and those who have received short-term episodic treatment):* 2.93 years
- How does the location of this program affect the clients? CHR Enfield location is located on the recently developed Magic Carpet bus line provided by the Town of Enfield. This bus line is limited but is helpful to the clients of Enfield. Our Bloomfield site is close to the center of Bloomfield and also on a bus line. CHR does serve towns in surrounding communities that are not accessible by bus. Our clients are largely dependent on LogistiCare or their own means which can makes attendance difficult.

**PROGRAM ACTIVITIES:** (program goals, defining features of program, and description of model)
CHR Adult Outpatient Program (AOP) programs use a number of evidence-based practices in treatment for trauma, substance use, mood disorders, gender-responsive care, and anger management. Treatment is provided in varying levels of intensity dependent upon client needs. We have 5 Intensive Outpatient Program (IOP) programs, multiple group therapies, individual, and family therapy. We offer a bi weekly Family Matters support group open to any family member of persons with mental illness and/or substance use. We offer medication management and psychiatric evaluations. CHR provides open access, same-day intake assessments and urgent care for existing clients who need to be seen immediately.

**Role in agency**
The outpatient clinic provides initial assessments and triage for the vast majority of clients who are admitted to the agency. The AOP clinic staffs hosts service-wide treatment team meetings, case conferences, and performs client evaluations for all other adult division programs as needed. Most clients in all CHR programs receive at least medication management at the outpatient clinic. The outpatient clinics coordinate closely with all other funded LMHA services including CSP, Employment Services, Mobile Crisis Response Team (MCRT), Clubhouses, Respite, Residential programs etc. Together these make up an integrated service system.

**Recovery focus, health & wellness activities**
In the outpatient clinic, recovery treatment plans are completed with the client and are focused on the goals of the client. Staff members are versed in the recovery model, person-centered care, and the stages of change. Within the clinic, staffed by the center for health and wellness and behavioral health home, are group education programs addressing smoking cessation, nutrition, exercise, and engagement in primary and medical care. The focus of AOP treatment is recovery and healthy living

**Utilization of Culturally and Linguistically Appropriate Services (CLAS) standards and/or co-occurring program models**
The Adult Outpatient Program (AOP) at CHR use the IDDT model of care providing stage-based groups and harm reduction, including not limiting services or discontinuing services in response to a clients' substance use. We use motivational interviewing and persuasion groups. The Enfield/Bloomfield AOP clinic provides services that are culturally and linguistically appropriate for Latino community. We have therapists, care coordinator staff, reception staff, and medical records staff who are bilingual and bicultural. CHR provides a language line to permit interpretation in nearly all languages on the spot. However, we are limited to individual therapy for monolingual Spanish speaking clients, which is a limitation for those needing Intensive Outpatient Program (IOP) or group treatment.

**Outcome measures employed**
The adult outpatient program uses the Brief Psychiatric Rating Scale as its outcome measure. This has been in place over the last 6 months. Per DMHAS we also use the MGAF. We also collect outcome data on employment, housing status, substances used in the last 30 days, self-help used in last 30 days and other indicators

**PROGRAM ACCESS & DISCHARGE:**

- Criteria for outpatient program referral and for discharge The Adult Outpatient Program treats all individuals with the exception of clients in DDS group homes or skilled nursing facilities. We do not decline to service clients based on severity of illness or substance dependency. The outpatient program is a time-unlimited treatment and most discharges occur when clients themselves disengage.
- The average length of time elapsing between receipt of referral and admission to the program is:

The clinic invites people to intake same day or next day. On average individuals attend an intake appointment within 2.2 business days.

- Barriers to admission include: Barriers to admission include transportation, homelessness, and people in pre-engaged stage of treatment who do not come for a first appointment. Periodically, clients need to wait at the clinic to be seen for intake or first psychiatric evaluation as part of the open access model and this can be hard for some people.
- Describe any community integration of the program: Staff from CHR Enfield/Bloomfield Adult Outpatient Program (AOP) attend regular meetings with the local hospital, VNA and other CHR staff who provide rehabilitation on the community. The Enfield/Bloomfield clinic provides community groups for families of the mentally ill and a support group is run in the nearby community: Hearing Voices. The outpatient clinic houses a pharmacy. We have periodic meetings with the police department and department of social services to coordinate services. We are connected to the local court via our Jail Diversion program. Staff have participated in a variety of community programs including Healthy Enfield and are looking forward to participating in the North Central Opioid Addiction Task Force.

**PLANS FOR CHANGE OR CHANGES ANTICIPATED:**

- Please describe changes you implemented or plan to implement in response to DMHAS goals for a recovery-oriented system.

CHR outpatient program uses collaborative documentation and person-centered care. We have implemented an open access and urgent care clinic so that clients can use the service as needed. Outpatient therapists regularly make referrals for employment services, transportation assistance, housing assistance, and outpatient rehabilitation programming to assist clients to meet their goals. Outpatient treatment is time-unlimited and offers a diversity of

programming to address client choice. The outpatient clinic has been utilizing peers in the waiting area as greeters to assist and support clients.

- Please describe barriers, challenges, tensions, differences in philosophy, system issues, or obstacles that need to be addressed.
  - Transportation
  - There are significant limitations related to strict rules limiting the credentials of individuals who can assess and write commitment papers for clients at risk. In the clinic, that is psychologists and psychiatrists only.
  - It is a serious issue that there are no identified providers for young adults with developmental disabilities who are not eligible for DDS services or DMHAS grant-funded services because autism spectrum disorders are not classified as severe and persistent mental illnesses. Consequently, there is insufficient training of staff and resources for rehabilitation.
  - Access to intermediate and longer term hospitalization is problematic.
  - Lack of homeless shelter space and affordable housing.
  - Problems with recruiting bilingual and/or bicultural clinic providers.
  - Lack of residential treatment programs for clients with very serious symptoms.
  - There is a big gap in services for middle-aged, severely ill clients who have lived with their parents all their lives when the parents reach an age that they are no longer able to adequately respond to the clients' needs.
  - Increase in opiate addiction and overdoses.
  - Increase in suicides and its impact on staff members who are exposed to these losses. It would be nice if there was an initiative to address this and support the staff.
  - Cuts to DMHAS funding

## CHR-ENFIELD FOCUS GROUP HIGHLIGHTS:

At CHR-Enfield, NCRMHB met with a small group of high-needs people served by the program. They were in different places in their recovery so provided a range of perspectives about the Intensive Outpatient Program and the Standard Outpatient Program groups. NCRMHB also met with a group of staff. The Review Team was concerned that there was an atmosphere where people felt reluctant to talk. We did not encounter such hesitance to discuss agency issues in other agency settings, and wondered how CHR could develop a more convivial atmosphere. There was some discussion that required prodding and careful facilitation to get staff to open up about issues ranging from diversity, cultural awareness, and unequal caseloads.

Some positives about the program:

- Medical renewals are done at CHR – people served by the program do not have to go elsewhere.
- CHR-Enfield plans to open a new methadone program in 6 months.
- Staff plans to add new groups to the program and new staff so they can see more people served by the program.

Some concerns about the program:

- The staff seemed reluctant to share their perspectives in the focus group. No other agency we reviewed had such hesitance in discussing their programs. Perhaps this group was unusually shy but we were concerned the culture of the agency impacted staff's interest in open dialogue.
- Cultural awareness was an issue that came up. Some staff seemed to think that Enfield lacked diversity and that's why there weren't more culturally diverse people served by the program; after some discussion, one staff spoke up and shared that perhaps lack of diversity on staff resulted in lack of culturally diverse people served by the program.
- CHR does not seem connected to other agencies.
- The number of therapy sessions for Intensive Outpatient Program (IOP) (6-8) seemed low, but this is dictated by insurance companies.
- It seems like staff want more training but most training is only offered online and is cookie cutter. The training seemed to lack depth and diversity.
- The Review and Evaluation (R&E) Team did not see the grievance policy posted.

### FEEDBACK FROM PEOPLE IN RECOVERY:

- **Ways this program has been helpful to people served by the program:**
  - Helped with finding an apartment
  - Shorter wait time to get into Intensive Outpatient Program (IOP) than at other agencies
  - Focus groups are based on people served by the program' needs; group leader has good questions and good ideas; groups help people relate to one another
  - Help people gain confidence

- **Client concerns about program:**
  - Most people talked about how the IOP program is too short at 3-4 weeks; it seems that the program length is determined by insurance, and cannot be extended without extenuating circumstances during the final days of the program.
  - Want case managers to help with other issues

- **Cultural awareness of program:**
  - People in recovery agreed that cultural differences were respected

- **Grievance Policy:**
  - Everyone is given a grievance policy to sign before treatment begins
  - People feel comfortable talking to the supervisor or group leader with any grievances

FEEDBACK FROM STAFF:

- **Special aspects about program:**
  - Urgent care isn't advertised but the Open Access therapy, including 2 sessions of emergency treatment, are available
  - Coordinated efforts help keep people out of the hospitals
  - CHR is like family – it's consistent support in people's lives
  - All groups are co-occurring

- **Staff concerns about program:**
  - Some staff shared that issues of diversity can affect quality of care. Other staff felt that CHR did not have diverse people served by the program. It is unclear whether this is because the staff diversity does not reflect the community, or whether there are few people from diverse backgrounds in the area. One staff felt there were few Spanish speaking people served by the program because the transportation to CHR was an issue.
  - The program evaluation component could be stronger. There are Likert scale evaluations administered every once in a while and therapists informally solicit feedback from people served by the program in groups, but no formal or comprehensive surveys other than the DMHAS Annual Satisfaction Survey exist.

- **Work with special populations:**
  - Staff discussed how language was a problem for some people they serve and shared that the language line was not enough help sometimes. Perhaps bilingual staff is needed.
  - There are no youth-specific programs

- **Staff Professional Development:**
  - Can do as many online trainings as desired
  - No budget for training outside of the agency; limited to in-house training
  - Trainings do not reflect diverse interventions and issues that come up; trainings are very narrow in focus or limited to what insurance wants to cover
  - Staff get unpaid time off to pursue professional development, and are paid 1-2 days for training per year. Some staff are told that training "interferes with productivity" and that they ought to "do (unpaid) training from home."

- **Grievance Policy:**
  - Staff share that people served by the program sign a grievance policy during intakes

### *RECOMMENDATIONS:*

- **Hire bilingual staff/more diverse clinicians:** When asked about working with people from different cultural backgrounds, a staff said "cultural considerations fall second to symptoms of recovery." The R&E team was not sure what was meant by this but hope all CHR staff understand the importance of culture in people's recovery efforts. Having diverse staff at the agency will help attract a diversity of people served by the program and ease people's concerns.
- **Provide and pay for better training:** Staff value professional development and do not seem to feel supported to pursue training. Since there is no upward career path and CHR salaries are perceived by staff to be lower than other agencies, the paucity of training and professional development opportunities may contribute to high staff turnover at CHR. In the group we spoke with, seven out of ten therapists were recently hired in the last year to replace staff who left.
- **Develop agency surveys:** Give feedback to staff and help people served by the program feel their opinion is valued. Currently it seems that no feedback mechanism exists. Staff talked about how programs that fund

CHR administer surveys, but staff admit these programs want to look good so the results may not reflect what is going on.

- **Initiate a Young Adult outpatient services program:** Young people are most at risk for mental health and addiction concerns. Enfield has a high incidence of issues related to young adults and addiction. It is surprising that CHR does not have outpatient services specifically geared to address these issues.

### *PROVIDER COMMENT:*

- In response to the concern about how "staff seemed reluctant to share their perspectives in the focus group" – CHR responded, "This was reviewed with the CHR agency leadership who report that they are working with the staff to address the work culture at this site. They are working to restructure staff meeting, and are actively addressing specific issues both within staff meeting and in individual supervision."
- Regarding our concerns about cultural awareness, CHR said they "actively work to hire a diversity of staff but it is difficult to find minority applicants." Moreover, CHR's HR Department is "actively exploring alternative methods of recruiting and reaching out to a diversity of potential applicants."
- In terms of CHR's connection to the community, CHR reassures us that "The Enfield clinic works actively with a broad array of service both provided by CHR and those in the community provided by other agencies. This includes actively working with client medical providers."
- When asked about how the number of therapy sessions for Intensive Outpatient Program (IOP) seemed low (6 to 8 sessions), CHR responded, "The typical length of stay for IOP in Enfield is 12 to 15 sessions." Perhaps the information we gathered from clients was inaccurate.
- In response to our observation that staff want more training but said that most training is only offered online and is cookie cutter, CHR said, "CHR offers a full training program including three half days of training for adult services annually. In addition, trainings on specific topics relevant to the work of the AOP are offered as needed. CHR recently sponsored and paid for a three-day training for staff on trauma specific therapy where staff had the opportunity to be trained in a cutting edge evidence based treatment approach. In the past, staff had the opportunity to attend trainings offered by DMHAS, however, these are no longer offered."

## Hartford Hospital's Institute of Living (IOL): West Grad Outpatient Program

*(Also serves CAC 23)*

***AGENCY QUESTIONNAIRE***

Program Description and Services

- **Staff: (share numbers)**
  - Agency Administrative staff: 2
  - Peer Support Staff: none currently
  - People in Recovery as Staff: Unknown
  - Agency Direct Program staff: 8 Adult Outpatient Program Clinic (AOPC) Staff, 10 IOL Residents
- **Location:**400 Washington St/West Grad Building
- **Total Program Funding:** $588,642
  - DMHAS funding: $205,233
  - Last Fiscal Year: $205,233
- **Program Capacity:** 600 + patients
  - Active Clients at time of review: 350 – 400 DMHAS Clients
  - Hours of operation per week: 8 am – 4:30 pm M – F
- **Number of training hours for staff:** 1:15 hrs./wk. IOL Grand Rounds
  - Types of training offered: CPR, CPI, CBT, Family Therapy class, etc.
- **Number of Peer-Run activities:** none currently
- **Mission Statement:** To serve Mental Health Needs, especially medication management for an outpatient population

**SERVICES FOR SPECIALIZED POPULATIONS**

- Persons with a co-occurring disorder: _IOL Dual Diagnosis Intensive Outpatient Program (IOP)
- Persons of different cultural backgrounds: _All Programs
- Young Adults (18-25):_IOL YAS
- Elderly (55+):_IOL Geri Day treatment
- Persons with a trauma history: _IOL ADTC or IOL DBT Program
- Persons with co-morbid health problems: _All programs and group at YAS

**UTILIZATION**

- Number of persons served, both duplicated and unduplicated in FY 2015: 350 – 400
- Average length of stay for FY 2015 *(as calculated by averaging the length of stay for those who have received long-term clinical support and those who have received short-term episodic treatment):* Clinic does ongoing treatment
- How does the location of this program affect the clients? We are on a bus line and easy access by car

**PROGRAM ACTIVITIES:** (program goals, defining features of program, and description of model)

**1.** Peripartum Program started Dec 2015 to treat the needs of women (and some men) who suffer from a peri – natal mood disorder

**2.** Resident Clinic – Third year experience in out-patient psychiatry training for IOL Psych Residents – Accepts wide variety of psychiatric illness

**3.** Adult Outpatient Clinic – outpatient medication management clinic for adults who suffer from CMI

STRONG FOCUS OF 3 PROGRAMS – is outpatient medication management

**Role in agency:** Outpatient services for IOL – currently focus is on Peripartum Program

**Recovery focus, health & wellness activities:** Recovery focus is used both with individuals who are recovering from CMI and for some individuals who suffer from dual diagnosis

**Utilization of Culturally and Linguistically Appropriate Services (CLAS) standards and/or co-occurring program models:** Bilingual front desk staff, language line and utilize interpreters when appropriate

**Outcome measures employed:** DMHAS Recovery Survey, Resident Patient Satisfaction Survey

**PROGRAM ACCESS & DISCHARGE**

- Criteria for outpatient program referral and for discharge: Adult Outpatient Program Clinic (AOPC) is closed for referrals except for PPD Program and Residency Clinic
- The average length of time elapsing between receipt of referral and admission to the program is: In PPD and Residency clinic – between 1-2 weeks
- Barriers to admission include: No slots for AOPC currently except for PPD program and Residency clinic has slots open throughout the academic year
- Describe any community integration of the program: Open to referral for patients who are considering pregnancy and may need medication. Patients who are pregnant and are suffering from a mood disorder and/or patient who are experiencing a post-partum mood disorder.

**PLANS FOR CHANGE OR CHANGES ANTICIPATED:**

- Please describe changes you implemented or plan to implement in response to DMHAS goals for a recovery-oriented system.
    - We are looking into adding peers to AOPC in 2016/17; two outpatients from West Grad are involved in patient Advisory Committee IOL
- Please describe barriers, challenges, tensions, differences in philosophy, system issues, or obstacles that need to be addressed.
    - Current Medicaid reimbursement rates make growth in AOPC general clinic unlikely

## IOL FOCUS GROUP HIGHLIGHTS:

The review group encountered an enthusiastic and committed long-term recovery group. The program is special in that it is time unlimited, and the group was the most easy-going, happy and supportive long term recovery group we met. They raved about each other, the supportive staff, and how IOL programs are life-saving and preventive. Another highlight is the new perinatal clinic which serves 60 people served by the program statewide.

### FEEDBACK FROM PEOPLE IN RECOVERY:

- **Ways this program has been helpful to people served by the program:**
  - "Even though it took me 3 years to figure out my treatment, this place never gave up on me"
  - One woman got better after her mental health diagnosis, so she was able to focus on her addiction issues knowing there was a co-occurring disorder
  - Helped people served by the program with basic needs like housing to help people stay sober – connection with South Park Inn helped provide shelter
  - Many people in the group have known each other for years, and they said they "wouldn't be alive without the group"; people felt empowered to be vocal about needs
  - Group leader makes people feel safe and connected; offer resources in the community and help people apply for disability or housing or whatever they need
  - People appreciate the random urine samples to help keep them on track
  - Everyone from the staff to the secretaries help make the environment warm and friendly; there is a lot of compassion; there is also a Patient Advisory Committee to get feedback

- **Client concerns about program:**
  - Parking can be difficult to find
  - There are not very many quality improvement questionnaires – people reported that there used to be one every six months but no longer
  - It would be nice to have more peers on staff

- **Cultural awareness of program:**
  - A person who identified as transgender shared she felt safe and welcomed at the IOL – she said a different organization turned her away
  - People felt accepted for who they are; one person was left alone in group until he was ready to engage

- **Grievance Policy:**
  - People are unclear about the grievance policy; no one knows who is the official grievance officer; another said there is a poster with a number to call, but someone wants to write a letter instead of calling to file a grievance but was not given that option.

### FEEDBACK FROM STAFF:

- **Special aspects about program:**
  - Some people have come to the IOL for decades – they are in the program for long-term recovery
  - The IOL has a clinical psychopharmacologist[15], so people served by the program can have a comprehensive med review (this is good for chronic patients with medical issues)
  - Starting to involve peers in the programming: a person-in recovery is on the Peripartum Steering Committee and she is on staff; IOL has a Patient Advisory Panel to offer peer feedback
  - Due to budget constraints, IOL chose to start the peripartum program to fit the most needs – took on 60 people statewide in the past year. This program helps the IOL specialize while expanding their offerings

[15] **Psychopharmacology** is the study of the use of medications in treating mental disorders. The complexity of this field requires continuous study in order to keep current with new advances.

- **Staff concerns about program:**
  - Patients need more Spanish-speaking clinicians – staff know that people served by the program share more in their native language and don't like the Language Line
  - Staff want to be able to accept new patients into the outpatient program, but there are not enough staff to accommodate. Current people served by the program have high needs and are in long-term recovery. Staff also want to provide more individual therapy services to people served by the program but currently there is a staff shortage.
  - It is difficult to refer people served by the program to other programs if they do not meet the level of care criteria because they are turned away
  - No further staff training on co-occurring issues than initial training
  - In the main clinic, they have not taken new patients in the program in 5 years – limited staff

- **Work with special populations:**
  - There is a new peripartum mood disorder clinic that accepts new people served by the program
  - All programs are co-occurring and people from different cultural backgrounds are welcomed
  - IOL has a young adult Intensive Outpatient Program (IOP)
  - There is staff diversity and staff will refer people served by the program to resources in the community

- **Staff Professional Development:**
  - Staff get cross-cultural training; there was a 2-day training on postpartum issues due to the new postpartum program; training matches with what staff need
  - Supervision is helpful – the emphasis is on education, because Hartford Hospital is a teaching institute
  - Staff get one week paid to attend conferences, complete training, and hotels and travel are paid; there is a professional development day as well as grand rounds every week; many generous benefits and educational opportunities

- **Grievance Policy:**
  - No official grievance officer – it is a little unclear what is the grievance policy
  - Since IOL is part of Hartford Hospital, perhaps people assume that grievances go to Hartford Hospital

### *RECOMMENDATIONS:*

- **Clarify grievance policy:** Help staff and patients understand the grievance policy and who to contact; on posted notices, provide an address or email for people to communicate in writing
- **Provide additional training on co-occurring issues:** Since the whole program addresses co-occurring issues, provide ongoing training on the topic
- **Continue to add peers on staff:** This seems like a great direction for IOL to head in! Include peers at every level of care to provide compassionate services
- **Administer more quality improvement surveys:** People served by the program noticed that IOL stopped administering these surveys. To get continual feedback, collect surveys bi-annually to understand gaps and highlight successes.

### *PROVIDER COMMENT:*

IOL staff stated: "We agree with the recommendations." Here is what IOL plans to do with our recommendations:

1) We have already asked for the DMHAS grievance policy posters and received them this week. There will be one on each floor's waiting room.

2) Additional training on dual diagnosis happens through our Grand rounds and continuing education. We are happy to provide ongoing staff meeting education on dually diagnosed patients and their treatment on an as-needed basis.

3) Program directors recently met with a member of IOL's Family Resource Center to discuss adding peers to staff. We agreed an area that would greatly benefit would be our Peripartum program and possibly in the Adult portion of our program. Also we have a great opportunity to add to peers to other parts of the IOL. Many of the patients in West Grad (as you noted) had been patients at the IOL/West Grad (or Brownstone 5th floor at H.H) for "decades." This pool of candidates could provide some stable peer representation to other departments too. We are excited about this process.

4) We do administer the DMHAS survey each year. We usually do this once yearly, in May/June. I think splitting this into a biannual process is a good suggestion.

## Community Health Affiliates (CMHA): Forensic Services Outpatient

***AGENCY QUESTIONNAIRE***

Program Description and Services

- **Staff: (share numbers)**
  - Agency Administrative staff: 53 Administrative staff
  - Peer Support Staff: 4 Peer Support Staff
  - People in Recovery as Staff: We do not collect this information.
  - Agency Direct Program staff: 258 Direct Service Staff
- **Location:** 270 John Downey Drive, New Britain, CT 06052
- **Total Program Funding:**
  - DMHAS funding: $298,968 JDW $60,000 JDFC
  - Last Fiscal Year: $298,968 JDW $60,000 JDFC
- **Program Capacity:** Our Forensic Services Programs have open admissions
  - Active Clients at time of review: 150 clients active as of 2/22/16
  - Hours of operation per week: Monday - Friday 8:00am-4:30pm
- **Number of training hours for staff:** All CMHA Clinical Staff are required to complete between 15 and 17 online courses which results in approximately 35 hours of training in our online training system. In addition to those requirements, the Forensic Services department requires all clinicians working in our clinical programs to attend a 16-hour Start Now Training (which is a clinical group curriculum), all clinicians are also required to attend trauma trainings as they become available (Seeking Safety 16 hours, TREM 16 hours, Understanding Trauma, Beyond Trauma, etc.). CMHA has committed to learning the Model of DBT and 3 Forensic Clinicians were selected and attended week 1 of the DBT intensive training in December 2015 and will be returning for a 2nd week this coming June, in addition to this they attend a weekly consultation team for ongoing training and support in the model
- **Types of training offered**: Start Now training (CBT based curriculum designed for Forensic/co-occurring population), specialized Trauma Trainings including Seeking Safety, TREM, M-TREM, DBT Intensive trainings and consultation team, Motivational Interviewing, Co-occurring trainings, etc. CMHA also utilizes an Electronic Training system which provides a range of trainings. All CMHA staff providing direct service are also required to be trained in PMT (Physical/Psychological Management Training) which is a full day initial certification and annual renewal half day training.
- **Number of Peer-Run activities:** At this time there are 9 Peer run activities operating out of 4 locations, there are also 4 Peer Recovery Support Staff who provide 1 on 1 service to many clients throughout our system.

**Mission Statement:**
CMHA is a leading provider of an integrated health and behavioral health care system for children, families and adults. By fostering improvement in the quality of life for their clients, CMHA contributes to the well-being of the communities it serves.

**SERVICES FOR SPECIALIZED POPULATIONS**

- Persons with a co-occurring disorder: Yes
- Persons of different cultural backgrounds: Yes
- Young Adults (18-25): Yes
- Elderly (55+): Yes
- Persons with a trauma history: Yes
- Persons with co-morbid health problems: Yes

**UTILIZATION**

Number of persons served, both duplicated and unduplicated in FY 2015: There were 386 clients served in FY15 for JDW and JDFC. (Duplicated count=451)

| CODE | Total |
|---|---|
| JDFC | 272 |
| JDW | 179 |
| Grand Total | 451 |

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- Average length of stay for FY 2015 *(as calculated by averaging the length of stay for those who have received long-term clinical support and those who have received short-term episodic treatment):* 21.5 months

- How does the location of this program affect the clients? There is limited bus service on this street and many clients have to walk from the intersecting streets, however, transportation is provided by CMHA for all groups and many clients utilize that service, however it is limited to groups due to limited resources.

**PROGRAM ACTIVITIES:** (program goals, defining features of program, and description of model)
The Forensic Services clinical programs provide specialized outpatient mental health, substance use and co-occurring services to people that have current or previous legal involvement. There are 5 programs in the Forensic Department at CMHA. They include Jail Diversion (JD), Jail Diversion for Women (JDW), Jail Diversion Forensic Counseling (JDFC), Connecticut Offender Reentry Program (CORP), and Multidisciplinary Team (MDT). The two outpatient programs are JDW and JDFC.

CMHA's Women's Jail Diversion program is a gender-specific treatment program for women who have trauma, substance use and/ or mental health problems and are at risk of Incarceration. The program provides group therapy, individual therapy, intensive case management, vocational services, and psychiatric services. In addition to these services the program also has limited Respite services.

JDFC provides treatment for clients who are at risk of incarceration, who have mental health problems and/or who struggle with substance abuse. This program offers group therapy, individual therapy, and psychiatric services. Clients can be referred for vocational services or case management services as well. Limited Respite services are available for individuals in this program as well.

The groups provided in the Forensic Services Department are all gender specific and include Start Now (a clinical group curriculum), Dialectical Behavioral Therapy (DBT), Matrix, Trauma, Affect Regulation, Co-occurring, Fatherhood, and others, depending on the needs of the clients. Clients typically begin the program with an intake that involves a Clinical Intake and a Psychiatric Evaluation the next day. Most clients begin in Engagement group, which is the only open group within each 6-week group cycle. Most clients are seen 2-3 times per week until they complete various program requirements and are stable enough to transition to a lower level of care. Each client's completion criteria is unique, and assessed throughout treatment by the team.

**Role in agency**
Forensic Department as described above is part of an array of services offered to adults at CMHA. Informally, it is considered a level of care between Adult Outpatient (AOP) and Adult Intensive Outpatient Program (AIOP) services due to service intensity. Legal entities in the community including New Britain court, Bristol court, Probation, Parole, and the Department of Corrections communicate primarily with the Forensic Department when mental health services or information is needed. In addition, due to the frequent co-involvement of our clients in legal issues, the Forensic Department acts as the liaison and experts to assist staff and clients throughout the CMHA organization. Please refer to the Organizational Chart for further details.

**Recovery focus, health & wellness activities**

Part of CMHA's commitment to recovery, clients' treatment can involve activities related to their overall wellbeing, as part of a more holistic approach. CMHA is a Behavioral Health Home (BHH), which is a model that integrates physical health and mental health. Although specific clients are identified by DMHAS as eligible for these services, each client is offered the same opportunities. BHH sponsored activities include Men's and Women's Health Groups, meditation, yoga, and smoking cessation.

CMHA clients are also offered membership at the Psychosocial Rehabilitation Club (PSR), Team Time. At the Club, wellness activities include Zumba, Yoga, Nutritional education/cooking, walking group, and Gardening.

In addition, there are specific wellness activities that are on site where Forensic services are provided. There is a quarterly Friends and Family event where clients are able to invite friends and family to visit, meet staff, learn about specific topics or programs, and share in refreshments. During this time, many clients also choose to share their story with the group, talk about their successes with CMHA services, and share a talent.

JDW also has funding from DMHAS for additional activities such as quarterly outings for the women, such as going to the movies, hiking, or to have a picnic. Twice annually, JDW staff organize a Resource Day. These events start with breakfast, small group presentations of community/agency resources, lunch, a craft activity, a wellness activity such as yoga, and at times, a forum for clients to share about their recovery and/or a skill/talent.

**Utilization of Culturally and Linguistically Appropriate Services (CLAS) standards and/or co-occurring program models**

Currently, CMHA is involved in the CONNECT initiative, Connecticut Network of Care Transformation (CONNECT), to evaluate and improve our practices in relation to the Culturally and Linguistically Appropriate Services (CLAS) Standards. This initiative and the Trauma-Informed and Gender-Responsive (TAG) Practice Improvement Initiative are efforts that CMHA has chosen to participate in with the intent of providing the most welcoming and current services to our clients. The agency also utilizes approved models, mostly evidenced based, for treatment and groups. Some of these co-occurring models include Dialectical Behavioral Therapy (DBT), Start Now, Matrix, Trauma Recovery and Empowerment Model (TREM), and Seeking Safety. Our Adult services are equipped with staff that are trained and comfortable working with clients that present with mental health as well as substance abuse issues. CMHA adopts a Harm Reduction model using Motivational Interviewing techniques throughout all phases of treatment. Clients are offered a treatment plan based on their unique needs that can range from case management services, individual therapy, group therapy, medication management (groups and psychiatric services) to Intensive Outpatient Therapy levels of care.

**Outcome measures employed**

CMHA administers various surveys to obtain information from our staff and clients. The DMHAS Client Satisfaction Survey is conducted annually and once results are compiled, they are evaluated and discussed among staff. In addition, the DLA-20 (and previously the GAF), were outcome measures used to determine progress of clients while in treatment.

## PROGRAM ACCESS & DISCHARGE

- Criteria for outpatient program referral and for discharge: Admission criteria for the Forensic Services Programs are as follows:
- JDW: Female age 18 or older who has criminal justice involvement and has a trauma history and has had issues with substance use at some point in their life. Majority of clients present with co-occurring Mental Health and Substance Abuse issues.
- JDFC: Adult age 18 or older who has criminal justice involvement and has a mental health and/or substance use disorder.
- The average length of time elapsing between receipt of referral and admission to the program is:
  Program goal is to schedule within 48 hours of receipt of referral, most referrals are scheduled within 1 week.
- Barriers to admission include: Level of care needs- if a client is in need of outpatient or Intensive Outpatient Program (IOP) we accommodate those needs quickly at CMHA (OP level of care we provide directly and IOP

we refer to our Winthrop Street facility). When a client is in need of residential treatment for substance use that is often difficult, however, clients are assisted to get into those levels of care from intake.

- Describe any community integration of the program: Community integration for the JDW program includes intensive case management services that happen in the community as well as in the office. The women are introduced to various resources and encouraged to become more involved with their community. Some clients have employment needs or other basic needs that require community outreach by staff as well as clients. In the JDFC program, once needs for case management are identified as significant, referrals for additional case management services within CMHA are made. There are drop in hours offered weekly on site to all Forensic outpatient clients for case management and vocational support. The importance of assisting clients to be successful in their communities is necessary to their overall recovery. Therefore, these services are not provided without that perspective in mind. Natural supports and other community services/involvement is assessed at intake and encouraged throughout all phases of treatment. For example, if a client obtains employment, CMHA tries to adjust the treatment schedule so that a client may continue to be successful with treatment (especially in the eyes of the court).

**PLANS FOR CHANGE OR CHANGES ANTICIPATED:**

- Please describe changes you implemented or plan to implement in response to DMHAS goals for a recovery-oriented system.

- CMHA is Connecticut's first Joint Commission accredited Behavioral Health Home and the DMHAS BHH services have been rolled out throughout the organization over the last year. Some of the clients served by these programs meet the BHH criteria, as a result increased efforts have been rolled out to integrate Behavioral Health and Medical health needs. This has enhanced the services provided at the organization. By working with clients on both Behavioral Health and Physical health the organization is able to take a much more comprehensive approach to client care.

- CMHA has been reviewing opportunities to increase Peer involvement at CMHA, Peer Run Double Trouble group is active at our Social Club and at one point the facilitator was a graduate of the JDW program. Organizationally, we are having ongoing discussions re: the increase of Peer Involvement to enhance our service system. In an effort to improve in this area, CMHA has been working with Advocacy Unlimited, TOIVO, and hosted a Recovery University Course late last summer.

- CMHA is also actively participating in both the Trauma-Informed And Gender-Responsive (TAG) initiative and the CONNECT initiatives (described in item 2 c) – both initiatives are assisting us in improving our services and treatment environments.

- Please describe barriers, challenges, tensions, differences in philosophy, system issues, or obstacles that need to be addressed.

One challenge to our Outpatient programs at CMHA is our Show rate for clinical appointments. CMHA has been looking at No Show data which indicates that our Show rate is right around 50% throughout our system. We have made efforts to improve in this area including the utilization of an Automatic Reminder Call system. However, this continues to be a struggle for which our system is attempting find solutions. In addition, transportation to group appointments is being offered but transportation to other appointments continues to be a reported barrier to treatment.

The need for increased immediate access to inpatient substance abuse treatment is another challenging area. The process to locate an available bed in a timely manner has been a system wide issue for our clients. Often it takes weeks or even months to access a bed despite efforts from both staff and clients.

Also immediate access for emergency shelter admissions- the 211 system for shelter intakes does not mean a client will be admitted to a shelter and often takes 2 weeks to get the initial appointment. We utilize 4 respite beds specifically for the Forensic Services population. After a 90 respite stay it is often difficult to place a client in a more permanent situation. Many clients with the Forensic Services population need housing and employment. Often times the criminal record is a barrier for both.

Despite the fact that CMHA vocational services are integrated within the Forensic teams, we continue to struggle with some clients being able to find employment due to criminal justice involvement and/or criminal records. Our Employment specialists continue to develop programming and Job Develop specifically for our clients but this has been a barrier to long term stability for many of our clients. Without employment many individuals cannot obtain or maintain housing which is another major barrier to treatment.

One final area of major concern for our organization is the ongoing State budget situation. Pending Legislative decisions, CMHA may need to take a serious look at program closures if there are cuts to funding. This would have a major impact on our local mental health system.

## CMHA FOCUS GROUP HIGHLIGHTS:

People in recovery appreciated CMHA a lot. Despite the fact that the group we met with were court-mandated to attend therapy, the clients from this review were the most cohesive, positive group of women. They were warm, supported each other, and raved about the program. There was a lot of laughter and lightness.

### FEEDBACK FROM PEOPLE IN RECOVERY:

- **Ways this program has been helpful to clients:**
  - "CMHA saved my life"; people learn to stay away from triggers: "I gain skills at CMHA."
  - "Thanks to this program, I'm not in jail and have stayed out of trouble for over 7 years."
  - Sense of community: "I was surprised at how honest I was because I was so comfortable"
  - CMHA helps with housing; the vocational program helps keep people out of jail, case managers offer food, clothes, and case management
  - One woman shared that she does not have close friends outside of the group. She feels she can be honest and doesn't feel judged when she is with the group. There is a sense of community among clients.
  - Case managers helped some of the women keep their housing and secure their finances. Case Managers help with budgeting and will hold rent payments for people. CMHA can arrange to get money directly from people's payroll and pay rent on their behalf. This motivates some to focus on their recovery rather than be overwhelmed by bills.
  - Case managers also help with advocacy – aiding people with the Department of Children and Families (DCF).

- **Client concerns about program:**
  - Buses drop people off at the end of the street so they must walk half a mile to CMHA. This can be a challenge in the winter. CMHA stated that this issue has been resolved (see Provider Comments).
  - People in recovery complained about their psychiatric care. They said they received medication that did not work, had bad reactions to medication, and wanted psychiatrists to get to know them before prescribing medication. The appointments were reported to be 5-10 minutes. These concerns were conveyed to managers during the visit and they are addressing them.

- **Cultural awareness of program:**
  - Women reported that staff is diverse and Spanish-speaking

- **Grievance Policy:**
  - None of the people in recovery who spoke with the NCRMHB review team seemed to know about the grievance policy. It is unclear why since the policy is posted in the waiting room. CMHA provided NRMHB with pictures of their 270 John Downey Drive lobby bulletin board which had the client grievance policies clearly displayed.

### FEEDBACK FROM STAFF:

- **Special aspects about program:**
  - Staff use a harm-reduction model. This means meeting people where they are at. Staff will attend court dates for moral support; many people served by the program are court-mandated to attend therapy so staff must get past the initial resistance from people served by the program – but by the end of the 8-week program some people served by the program don't want to leave.

- **Staff concerns about program:**
  - Need case managers**:** Clinical staff also serve as case managers – this is a strain on staff
  - No pharmacy on site. People served by the program use Beacon Pharmacy, which can deliver.

- Staff work to re-diagnose people with chemical dependency so they are more aware of underlying mental health issues. There is some concern that this dilutes the treatment for chemical dependency, and that this needs to be given equal weight rather than focus too much on mental health.
- Continuity of care is difficult with limited resources and lack of insurance. Program is time-limited.
- In the men's court-mandated program, case management is lacking and men do not want to go to drop-in centers; it would be easier if they can integrate clinical services and case management. There is only one case manager for the men's court-mandated program.
- All programs have to be evidence-based models (EBMs), some staff want to pick and choose aspects of different models to fit individual needs, but everything must fit into EBMs. This also means that some staff feel they are constantly collecting evidence rather than offering services. Some staff feel that the model is getting in the way of offering services people served by the program need, or "making the shoe fit".
- In supported employment programs, if people served by the program say they want to work, staff must work with them even if they are not perceived as ready, but if people served by the program cannot find employment the program loses points in the state reviews.
- Since they are using the "Start Now" model (a clinical group curriculum), there is not a lot of wiggle room to accommodate people's learning needs.
- Due to HIPAA, staff is not supposed to follow up after program discharge

- **Work with special populations:**
  - Jail diversion/court-mandated people served by the program
  - Gender-specific groups; women's group is 18-65 year olds, of different ethnicities
  - Staff understand co-occurring issues well because all people served by the program have co-occurring issues.
  - Trauma-Informed And Gender-Responsive (TAG) initiative: revamped culture of the agency to be helpful and changed furniture to make space less triggering and more welcoming

- **Staff Professional Development:**
  - 80 hours of training a year; supervision process is helpful to reviewing people served by the program; professional development is discussed among managers during weekly meetings
  - CMHA gives surveys to staff and people served by the program and groups every 6 weeks – so they are constantly evaluating what is needed

- **Grievance Policy:**
  - In intake, in the welcome packet

### *RECOMMENDATIONS:*

- **Continue to offer case worker support to build trust in psychiatric settings:** People who had psychiatric appointments alone reported feeling ignored and mistrust, and struggled to follow-up. Those who had their case worker with them when going to see their psychiatrist felt better heard with an advocate by their side.
- **Work on continuity of care issues:** Offer visiting nurses and continue referrals to peer programs to help people served by the program after discharge. People appreciate the care they get at CMHA and want to continue getting a level of support when they leave the program.
- **Help people served by the program learn about the grievance policy:** While the grievance policy is clear to staff and posted openly in the waiting room, it is not clear to people served by the program. Perhaps helping people read through the policy at intake and reminding them by pointing to the policy notice in the waiting room may help.

### *PROVIDER COMMENT:*

**Overall:** CMHA is unsure why the NCRMHB chose Jail Diversion Forensic Counseling and the Jail Diversion for Women's Programs for this Report on Outpatient and Co-occurring Services, as Standard Outpatient and Intensive Outpatient Programs were evaluated in almost all other CAC programs. While CMHA is co-occurring capable in all of its CMHA programs, comparing like outpatient programs across all CAC sites may have made for a more consistent evaluation approach. A Young Adult Outpatient Program at Capital Region Mental Health Center was also included in the report, another mismatch with Standard Outpatient Programs, as it serves an entirely different population.

Additionally, in reading the report, it is not clear if the questions and responses pertained to the selected Outpatient and Co-occurring Program or to the agency as a whole. At times the interviewees were likely confused and may have answered from either perspective, introducing inconsistencies across provider reports.

**Staff Training:** CMHA provides 16 hours of staff orientation training to all new hires that includes an overview of agency programs, client rights and responsibilities, HIPAA privacy and security, CareLogic (EMR) training, agency incident and accident reporting and CT legislation around behavioral health care including mandated reporting.

Also, in response to the opioid crisis and the high percentage of co-occurring clients at the agency, CMHA has recently trained all staff in the use of Narcan and provided Narcan kits to every agency site and to home based programs (ACTT/YACTT teams, Family Based Recovery). CMHA also offers Narcan "prescriptions" to clients and family members.

**Services for Specialized Populations:** Here is some specific data initially missing from the report:

- Persons with co-occurring disorder (we have attempted to pull this data from our EMR but the query is not functional at this time); estimates are that 90% of the population is co-occurring.
- Persons of different cultural background (based on FY 2015 data): Caucasian (54%); Latino (29%); Black/African American (13%); American Indian (.5%); Native Hawaiian or Other Pacific Islander (.2%); Other (2%); unknown (1.3%)
- Young Adults (18-25) – 21.73%
- Elderly (55+) – 7.85%
- Persons with a trauma history – 71.2%

**Focus Group Highlights:**
In response to the client comment that "Buses drop people off at the end of the street so they must walk half a mile to CMHA. This can be a challenge in the winter," CMHA explains that they have been actively working on this issue, and that it has been resolved. They explain, "With the opening of Fast Track, bus routes have changed within New Britain. In response to increased services at 270 John Downey Drive, CMHA's CEO has been advocating for increased bus service to 270 John Downey Drive for the past two years. Since March, 2015, buses provide services to all of John Downey Drive five (5) times daily."

It was stated under "Grievance Policy" that "No one knows about the grievance policy." CMHA is unsure of why this comment was made, as their Grievance Policies "have been posted clearly in our waiting room since we opened the site." The grievance policy was also "included in our Client Handbook, which the client receives and signs at the beginning of treatment." Nevertheless, CMHA assures, "we will ensure to specifically review the grievance policy at intake so the clients will get a better understanding of these procedures."

CMHA has 9 full time equivalent prescribers. CMHA's Client Rights Policy, which is in the Client Handbook and provided to the client at program intake, states that the client does not like his provider, he/she has a right to request another provider. Additionally, clinical case managers advocate for clients' needs with the prescriber by

accompanying them at prescriber visits and coaching them to convey their concerns directly to the prescriber so that clients feel heard and validated. Additionally, all Prescriber appointments are scheduled for 20-minute time blocks and clients are also assisted by a full time medical assistant. Any issues with medication doses or reactions are managed by the medical staff.

**Feedback to Recommendations:**

*Build trust between doctors/prescribers and people served by the program:* The team is addressing this issue on an ongoing basis by offering assistance to clients in addressing their concerns directly with prescribers. Some clients have requested Medication Assisted Treatment (MAT), which we will begin offering to forensic clients in the next few months.

*Continuity of Care Issue:* Although the Intensive services of the Women's Jail Diversion program is time limited, the Jail Diversion Forensic Counseling program is a long term outpatient program and can provide therapy to clients who complete the higher intensity JDW program and are in need of step-down services. The recommendation to engage more with community providers such as visiting nursing is excellent. With the addition of the Behavioral Health Home (BHH) in Forensic Services, coordination with visiting nursing and other community supports has improved. We are seeing great success in linking clients to case managers and nurses who can assist them with both behavioral health and their physical health needs.

*Grievance Policy:* Previous comments address this issue. Also the program's team structure allows for all concerns to be addressed through program leadership at any time. If and when a client would like assistance with filing a grievance, they are provided with direction and assistance from any CMHA staff member to make that complaint.

## Capital Region Mental Health Center (CRMHC): Adult Co-Occurring Disorders Unit

*(Also serves CAC 18)*

***AGENCY QUESTIONNAIRE***

Program Description and Services

- **Staff:**
  - Agency Administrative staff: Program Director
  - Peer Support Staff: No staff assigned to this program but are available to program via Peer Support Center
  - People in Recovery as Staff: see above
  - Agency Direct Program staff: Two Senior Clinicians, eight clinical staff (one position is vacant) and two psychiatrists are assigned to the team.
- **Location:** 51 Coventry St. Hartford, CT
- **Total Program Funding:** ___N/A_____
  - DMHAS funding: _____
  - Last Fiscal Year: _____
- **Program Capacity:**
  - Active Clients at time of review: 276 clients
  - Hours of operation per week: 40
- **Number of training hours for staff:** Staff participate in a range of training activities, some on line, some in person, recent initiatives regarding training in the new DMHAS electronic record, recent training in "words can hurt", upcoming training in fire-setting behaviors.
  - Types of training offered: see above
- **Number of Peer-Run activities:** The Peer Support Center has a full range of peer –run activities including groups and other activities.
- **Mission Statement: The Mission of Capitol Region Mental Health Center (CRMHC) is to partner with persons in recovery to ensure access and provision of quality behavioral healthcare services**

**SERVICES FOR SPECIALIZED POPULATIONS**

- Persons with a co-occurring disorder: estimated 221
- Persons of different cultural backgrounds: Team census is 26% Hispanic, 1.4% Asian, 47% African American
- Young Adults (18-25): Three young adults on team- most served by YAS
- Elderly (55+): 32%
- Persons with a trauma history: estimated 190
- Persons with co-morbid health problems: estimated 140

**UTILIZATION**

- Number of persons served, both duplicated and unduplicated in FY 2015: 322/276
- Average length of stay for FY 2015 *(as calculated by averaging the length of stay for those who have received long-term clinical support and those who have received short-term episodic treatment):* N/A we provide time unlimited treatment.
- How does the location of this program affect the clients? Program is easily accessible via public transportation, medical transportation, dial-a-ride etc.

**PROGRAM ACTIVITIES:** (program goals, defining features of program, and description of model)
Program provides individual and group therapy, employment services, uses evidence-based practice of co-occurring disorder treatment. Most clients served have co-occurring disorders.

- **Role in agency:** One of four teams in Outpatient Department.
- **Recovery focus, health & wellness activities:** Community Support Services, Person centered recovery planning, access to wellness activities via assigned Behavioral Health Home staff, access to Peer Support and Recovery services.
- **Utilization of Culturally and Linguistically Appropriate Services (CLAS) standards and/or co-occurring program models**

CRMHC has longstanding practice regarding co-occurring disorder treatment. There is a current initiative to refresh this. Program Director of team is member of agency multicultural committee looking at client population issues. Three clinicians and one psychiatrist on the team are Spanish-speaking, in addition we have access to Language Line for clients who speak languages with which staff are not proficient.

- **Outcome measures employed**

Every six months, clients are assessed via our Periodic Assessment tool which uses the National Outcome Measure, data reported via WITS electronic system to DMHAS.

## PROGRAM ACCESS & DISCHARGE

- Criteria for outpatient program referral and for discharge: Criteria for admission - CRMHC serves adults (age 18 and older) who reside in Hartford (Catchment Area 23) or the surrounding towns of West Hartford, Farmington, Avon, Canton and Simsbury (Catchment Area 18). The Center specifically targets the majority of its services to poor persons with severe and persisting mental illness, many with co-occurring substance abuse disorders who are at risk for psychiatric hospitalization.
  Discharge- Discharge will occur upon a client meeting his or her treatment goals and objectives, or upon requiring a level or type of service not offered by Capitol Region Mental Health Center (CRMHC). For continuity of care, discharge instructions will be reviewed with the client and/or significant other to insure the client is discharged safely and informed of follow-up care. Other circumstances may require unplanned discharge of a client, including but not limited to, extended incarceration, treatment refusal, death.
- The average length of time elapsing between receipt of referral and admission to the program is: Approximately two weeks
- Barriers to admission include: None
- Describe any community integration of the program: Program works extensively with community providers including residential, group homes, and community support teams. We also have monthly collaborative meetings with Blue Hills Substance Abuse Services and also collaborate with area providers via the Community Care Team meetings and the monthly meeting with Emergency Departments.

## PLANS FOR CHANGE OR CHANGES ANTICIPATED:

- **Please describe changes you implemented or plan to implement in response to DMHAS goals for a recovery-oriented system.**
  - Continued focus on person centered services, assessment of client satisfaction
  - Recent implementation of Behavioral Health Home program to provide better integration of medical and behavioral healthcare, and implementation of on-site primary care for clients who have difficulty accessing primary care elsewhere. We are also starting a Suboxone clinic on site for our clients who are opiate dependent.
- **Please describe barriers, challenges, tensions, differences in philosophy, system issues, or obstacles that need to be addressed.**
  - Lack of day programming that is available for clients with co-occurring severe mental illness and substance abuse.

Differences in probate law for mental health and substance abuse make it difficult for some of our more symptomatic clients to access longer term substance abuse treatment.

## CRMHC FOCUS GROUP HIGHLIGHTS:

Capital Region Mental Health Center works with some of the most psychiatrically acute and complex population of adult individuals seeking mental health/substance abuse services in Region IV. Based on staff interviews, the agency seems (1) proud of their ability to work well with this population, (2) genuinely cares about the well-being of people served by the program, and (3) respects their ability to work well as a team. Case management is seen as not just a service, but a life line to bridging people served by the program potentially 'lost' in the community. Integrated staff that includes medical service providers make for a well-rounded team. Crisis intervention services are available, as well as coordination with Jail Diversion staff in the court system.

Behavioral treatment interventions identified included: (1) Integrated Dual Treatment Model, Motivational Interviewing, Stages of Change, and Case Management. (2) Groups identified included Intensive Outpatient Program (IOP), DBT, Trauma Treatment, and Relapse Prevention (but not for Spanish speaking people served by the program exclusively). When an individual identifies a treatment need, or a staff is interested in a treatment model/intervention, administration will approve their ability to take the training to develop these services. However, there is no cap on the number of people served by the program a clinician can receive (which can be a barrier to the quality of services).

Barriers to services are consistently identified as resource changes. The budget changes impact CRMHC's complex people served by the program by decreasing safety net resources such as food, housing, and transportation. Crisis hours have decreased. According to CRMHC administrators, crisis services are still available Monday – Friday from 8am – 8:30PM, which is after CRMHC's regular service hours. Nonetheless, CRMHC crisis services are no longer available weekdays after 8:30PM, a critical time for need. While data does not support an increase in police involvement, fewer hours for crisis care services may put people served by the program at risk for police involvement. Certainly, some Black church leaders in the Hartford area are concerned that their congregants are at risk for being jailed for mental health or addiction issues instead of getting the necessary treatment.

The staff group was one of the most racially diverse and cohesive groups the review team encountered. Multiple staff spoke Spanish and led bilingual groups. The program director was present but staff seemed comfortable to express frustrations in front of him. There was an easy rapport among staff and they often anticipated each other's responses, finishing each other's sentences and adding their own perspectives. There were at least 10-12 staff at this meeting, and they confirmed that they met every morning to discuss ongoing issues and to troubleshoot together. Everyone shared a sense of humor and a sense of enthusiasm and commitment to their work. While staff admitted that the location of CRMHC is in a "tough" neighborhood of Hartford, there was sensitivity to the fact that many people served by the program were from the neighborhood and actually felt comfortable there, whereas the people served by the program from outside Hartford may have safety concerns. Given CRMHC's obligation to provide services to Hartford, West Hartford and the Farmington Valley, CRMHC's location is more of a barrier to individuals living on the outskirts of its catchment area.

The Person-In-Recovery Focus Group was 'warm and fuzzy'. Since many of the focus group participants had been involved with CRMHC for a long time, it was difficult to determine the quality of the intake process, but participants reported having their needs met including getting referrals to services/programs outside of CRMHC. Three people spoke of co-occurring programs and Peer Services in-house. One person spoke of how housing changed his life and another spoke of housing supports that are helpful to her. People talked about being encouraged to use church, Alcoholics Anonymous/Narcotics Anonymous, Advocacy Unlimited, and mobile crisis services.

People seemed to enjoy services and feel connected to their service providers. Many participants have had long histories of services due to complexity of needs.

People served by the program at CRMHC are in long-term recovery but they are also some of the most easy-going and positive people. There were several staff who helped people served by the program with surveys and with translation. The review team noted the staff interpreter for sign language – this is a unique service. One person shared that he would rather take two buses to come to CRMHC than to take one bus to attend an agency closer to his home.

Another person who initially came due to mandated probation admitted that the group helped him feel welcome and now he values services at CRMHC. The people served by the program and staff have been at CRMHC for a long time – there was a staff who has been at the agency for over 25 years, and an indivdual who has been served by the program for over 15 years! This long-term care and staff stability probably helps people feel safe and supported.

FEEDBACK FROM PEOPLE IN RECOVERY:

- **Ways this program has been helpful to people served by the program:**
  - The groups and ongoing support help people prevent relapse; give people hope
  - Mobile crisis is a useful tool to access in cases of emergency, or in case people served by the program need someone to talk them through a tough moment
  - People feel comfortable at CRMHC; they get support, have choices, and can express themselves; CRMHC also helps keep people served by the program busy – the programs provide structure for people's lives
  - Staff have lived experience with mental health and/or addiction so they are sympathetic to people served by the program and can provide a much more personal therapy experience
  - One gentleman was in and out of prison for 7 years, but has been stably housed and living in recovery since he started going to CRMHC – he credits his recovery to the agency

- **Client concerns about program:**
  - People served by the program seemed happy about the program and the group – they were only concerned that the budget cuts would negatively impact the programs and that staff would be laid off; people served by the program vouch for staff and want to give them all a raise

- **Cultural awareness of program:**
  - People said that everyone is welcome; "you see every nationality here"; "there's no drama or judgment" – people served by the program were diverse in age, gender, and racial background and staff reflected this diversity

- **Grievance Policy:**
  - People seemed to know who to talk to if they have a complaint, and one person had met with the grievance officer; people served by the program seemed self-aware and said they would consult with their therapist to make sure it is a concern that can be addressed by staff before filing a complaint

FEEDBACK FROM STAFF:

- **Special aspects about program:**
  - The program has a diverse component, including bilingual and bicultural programs
  - Has employment services that go above and beyond to help people served by the program; staff have connections in the community to connect people with housing and jobs
  - Some staff are called familiar names like "Auntie" by people served by the program – some therapists are people's only social connection; staff are supportive of one another to help people served by the program and not afraid to pitch in and help each other
  - Staff are not afraid to meet people where they are and go into the community
  - People served by the program are high utilizers who have major behavioral health issues, but they are never rejected at CRMHC. The agency prides itself in its willingness to take people no one else wants to treat
  - Staff anticipate a new Suboxone clinic starting soon

- **Staff concerns about program:**
  - With budget cuts, the mobile crisis unit hours have been reduced. Mobile crisis no longer goes out on weekends or after 8pm on weekdays. There are big concerns about overnights and police relations

with people served by the program. Due to this change, the staff is worried that Emergency Rooms will be flooded and people served by the program will be shifted into prisons.
    - There is concern about lay-offs, decreasing money to services, and teams consolidating due to state budget cuts, which means new team members may be forced to join their team
    - State budget cuts impacted LogistiCare, which provides free medical transportation for many people served by the program. A reduced LogistiCare budget will limit people's access to services
    - There is a constraint in how services are delivered to the Spanish community. There is a sense the agency doesn't prioritize Spanish services. The last leadership at CRMHC wanted to integrate Spanish people served by the program with other CRMHC people served by the program to save money and consolidate programs. This was a limited resource issue – the cuts in funding meant staff must fill holes by playing multiple roles instead of focusing on the needs of the Spanish population. Now there is no IOP (Intensive Outpatient Program) for Spanish people served by the program but Hartford has a large Spanish community. There is no DBT or trauma group for Spanish-only people served by the program. Only one substance abuse group exists for Spanish speakers.

- **Work with special populations:**
    - Staff work with bilingual and Spanish-speaking people served by the program
    - There is a young adult program
    - The majority of people in the program have co-occurring issues – staff believe they use substances to treat underlying mental health issues

- **Staff Professional Development:**
    - Staff feel there is not enough training and now the DMHAS training division is cut, so staff must pay for some trainings; while supervisor will sign off on requested training, staff must play a proactive role to seek out training; it's not automatically offered.
    - Staff believe that weekly supervision is helpful.
    - When asked how the administration addressed staff professional development, the review team received a lot of blank looks.
    - There is a difference between union and non-union jobs at the agency. Union rules dictate raises and promotions are based on seniority. This affects professional development.
    - Staff fear that if they acquire expertise in a particular area, they will get inundated with people in the program who would benefit from that expertise.

- **Grievance Policy:**
    - Policy is posted everywhere in Spanish and English; people served by the program know how to advocate for themselves

### *RECOMMENDATIONS:*

- **Create more Spanish-only programs:** Given the high needs and the big Spanish population in Hartford, it is important to be culturally sensitive to this group by offering more Spanish-speaking programs and groups.
- **Connect staff with relevant trainings:** Staff seem curious and eager to learn. Given the few benefits offered at CRMHC, consider offering more professional development and training opportunities.
- **Help people served by the program with transportation:** Consider working with Regional Mobility Managers (such as www.waytogoct.org) to help people served by outpatient programs navigate transportation options. Partner with the Department of Transportation to develop more options for people served by outpatient programs to access free or low cost transportation. This is especially important as LogistiCare may suffer budget cuts due to the state crisis.

### *PROVIDER COMMENT:*

In response to our Overall Recommendations, CRMHC shared:

- Recommendation #6 - Training:  Based on recent staff movement, CRMHC started offering free training multiple times a month with free CEU's for social workers.  A training calendar has been developed for the remainder of the year.  Additionally, as space allows, CRMHC offers training slots to staff of private providers at no charge.

- Recommendation #11 - Medication Assisted Therapy: CRMHC has 8 prescribers who are certified to prescribe Suboxone and opened a Suboxone clinic in May of 2016.

In response to the review and recommendations specific to CRMHC, they clarified:

- Crisis services are available Monday – Friday from 8am – 8:30PM, which is after our regular service hours. (This is addressing a concern about fewer crisis care service hours, which were cut due to budget constraints)

- Data does not support an increase in police involvement. (This is addressing a concern that fewer hours for crisis care may mean that people are getting jailed instead of being treated)

- There are 7 unions on site at CRMHC, and rules differ from union to union. Union members receive a generous training allotment to be shared among union members. (This is addressing union influence and concerns about training)

- **Staff: (share numbers)**
  - Agency Administrative staff: **1**
  - Peer Support Staff: No staff assigned to this program but are available to program via Peer Support Center
  - People in Recovery as Staff: Individual staff members disclose their recovery at their own discretion, but are not hired specifically as peer support staff members
  - Agency Direct Program staff: One Division Director, one part-time psychiatrist, one full time psychiatrist (vacant), one clinical manager (vacant), one supervising clinician, 2 Clinical Social Worker Associates (1 vacant), 1 Psychologist, 3 CSW's, 1 Nurse Clinician, 2 Marital and Family Therapists, 1 Community Clinician, 1 Mental Health Assistant 1, 1 Mental Health Associate, 12 Mental health Assistant 2's, 3 Vocational Rehab Counselors, 1 OT Supervisor, 1 COTS, 1 Rehab Therapist 2.
- **Location: 500 Vine Street, Hartford, CT 06112**
- **Total Program Funding:** _____
  - DMHAS funding: **$776,415 Client Support** Funds
  - Last Fiscal Year: _____
- **Program Capacity:** _____140_____
  - Active Clients at time of review: ____106_____
  - Hours of operation per week: __76_____
- **Number of training hours for staff**: Unlimited numbers of training hours are available to staff members. We strongly encourage staff training, and provide this on site as well.
  - **Types of training offered:** Extensive trainings of all types as identified in the DMHAS Education and Training catalog. In addition, specialized training in Circle of Security, Trauma informed Care, Attachment, Self, Regulation, and Competency, Extensive trainings on culture competency, conflict resolution and communication skills
- **Number of Peer-Run activities:** Multiple activities through the Peer Support Center, Toivo, Chrysalis, individual peer support, activities held on site
- **Mission Statement:** The Mission of Capitol Region Mental Health Center is to partner with persons in recovery to ensure access and provision of quality behavioral healthcare services

**SERVICES FOR SPECIALIZED POPULATIONS**

- Persons with a co-occurring disorder: **106**
- Persons of different cultural backgrounds**: all clients have diverse backgrounds, generally consistent with that of demographics of the City of Hartford**
- Young Adults (18-25): **106**
- Elderly (55+): **none**
- Persons with a trauma history: **all 106**
- Persons with co-morbid health problems:_____

**UTILIZATION**

- Number of persons served, both duplicated and unduplicated in FY 2015:_____
- Average length of stay for FY 2015 *(as calculated by averaging the length of stay for those who have received long-term clinical support and those who have received short-term episodic treatment):*_____
- How does the location of this program affect the clients? **Program is located in high density urban setting, surrounded by great poverty, crime, good bus system, rising rents but increasingly scarce housing stock but still affordable generally. Many social services are available by bus.**

**PROGRAM ACTIVITIES:** (program goals, defining features of program, and description of model)
See attached schedule of program activities. It is the goal of the recovery process within young adult services for young adults to find a life worth living, and choose within 4 categories of activities to develop this life, and explore for themselves how to develop this life. These activities are in the areas of: Clinical, Recreational, Social, and Vocational & Educational. Each client is told of the expectation to work on developing 20 hours, minimally, of activities within these 4 arenas, to develop a productive and effective recovery plan, and focus for treatment. An array of services within these 4 areas are offered, based on individual interests, concerns, strengths, difficulties, family issues, etc.

- **Role in agency**

Young Adult Services serves the 18 to 25 year-old population identified by the OOC coming from DCF, or through the front door of the agency, in need of highly specialized services for this population. Most often this group has significant trauma history, with substance abuse and dual diagnosis and family issues, and need for complex and sustained interpersonal and multiagency coordination.

- **Recovery focus, health & wellness activities**

As somewhat noted in the activities calendar above. There are also a number of clinical groups for our young adults, based on their needs.

- **Utilization of Culturally and Linguistically Appropriate Services (CLAS) standards and/or co-occurring program models**

CLAS and IDDT is integrated into evaluation, recovery planning, group process, and every aspect of the program. Family group is based on cultural norms of the population served, for example, and our 2 MFT's inform the process within the multidisciplinary team, so that each person in recovery identifies their world view for respect and clarity, at the core of recovery.

- **Outcome measures employed**

Vocational and educational involvement.

**PROGRAM ACCESS & DISCHARGE**

- Criteria for outpatient program referral and for discharge:

The criteria for discharge is person achieving their recovery goals and objectives, and or reaching age 26, and no longer being eligible for Young Adult Services.

- The average length of time elapsing between receipt of referral and admission to the program is:

CRMHC receives referrals through the Office of the Commissioner as well as through the front door process. The referrals from OOC are in liaison status for 2 years prior to admission to YAS as the liaison works on a thorough transition from DCF to the DMHAS system starting at the age of 16. Clients, who come through the front door are able to have an appointment scheduled within a week or two.

- Barriers to admission include:

Usually the team works on identifying individuals' barriers to care and works with the client to address them. Typically, the team is able to resolve issues while client is transitioning to the program.

- Describe any community integration of the program:

The YAS outpatient program employs 18 case managers, who are responsible for providing care in the community including: skill development and acquisition, assistance with daily living skills, recreational and social guidance, etc. The YAS team also includes vocational rehabilitation specialists, who work with clients in the community on meeting their vocational and educational goals. The recreational therapist is responsible for developing a schedule of events and activities that the clients attend in the community throughout each month.

**PLANS FOR CHANGE OR CHANGES ANTICIPATED:**

- Please describe changes you implemented or plan to implement in response to DMHAS goals for a recovery-oriented system.

Multiple changes have been implemented over time, and will continue to be, increasing the development of recovery capital within the community for young adults in the City of Hartford, and less dependence on the agency. Further alliances have been built with Chrysalis Center with a Thursday evening group for young adults; an alliance has been built with Toivo Center for transition of the Warmline to being a Statewide service staffed by and available for young adults, a prevocational option and valuable learning experience at the Spot. Additional developments are being pursued through YAS Biz and other available opportunities for learning and growing.

Emerging focus on use of the LIST for measurable skills teaching within the program, with person in recovery choice of goals and self-assessment feature more pronounced.

- Please describe barriers, challenges, tensions, differences in philosophy, system issues, or obstacles that need to be addressed.

Difficulties with transitioning some young adults to the community due to serious and severe histories of criminal behaviors, fire setting, arson, sexual assaults, need for housing and financial support to develop additional resources and options in the community. Difficulties with transition of young adults to the adult system due to significant difference in resources available to them, at times.

## CRMHC – YAS FOCUS GROUP HIGHLIGHTS:

Our focus group with young adults for the Young Adult Services (YAS) left many reviewers with questions and concerns about the program. While the focus group started out calmly, the pitch and tenor of the group quickly escalated as young adults shared frustrations about their perceived treatment at CRMHC. Of particular concern were reports of staff neglect, staff unresponsiveness, and housing referrals for units that were not vetted for safety concerns. Some young adults did attribute their recovery successes to certain staff at CRMHC, but many shared difficult moments about their interactions with other staff. Whatever is going on with the YAS program merits a more thorough review and a concerted effort to re-establish trust between staff and young adults. Young adults seemed motivated to move on and become independent, but perceive some staff as triggering and a barrier to their recovery. Many young adults are concerned that they are aging out of the system and do not yet have the skills to succeed.

The staff group shared differing perspectives and attitudes regarding the young adults. Some staff were aware of the multiple layers of trauma young adults worked through, and the complexities of transitioning from the DCF system to DMHAS. These staff members also felt that young adults could overcome their challenges with patience and guidance. Other staff stated that some young adults will never be able to work and felt that young adults were taking advantage of all the free offerings from the program. It is evident that some staff had more training and were more well-versed with co-occurring issues than others. During the focus group, there seemed to be disagreement among staff about appropriate approaches to working with young adults. For their own professional development, staff wanted more access to and notice of available trainings; one staff thought it was important to mandate co-occurring training so that all staff could be on the same page about co-occurring issues. In general, the staff seemed passionate and invested in their jobs. Most staff thought that young adults most valued free activities and gift certificates or cash assistance, and they believed that young adults wanted less therapy and less accountability; but young adults actually expressed that they valued accountability from their clinicians and case workers – that they appreciated mentorship and guidance most, and touted those as the reasons why they came to CRMHC.

In response to the focus group concerns, the Director of the YAS program stated that since his arrival to the program three years ago, he has implemented major changes that address many of these frustrations. In regards to the housing issues, he acknowledged that CRMHC staff have limited control over housing referrals in the neighborhood (which is a "rough" neighborhood), but for the residential program at Hilltop, he has changed the staff almost completely and put in place accountability measures that resulted in a 50% drop in critical incidences in the last two years. The Director also instituted staff retreats and trainings to help clinicians and case managers adapt to a new way of working with young adults: by teaching them skills rather than giving them handouts. The struggles he sees with the transition from this shift in approach is similar to a struggle he saw when CSP case management (which has a similar approach of "teach a person to fish rather than give them the fish") was instituted a few years ago. He says that the transition will take time and it requires ongoing training with staff, some of whom have worked at CRMHC for many years and are used to the way things were. He also acknowledged that young adults will need time to get used to the shift. The Director also shared that staff who are longtime employees of CRMHC need time, patience, and ongoing training to change their behaviors. Meanwhile, the Director has implemented the YAS Activities calendar to offer fun events for young adults every day of the week, including weekends, to help youth socialize. He also created accountability around transportation to make sure staff give rides to young adults who need them.

### FEEDBACK FROM PEOPLE IN RECOVERY:

- **Ways this program has been helpful to young adults:**
  - The location is convenient and on a bus line; the agency provides bus passes to young adults
  - Some staff are helpful to young adults in terms of finding housing and jobs; one person was thankful that staff helped him get food stamps, find housing, and appreciated that his clinician was helpful at addressing his mental health issues. He reported receiving useful tools and gets along well with staff.
  - Some clinicians offer useful tools to certain young adults
  - Young adults share that there are some "good staff" at CRMHC, and defined "good staff" as those who are supportive, and who could hold teens accountable for their actions and help talk them out of self-defeating behaviors. Teens expressed interest in having accountability from program staff. They

also wanted staff to listen to them – young adults expressed that they do not want a quick solution. They want guidance. They want staff to help them learn and be independent.

- **Concerns expressed by young adults about the program:**
  - Young adults believe some staff are lazy or unresponsive; they theorized that the vetting process to hire staff is not rigorous. "Some staff care; others don't." Young adults believe certain staff are unprepared or untrained to handle the amount of trauma many young adults bring to the program.
    - Young adults said that some staff at CRMHC are not proactive and do not seem trained to handle YAS trauma. Young adults said that in comparison with other agency programs' staff that they have interacted with, CRMHC YAS staff were as not as helpful in crisis response.
    - Young adults reported that some staff's behavior actually escalates situations; other staff call the police right away instead of working to de-escalate the situation; young adults felt that staff lost track of certain young adults or do not do an adequate job of follow-up.
    - One case worker is reported to be unreliable – a young adult reported that this person was often absent "due to injuries" and was unresponsive to client calls. He said that when he was struggling, no one called to follow up. This young person was homeless for a time and felt that few staff at CRMHC made the effort to connect with him, even though he sought help from the program.
    - Some CRMHC staff are appreciated by young adults, but young adults suspected that responsive staff are laid off or move on to other jobs due to the low pay, while unresponsive staff continue to stay employed at CRMHC.
    - Young adults reported that some staff threatened young adults, and then staff would "play the victim" if young adults reported those threats. One young adult reported that a staff told him to "get over it" when he was struggling with his mother's death.
    - Young adults complained that doctors are rarely around and not accessible, and shared that they would make appointments with the doctor, arrange for transportation, show up, wait, and then were told that the doctor called out sick. Multiple young adults reported this happening several times.
  - There seems to be a power struggle or a power dynamic issue at hand
    - Staff are seen as gatekeepers for services and for activities – staff have control over who goes to what groups; young adults reported that if they "misbehave" or are perceived as misbehaving, they are not allowed to participate in activities. Staff also have control over private transportation for young adults, and can choose to withhold transportation by refusing to offer bus passes or refusing to offer rides to young adults. Young adults said, "staff will pick up people on the activity list that they want." For young adults who have mobility issues, who feel unsafe in their neighborhoods, or who are not able to navigate the bus system, transportation can be a big barrier to receiving services.
    - At Hilltop, the residential program, there are reports of power struggles. Young adults felt punished when staff are slow to respond to safety concerns in their housing unit.
      - Several young adults shared stories of unresponsive staff when they reported safety concerns in their housing units in the community. A couple of young adults shared frustrations with basic plumbing issues that went unaddressed by staff.
    - Young adults felt that they have to prove staff wrong – many expressed frustrations with being treated like they are a liability and want to get better and become independent
  - Young adults claimed that the agency "has a long list of slum lords" that CRMHC referred young adults to for housing – many young people complained about bad apartment conditions and unresponsiveness to requests to help them move. The residential program – Hilltop is perceived to be unsafe and not secure. There were reports of staff taking young adults' belongings. One youth experienced theft when he was asleep; one day he woke up to some of his valuable belongings missing. Young adults wanted CRMHC to screen landlords. They heard a lot about drugs and theft in the housing CRMHC refers them to – so they do not feel safe.

        - The housing problem negatively impacts many young adults' recovery because they feel unsafe and their traumas are triggered by their living situation. "Stable housing is important but bad housing makes it worse."
    - There is a concern that DCF is constantly involved; young adults thought that getting treatment at CRMHC meant that DCF would stay away, but that hasn't been the case. A young woman shared that because she was pregnant and seeking treatment at CRMHC, DCF became automatically involved and she felt targeted because she was seeking behavioral healthcare.

- **Cultural awareness of program:**
    - It is unclear to what extent young adults feel that the program meets their needs from a cultural awareness perspective. It does not seem that all CRMHC YAS staff understand or appreciate young adult culture, which is a component of building mutual trust and respect. It seems that some basic needs including housing and feeling safe and secure need to be addressed.

- **Grievance Policy:**
    - While some young adults seemed aware of the grievance policy, many feel it is a joke and do not believe that filing grievances or speaking up about their concerns made any difference in their treatment (or perceived lack thereof). "Client rights are BS – we've told them everything and they do nothing."

FEEDBACK FROM STAFF:

- **Special aspects about program:**
    - Staff shared a myriad of programs that YAS offers, among them are recreation programs, supports for all kinds of youth, financial literacy, and housing. There is a financial counselor and a vocational program. Young adults are given food cards, bus passes, and they are offered daily fun socializing opportunities posted on the Activities Calendar. Young adults have a group called "Let's Ride" that teaches them about how to use buses and navigate the public transport system.

- **Staff concerns about program:**
    - Some staff felt that youth are just making excuses about their abilities to transport themselves and they just want a free ride
    - Some staff have concern that the location of CRMHC is dangerous or triggering for young adults, especially since some come from Simsbury or Avon and are not acclimated to the issues of certain neighborhoods in Hartford. This concern extends to housing referrals in Hartford.

- **Work with special populations:**
    - Young adult and co-occurring issues

- **Staff Professional Development:**
    - Staff said that they need more awareness of the training that is available. Staff claimed there is no awareness of professional development. One staff thought that all staff should have mandated co-occurring training so they could all be on the same page about how to address co-occurring issues. Staff felt that the administration does not address professional development as much as they would like.

- **Grievance Policy:**
    - Posted on the bulletin board but difficult to find and small

### *RECOMMENDATIONS:*

- **Address trust issues between young adults and YAS staff:** It is evident that trust is fragile between staff and young adults, and while certain staff were highlighted as helpful, young adults felt that many staff actively

worked against their recovery. To address this issue, perhaps via a facilitated dialogue between those groups, or identifying key people who could benefit from ombudsman services would improve the perception of the YAS program for young adults.

- **Address safety concerns (emotional and physical) for YAS housing:** Security is the second most important basic need on Maslow's hierarchy of needs, after sleep, so to help people on their recovery, they need to feel safe and secure. To address this, perhaps the agency can consider organizing a housing ombudsman, specifically to advocate for young adults and to hear their concerns, and to teach them how to live independently. It is evident that young adults feel frustrated and do not know where to go or how to address their safety concerns in a timely manner with staff. Young adults need opportunities to learn about reasonable expectations for housing and they need to feel heard.
- **Young Adult Transition from DCF to YAS needs to be addressed:** There are huge differences in treatment and program offerings between the DCF program (meant for infants to 18-year olds) and the YAS program (meant for 18-25 year olds) that can negatively impact young adults' lives without a smooth transition process.
- **Young Adult Transition from YAS to Standard Outpatient Program (SOP) and CSP services needs to be addressed:** There are huge differences in treatment and program offerings between the YAS program and the adult SOP and CSP programs. These differences can negatively impact young adults' lives without a transition process. Several young adults expressed great anxiety that they would soon age out of YAS and were not ready.
- **Offer more professional development opportunities or ways for staff to advance within the agency:** Staff wanted more professional development and some were concerned that staff turnover related to lack of advancement opportunities
- **Make it clear to all staff what trainings are available and offer relevant trainings as needed:** Many staff expressed interest in more trainings but were not aware of the available training opportunities. One staff stressed the need for more education on opioids, and also on co-occurring issues.

### *PROVIDER COMMENT:*

- Regarding unavailability of doctors – the team had one FTE doctor position empty due to a retirement at the time of the interview. Subsequently, a bilingual psychiatrist has been hired and is providing 40 hours of service per week to the team and people in recovery.

- Regarding requests for more professional development - based on recent staff movement, CRMHC started offering free training multiple times a month with free CEUs for social workers. A training calendar has been developed for the remainder of the year. Additionally, as space allows, CRMHC offers training slots to staff of private providers at no charge.

- **Staff: (share numbers)**
  - Agency Administrative staff: Maybelle Mercado
  - Peer Support Staff: 0
  - People in Recovery as Staff: undisclosed
  - Agency Direct Program staff: 35
- **Location:** Hartford
- **Total Program Funding :**
  - DMHAS funding: 960,575
  - Last Fiscal Year:
- **Program Capacity:** 540
  - Active Clients at time of review: 641
  - Hours of operation per week: 52
- **Number of training hours for staff:** 20
  - Types of training offered: Safety Training customer service clinical trainings, ie, Trauma Informed Cultural Competency, HIPAA
- **Number of Peer-Run activities**: 0

Mission Statement: HBH serves the health needs of youth, adults & families by taking a holistic, intergraded, collaborative and culturally competent approach to client care that strives to promote wellness and independence to their fullest potential.

**SERVICES FOR SPECIALIZED POPULATIONS**

- Persons with co-occurring disorder: 60%
- Persons of different cultural backgrounds: 65%
- Young Adults (18-25): 70
- Elderly (55+): 235
- Persons with trauma history: 65%
- Persons with co-morbid health problems: 55%

1. **UTILIZATION**
   - Number of persons served, both duplicated and unduplicated in FY 2015: 1,559
   - Average length of stay for FY 2015 *(as calculated by averaging the length of stay for those who have received long-term clinical support and those who have received short-term episodic treatment):* 3.5 years
   - How does the location of the program affect the clients? HBH two locations are strategically conveniently located in the north and south end of the city in line with public transportation.

2. **PROGRAM ACTIVITIES:** (program goals, defining features of program and descriptions of model)
   - Treatment completed successfully
   - Stable Living Situations
   - Employed
   - Improved/ Maintained GAF Score

   a. **Role in agency**
   b. **Recovery focus health & wellness activities**
   HBH currently does not have a recovery focus health & wellness activities integrated within our treatment, however that is the direction we will be focusing on for the upcoming fiscal year.

**c. Utilization of Culturally and Linguistically Appropriate Services (CLAS) standards and/or co-occurring program models**

HBH is unequivocally committed to providing linguistic appropriate services. HBH's staff is presented at the very beginning of their orientation with our LEP policy. The policy was developed with the goal of ensuring that individuals and families with culturally diverse backgrounds and/or linguistically different needs have access to translation services. The policy facilitates the process for planning and service delivery which will be conducted in a way that facilitates the individual's desired outcomes. This includes ensuring that people with Limited English Proficiency (LEP) are provided, free of charge, accurate and timely assistance to obtain effective and meaningful access to services. This policy also establishes guidelines for the provision of interpreters for people with heating impairment and assures that speech language and hearing services are available free of charge. HBH believes in complying with the CLAS standards and applying them within our co-occurring program models.

**d. Outcome measures employed.**

## 3. PROGAM ACCESS & DISCHARGE

**a.** Criteria for outpatient program referral and discharge: HBH currently has open access, there is no waiting time and walk-ins are welcome for our outpatient program.

**b.** The average length of time elapsing between receipt of referral and admission to the program is: 0

**c.** Barriers to admission include: need for a higher level of care.

**d.** Describe any community integration of the program: HBH works closely with Easter Seals and Chrysalis Center, YMCA, TIVO, Faith Based Community Centers Charter oak Health Center, services

## 4. PLANS FOR CHANGE OR CHANGES ANTICIPATED:

**a**. Please describe changes you implemented or plan to implement in response to DMHAS goals for a recovery-oriented system.

- Develop Peer support Groups
- Develop a focus health and wellness activities approach within our treatment

**b.** Please describe barriers, challenges, tensions, differences in philosophy, system issues or obstacles that need to be addressed.

- Ongoing state funding cuts that impacts directly to mental health services
- Lack of funding to provide supportive services and growing substance abuse epidemic
- Supportive funding to smaller urban city agencies that provide cultural competent services and continue to do more for less.

## HBH FOCUS GROUP HIGHLIGHTS:

The Hartford Behavioral Health staff were congenial, patient, and friendly. They seemed to have a good rapport and joked easily. Staff shared that they genuinely liked each other and love what they do. One of the staff was also a manager of the program, so she participated in the focus group. The staff said that of 800 people served by the program, 250 are monolingual Spanish speakers. This agency was highlighted because it prioritizes cultural competency in its services and works with a high number of monolingual foreign language people served by the program.

### FEEDBACK FROM PEOPLE IN RECOVERY:

We were not able to meet with a client group. We did meet with two individuals separately to conduct key informant interviews. The Program Supervisor for Adult Outpatient Services shared that groups were not very popular at HBH, and that groups were often canceled due to lack of participation.

- **Ways this program has been helpful to people served by the program:**
  - Both clients we met with seemed very satisfied with the treatment at HBH.

- **Client concerns about program:**
  - Neither person seemed to know about co-occurring treatment or the value of co-occurring programs. One of them wondered why it was important to consider addiction in his recovery, since he felt he only struggled with mental health. The other stated she was not assessed for addictions or co-occurring issues at intake – only mental health.

- **Cultural awareness of program:**
  - Both people noted that HBH had a high regard for cultural sensitivity – that they felt safe and welcomed and very supported by staff. One of them had gone from agency to agency and he stated that HBH is great because the staff check in with him often and he feels cared for. The other said staff "make you feel at home."

- **Grievance Policy:**
  - Both people seemed comfortable telling their case managers about grievances, and one shared that she was informed about the grievance policy upon intake at HBH.

### FEEDBACK FROM STAFF:

- **Special aspects about program:**
  - All support staff have Masters' Degrees and are bilingual; all staff are required to take training on cultural competency annually; diverse staff who know Hartford well
  - There is a prescriber only program – where people come only for the medications
  - Open Hours
  - Will accept "difficult" people
  - Collaborative partnership with Chrysalis and Easter Seals to offer vocational services to people served by the program at other sites

- **Staff concerns about program:**
  - Parking is difficult and the main entrance is hard to find
  - Managerial turnover, politics, and procedural change were cited as difficult for staff
  - Perhaps referral to outside programs more difficult for people served by the program than having all services with trusted clinicians in-house
  - Staff want a quality control person who helps with the high caseload; they want an engagement specialist to figure out documentation and help with the "constant auditing"
  - Staff shared that there were more people on staff in the past, but now there are fewer people doing more work – so some clinicians are also managers. This is tough on people.

- **Work with special populations:**
  - About 30% of HBH people served by the program are monolingual Spanish speakers, so many of the staff are bilingual in Spanish and all staff are required to take annual cultural competency training
  - All clinicians work with co-occurring issues

- **Staff Professional Development:**
  - Staff say HBH will pay staff for their time and cover training fees up to $500 per year. The supervisor also identifies and sends staff to appropriate trainings; each staff has a niche – the family therapist got specialized training; staff can pick their own training for their own development – staff felt that management is very supportive of training, and that leadership is responsive via text and phone

- **Grievance Policy:**
  - The policy is given to people served by the program in a booklet at intake, and discussed in the discharge letter

### *RECOMMENDATIONS:*

- **Improve access to building:** Create lawn signs; write directions online; offer clear instruction for parking. Parking is difficult and the main entrance is hard to find
- **Offer a quality control person who can help staff manage paperwork with the high caseload:** Staff would like the extra support; they want an engagement specialist to figure out documentation and help with the "constant auditing."
- **Hire more clinical staff:** Staff shared that there were more clinicians in the past, but now there are fewer staff doing direct therapy work. To help out, some managers also serve as clinicians. This strains a staff that already carries a high work load.
- **Develop groups led by people in recovery:** Groups do not seem to be well attended at HBH. At other agencies, NCRMHB reviewers noted that groups can be a positive and empowering way to help people in recovery. Groups led by people who are getting services from the agency can be especially effective because organizing a group gives people agency and confidence. At other agencies, staff offer resources and toolkits so people can develop groups based on their own interests. While staff are present at groups, people in recovery tend to lead the groups. This model seemed to enhance people's recovery experiences. Perhaps the challenge with groups at HBH stem from cultural issues, but while some cultures make it difficult for groups to be effective, it may still be worthwhile to offer groups as an option for people to connect and socialize.

### *PROVIDER COMMENT:*

HBH agency leaders shared that they appreciated the review process. The Executive Director said she "learned a lot" about what works for other providers and what models to adopt. She also stated that she felt it was "good to compare populations and challenges among agencies." HBH leaders believed the review process was positive, and that the report was a useful tool for HBH to continue improving their programs. One manager shared, "It is nice to read the positives about HBH and areas we can improve on." Agency managers and staff also reflected that they thought the process went well.

HBH leaders wanted to share the following:

- Our support staff, while are bilingual, do not hold master degrees. We only require our clinicians to hold Masters' Degrees and they are not all bilingual.

- Since the review, when staff stated they want "a quality control person who helps with the high caseload," HBH has been able to hire a quality control person.

**Staff:**
o Agency Administrative staff: 15
o Peer Support Staff: 1
o People in Recovery as Staff: Unknown
o Agency Direct Program staff: 28 (clinical FTE's)

**Locations:**
o 91 Northwest Drive Plainville, CT
o 10 North Main Street Bristol, CT
o 75 North Mountain Road New Britain, CT
o 36 Russell Street New Britain, CT
o 999 Asylum Avenue Hartford, CT

**Total Program Funding: $7,051,618**
o DMHAS funding: $1,874,680
o Last Fiscal Year: $2,205,420

**Program Capacity:**
o Active Clients at time of review: 2,548
o Hours of operation per week: 54.5

**Number of training hours for staff:** Wheeler Clinic Annual Mandatory Training is 2.5 hours in an e-learning environment. New staff orientation is 24 hours of in person live training at the start of employment and there is an additional 15 hours of department specific training in the e-learning environment for Adult Outpatient Staff.

Types of training offered:
□ Motivational Interviewing
□ Privacy and Security
□ Infection Control
□ Corporate Compliance
□ Work Place Violence
□ Fire Safety
□ Gambling Integration
□ DSM5 Overview
□ Understanding Psychological Trauma & Trauma-Informed Care
□ Collaborative Documentation
□ Advanced Co-occurring Disorders Training
□ Integrated Whole Person Healthcare
□ Suicide Risk Management Training

 **Number of Peer-Run activities:** The Peer Counselor has ongoing involvement in outpatient groups, Alumni Groups across the department, and Quarterly Wellness Activities.

 **Mission Statement:** "Wheeler provides equitable access to innovative care that improves health, recovery and growth at all stages of life".

**SERVICES FOR SPECIALIZED POPULATIONS**

 **Persons with a co-occurring disorder:** Intensive outpatient and outpatient level of care including group, individual and family services. Wheeler participated in the Co-Occurring Disorders Initiative with DMHAS in 2014 and achieved designation as "co-occurring capable".

 **Persons of different cultural backgrounds:** All Wheeler employees strive to provide culturally and linguistically sensitive and responsive services.

 **Young Adults (18-25):** Young Adult Group Services are available

 **Elderly (55+):** Outpatient groups are available for Older Adults. In addition, Wheeler targets outreach to Older Adults through community outreach, established relationships with Senior Centers and a variety of other community based organizations including local hospitals.

 **Persons with a trauma history**: Outpatient groups are available including Women's Wellness Group, Men's Empowerment Group and individual therapy. Wheeler participated in the Trauma and Gender Initiative with DMHAS from 2012-2014.

 **Persons with co-morbid health problems:** Wheeler is a fully integrated organization, focused on whole person care. Primary Care and dental services are available to all clients and attention to both medical and behavioral health needs is present throughout the integrated treatment planning and multidisciplinary treatment team approach. Wheeler also offers Care Management Services to individuals with complex comorbid medical conditions.

**UTILIZATION**

a. Number of persons served, both duplicated and unduplicated in FY 2015:
Unduplicated = 5,147 vs. Duplicated = 8,696

b. Average length of stay for FY 2015 *(as calculated by averaging the length of stay for those who have received long-term clinical support and those who have received short-term episodic treatment):* 6.5 months

c. How does the location of this program affect the clients? The location of our five outpatient offices across Central Connecticut and Greater Hartford area allows for easy, immediate access to outpatient services. Transportation is also discussed upon engagement to assist with barriers to care.

**PROGRAM ACTIVITIES:** (program goals, defining features of program, and description of model)
Wheeler Clinic Adult Outpatient Programs delivers innovative care to individuals, families, and communities by providing services that support the recovery of families and individuals who experience co-occurring mental health and addictive related disorders including gambling. We provide integrated healthcare services that are trauma-informed and gender-responsive. Wheeler Clinic Adult Outpatient services address a diverse range of needs and backgrounds, enhance strengths and provide the supports that encourage recovery from challenges for a satisfying life in the community.

Behavioral Health Outpatient and Intensive Outpatient Levels of Care:

- ✓ Individual Therapy
- ✓ Group Therapy

- ✓ Family Therapy
- ✓ Intensive Outpatient
- ✓ Medication Management

**Role in agency**

Wheeler's outpatient programs provide an essential level of support to more than 5,400 individuals each year and provides the primary foundation of the agency's behavioral health continuum for adults. Wheeler has participated in a number of DMHAS initiatives to ensure high quality services for individuals with co-occurring disorders. DMHAS selected Wheeler to participate in the DMHAS Co-Occurring Disorders initiative in 2007 and the Co-Occurring Disorders and Supervision Competency initiative in 2014. **In November 2014 Wheeler achieved Dual Diagnosis Capability in Addiction Treatment (DDCAT) designation from DMHAS with a score of 100% for its 999 Asylum Avenue, Hartford and 75 North Mountain Road, New Britain adult outpatient services sites.** Wheeler has been accredited by the Joint Commission since 1988 and achieved Behavioral Health Home certification during this year.

**Recovery focus, health & wellness activities**

- ✓ Access Health & Introduction to St. Francis Medical Services
- ✓ Smoking Cessation & Tour of Facility
- ✓ Eye Health
- ✓ Blood pressure Screenings
- ✓ Diabetes Education
- ✓ Healthy Eating
- ✓ Asthma and Seasonal Allergies

**Utilization of Culturally and Linguistically Appropriate Services (CLAS) standards and/or co-occurring program models**

CLAS: On January 19, 2016, Wheeler began a new organizational initiative intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a Wheeler Clinic Health Equity Implementation Plan that meets the federal Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) Standards.

**Co-occurring program models**

Wheeler Adult Outpatient Services employs Hazelden's Co-occurring Disorders Program (CDP) throughout its outpatient continuum including outpatient and intensive outpatient groups and individual modalities.

**Outcome measures employed**

Adult Outpatient Services utilizes the Daily Living Activities 20 (DLA20). It is a 20 question functional assessment measuring the daily living areas impacted by mental illness or disability.

**PROGRAM ACCESS & DISCHARGE**

Criteria for outpatient program referral and for discharge:

**Eligibility Criteria:** Wheeler employs the American Society of Addiction Medicine (ASAM) criteria for determining client eligibility, guidelines for placement, continued stay and transfer/discharge of clients with substance use disorders. Wheeler has the capacity to serve clients meeting the ASAM criteria for Level 1 (outpatient) or Level 2 (intensive outpatient) services. Clients in need of detox or Level 3 and 4 will be provided a referral for this higher level of care.

In addition to ASAM, Wheeler uses a Utilization Management (UM) tool to assist in the identification of level of care needs for outpatient clients. The UM Acuity Tool incorporates information collected throughout the intake assessment to provide a score of 1 – 4. A score of four represents the highest need and is generally referred to an intensive outpatient level of care. A score of one is the lowest and indicates one outpatient group weekly is most appropriate. The UM tool provides the intake clinician with a summary of key findings that support clinical decision making, specifically related to level of care. UM also supports tracking of higher risk clients in ongoing care as it allows for these clients to be reviewed as needed. The UM domains include:

- ✓ Axis I Diagnosis
- ✓ Patient Health Distribution Score
- ✓ Level of Risk (suicidal and homicidal)
- ✓ Trauma Symptoms
- ✓ Functioning
- ✓ MGAF/DLA-20
- ✓ Problem Severity
- ✓ Stage of Change
- ✓ Substance Use
- ✓ Supports
- ✓ Physical Health

The suggested level of care provides an interpretation of combined data with a recommended score that is intended to be a guide in making treatment recommendations. This score, does not supersede the clinical judgement of the clinician and supervisor, but rather supports it by serving as an added element of data.
Every intake completed at Wheeler is reviewed by the appropriate clinical supervisor as part of the disposition process. The clinical supervisor reviews the assessment, diagnosis, formulation and treatment recommendations.

**Discharge Criteria:** Wheeler also uses ASAM criteria for determining discharge. Clients are discharged when:
 The client has achieved the goals in his or her treatment plan, therefore resolving the problem(s) that supported admission to the current level of care.
 The client has been unable to resolve problem(s) that supported admission to the current level of care, despite revision to the treatment plan and multiple interventions. Treatment at another level of care or type of service is therefore indicated.
 The client has demonstrated lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated.
 The client has experienced an intensification of his or her problem(s), or has developed new problem(s), and can be treated effectively only at a more intensive level of care.

- The average length of time elapsing between receipt of referral and admission to the program is: Wheeler Clinic offers immediate access to outpatient care, five days per week without a scheduled appointment.

- **Barriers to admission include**: Wheeler Clinic has a variety of resources available to assist clients with access to services including same day intake appointments, assistance with transportation, and supportive Care Management Services to assist with coordination of medical and behavioral healthcare.

- Describe any community integration of the program: Left blank

Wheeler Clinic has established relationships with: CCAR, Advocacy Unlimited, Intercommunity and Journey Home for HUB housing services, Hartford Dispensary for methadone maintenance, Alumni Group for individuals who have completed Wheeler Clinic outpatient services and have reintegrated into the community, and emergency mobile psychiatric services for clients experiencing a mental health crisis. Wheeler also hosts onsite AA meetings in various Adult Outpatient Services locations.

**PLANS FOR CHANGE OR CHANGES ANTICIPATED:**
**a. Please describe changes you implemented or plan to implement in response to DMHAS goals for a recovery-oriented system.**

Wheeler's Health & Wellness Center in Bristol achieved designation as a federally qualified health center look-alike in May 2015 and received a new access point community health center grant effective August 1, 2015. We began providing primary care and behavioral health services at this facility in 2013 - providing critical access to care in a medically-underserved portion of the city. In 2015 the center provided primary, behavioral health, dental care and enabling services to more than 1,100 patients. This center serves patients across the lifespan.

Over the course of the past few years, our Board of Trustees, leadership and community partners have worked collaboratively to design strategies to address the alarming disparities in health and in access to health care so many of the behavioral health consumers we currently serve face. We will address these disparities, documented in the clinic's *Outcomes in Integrated Care* report, by expanding the scope of our designation as a federally qualified health center to provide integrated primary and behavioral health care for adults with serious mental health and addiction disorders in Hartford, New Britain and surrounding communities.

Individuals with serious mental illness and co-occurring substance abuse disorders are often reluctant to engage in primary care services and experience disparities in access to health care and health care outcomes. Many of the patients Wheeler currently serves from Hartford, New Britain and surrounding communities do not have a primary care physician, experience multiple co-morbid health disorders and are frequently seen in the emergency department. These patients have difficulty engaging in primary care through traditional channels, including traditional community health centers and health department programs. Their experience of stigma in health care settings and past exposure to trauma often create substantial barriers to care.

Wheeler has been approved by HRSA to expand the scope of its federally qualified health center designation to include our existing outpatient service sites in Hartford and New Britain:

 **Wheeler's Hartford Health & Wellness Center**, located at 999 Asylum Avenue, Hartford, Connecticut 06105, will address the needs of this population residing in Hartford and Bloomfield. Significant disparities in access to health care services exist within these communities: more than 38,000 low-income residents of the service area are not currently served by a community health center.

 Wheeler will expand our current service site, **Wheeler's New Britain Health & Wellness Center**, located at 75 North Mountain Road, New Britain, Connecticut 06053, to address the needs of this population residing in New Britain and Berlin, Newington, Plainville, Plantsville and Southington. Significant disparities in access to health care services exist within these communities: more than 31,000 low-income residents of the service area do not currently receive care from a community health center.

Wheeler has already created a pilot, coordinated, integrated primary and behavioral health care service continuum embedded in a trauma-informed, culturally constructive and gender-responsive environment at the Hartford location and will build a similar model in New Britain. This model provides a more effective path to engagement in primary and preventive care for individuals with SMI and addiction disorders. The need for these services is critical and this model significantly enhances both individual and population health outcomes.

**b. Please describe barriers, challenges, tensions, differences in philosophy, system issues, or obstacles that need to be addressed.**

 DMHAS supports co-occurring service delivery, but reimbursement remains a challenge for providers. Regulations require vigorous documentation oversight which strains resources.

 Access to inpatient and detox levels of care is challenging as resources are limited.

 Transportation services are limited for the adult population.

## WHEELER FOCUS GROUP HIGHLIGHTS:

Wheeler Clinic is a non-profit that has some safety net state funding, but mainly operates on its own fundraising efforts. The easily accessible location in Hartford makes it the highest volume site with 25 groups a week and over 800 active people served by the program. The staff must communicate well to juggle so many people served by the program in such a small space. The review team met with an all-men's addiction group. Many are court-mandated to be in therapy, and this group was large and quiet. One reviewer was concerned that Wheeler has a "non-compassionate approach." But the same reviewer noted the multi-disciplinary approach to therapy and the holistic treatment in regards to treating the mind and body.

### FEEDBACK FROM PEOPLE IN RECOVERY:

- **Ways this program has been helpful to people served by the program:**
  - Helped with getting insurance
  - People served by the program like one-on-one time and groups
  - Program got a client out of using drugs: "changed my life" – said he would be in a park with drugs without Wheeler
  - Helps people understand the different stages of addiction
  - Wheeler feels more substantive to people served by the program than other programs
  - Encouragement to call mentors and talk to people about struggles
  - Can always come back if needed

- **Client concerns about program:**
  - People served by the program want a parenting class
  - There is not enough time in a 1-hour class per week for such a big group of people to talk about all their issues; people served by the program want smaller groups (not a longer therapy group)

- **Cultural awareness of program:**
  - People say there is no discrimination and that the group leader is a good facilitator: "It feels safe"

- **Grievance Policy:**
  - 50% of people did not hear about the grievance policy or do not remember it; some people know to go to the front desk or talk to their group leader

### FEEDBACK FROM STAFF:

- **Special aspects about program:**
  - Wheeler has been recently selected to be a Federally Qualified Health Center (FQHC) and they have a co-location at St. Francis Hospital that offers dental care. There will be 3 locations by the fall to help underserved populations. As a FQHC, Wheeler must have a certain number of people in recovery on the Board – so peer feedback and involvement are valued.
  - Open Access model: 9am-5pm walk in and intake – immediate access to services
  - When state agencies turn away people served by the program – Wheeler will absorb them
  - Wheeler takes 100 slots a month with Hartford probation
  - Easy access on the bus line and near downtown Hartford; Wellness Center offers bus tokens
  - Integration with primary care

- **Staff concerns about program:**
  - The non-clinical, non-billable programs make a big difference in people's recovery – but they are not well funded
  - No funding for mental health transportation appointments

- High staff turnover means that people served by the program do not get continuity of care. With the modest salaries that Wheeler can afford, staff get training and gain experience at the agency but then they move onto higher-paid state jobs
- Need more space and resources for the volume of people served by the program – case management and non-billable programs are important, but underfunded
- DMHAS only funds substance abuse programs but wants Wheeler to offer co-occurring programs. It would be nice if DMHAS can offer trainings. However, DMHAS funding is the least restrictive so the agency is appreciative of the support.

- **Work with special populations:**
  - Many groups exist, all are co-occurring: from LGBTQ, to problem gambling, DBT, Intensive Outpatient Program (IOP), integrated health, trauma, anger management, to alumni groups
  - Program is big on after care and peer support – relies on peer run programs like Advocacy Unlimited and CCAR
  - Bettor Choice problem gambling program – program director has lived experience and serves as a peer resource; works with families as well as individuals

- **Staff Professional Development:**
  - Great training for staff: "Training and professional development at Wheeler are stellar." There is a full-time training staff at Wheeler who helps find training for staff and supports them to go to conferences.
  - Staff say supervision is one of the best parts of their job, and look forward to weekly supervision to discuss people served by the program.

- **Grievance Policy:**
  - Posted in the lobby; will tell people served by the program about grievance policy if they ask

### *RECOMMENDATIONS:*

- Hire more people of color on staff to reflect diversity of community members who frequent Wheeler.
- Offer training in cultural competency.
- Reduce size of classes to ensure adequate time for all participants to discuss their issues.
- Create a parenting class.
- Post a grievance policy and provide a copy to each first-timer.
- Assist towns in providing transportation and work with people served to parse transportation options.

### *PROVIDER COMMENT:*

Wheeler Management Staff reviewed this report and said, "We did not have any specific feedback or comments. Thank you for the work done by the regional mental health board to evaluate programs and systems."