



NORTH CENTRAL REGIONAL
MENTAL HEALTH BOARD, INC.

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Region IV Residential Rehabilitation Programs

Review & Evaluation Report 2018

Submitted To:
**The Department of Mental Health and
Addiction Services (DMHAS)**

Submitted By:
**The Review and Evaluation Committee
at North Central Regional Mental Health Board
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OUR REVIEWERS

The North Central Regional Mental Health Board's (NCRMHB's) Catchment Area Councils (CACs), now in our 45th year, continues to provide needed evaluation, education, and advocacy opportunities for the North Central region of Connecticut. Our members are people in recovery, family members, and service providers who are all passionate about our review and evaluation role and remain committed to our mission to serve as a voice for our communities. Below are our highlighted findings.

The following community members contributed to our Review and Evaluation Committee in 2017-18 by identifying programs to review, developing survey and focus group questions, serving as reviewers on site-visits, and giving feedback to our report:

- | | |
|----------------------------|--------------------|
| • Alan Coker | • Kathy Kaiser |
| • Susan Coogan (R&E Chair) | • Catherine Kriss |
| • Nichole Colquitt | • Daniel Langless |
| • Kathleen Douglas | • George LeBoeuf |
| • Carol Gilbert | • Larry Pittinger |
| • Denise Hart | • Alice Seidenberg |
| • Jennifer Henry | • Noemi Soto |

OVERALL PROGRAM THEMES

During the course of our reviews, we kept hearing that recovery is not just a 30-day issue. Even though we only reviewed 3.7R or 28-day, inpatient residential rehabilitation programs, which is one type of recovery support, we recognize that people access a whole range of co-occurring services. The range of services includes detox, community supports, inpatient, outpatient, intensive outpatient, and medication assisted treatment (MAT).

All the inpatient rehabilitation program staff we reviewed were thoughtful and acknowledging of multiple pathways to recovery. These include 12-step programs, religious or spiritual groups, secular programs, MAT, wellness-based holistic healing, active sober communities, and online or telephonic recovery supports. However, people's recovery prospects are not necessarily related to the *type* of program they are receiving, but rather the *quality* of human connections they gain from the experience. To be effective, recovery supports should be **accessible, patient-centered, and responsive**.

PRESERVE COMMUNITY ACCESSIBILITY:

Accessibility to supports and services is key to recovery. Preserve programs located in walkable communities. Put behavioral health programs in communities hardest hit with high overdose rates. Ensure that those programs have adequate resources to respond to people's needs. For example, Blue Hills is located in the heart of Hartford's North End and is well-known by community members as an accessible service agency in the neighborhood. Farrell in New Britain and InterCommunity in Hartford are also easily walkable and accessible via

public transportation. All three agencies accept walk-ins. These programs should be preserved and promoted since they are accessible to those that need help.

DEVELOP PATIENT-CENTERED PROGRAMS:

Patient-centered inpatient residential rehabilitation programs require culturally-competent and well-trained staff, and a culture of developing human relationships. This culture requires significant resources. To develop patient-centered care with our limited state budget, we must unpack our assumptions about private non-profit versus state-operated programs.

Privatizing services can strip our communities of critical resources if we are not careful. For example, Merritt Hall and Blue Hills have flexibility around a 28-day stay without any insurance limits, thanks to state funding. Therefore, those programs are able to help high-needs clients and keep them for much longer periods of time if they lack an appropriate placement after rehab. If we privatize our rehabilitation services and close Merritt Hall or Blue Hills, local non-profits will struggle to offer clients continued residential rehabilitation services after 28 days because most insurance companies will not authorize a longer stay.

While Blue Hills serves an important purpose in Hartford, the agency is not unique in its ability to accept probates. Probates are clients who are court-mandated to enter behavioral health programs. The current myth is that only Blue Hills and Merritt Hall can take probates, but our research with the court system indicates that hospitals, individuals, and their families have a lot of discretion around where they choose to receive services. InterCommunity and Farrell can also accept probates.

Nonetheless, when we privatize services, we have to address the issues of people who do not have insurance coverage for inpatient services (Medicare, Husky C, some commercial insurance) or who do not neatly fit into insurance-approved time limits for recovery. We must consider solutions for those who lack housing or family, or who are not yet ready for discharge. In making difficult funding decisions, we must use a scalpel, not a bat.

FUND WISELY:

Funding is a big concern for inpatient residential rehabilitation programs. The costs of offering staff 24/7 for complex medical issues are difficult to minimize. The private non-profit programs we reviewed – InterCommunity and Farrell Treatment Center – are both operating at a loss by offering residential rehabilitation services. Both programs stated that they have always been lean, but as a result of state funding cuts, they had to make layoffs and downsize programs. As a large regional agency, InterCommunity can absorb some of these cuts into their overall business expenses, but Farrell cannot. This indicates that small, local inpatient residential rehabilitation programs may have to close down in the future. We are concerned about this possibility, especially in the midst of an opioid epidemic.

Recovery is not predicated on whether someone chooses a private non-profit or a state-funded inpatient rehabilitation program. Each program has unique constraints. While Blue Hills has the ability to extend someone's residential stay if they lack housing or community

supports, as a state-funded agency, they must also contend with state regulations and union rules.

Recovery depends on whether the program can offer accessible, patient-centered care. While all the programs we reviewed can offer patient-centered care, state funding cuts threaten their ability to keep their doors open. Budget cuts also encourage the use of outpatient Medication Assisted Treatment (MAT) programs, which tend to offer more independence but less healthcare service-provider interaction.

Our reviewer Noemi Soto noted that funding recreational activities in residential rehabilitation programs is key to promoting recovery. Ms. Soto asserted,

“It is important that people understand that recreational activities are vital to the recovery process. Active addiction essentially reconfigures the brain to primarily associate pleasure exclusively with drug use. Finding joy and pleasure in healthy ways is probably the biggest barrier to long-term recovery. Life consequences might be enough to bring an individual to seek treatment; but a life with fewer consequences does not sustain long-term hope if pleasure and joy are not experienced or foreseeable in sobriety.”

Therefore, a variety of recreational activities and a range of recovery supports are necessary to long-term recovery. Decision makers should know that “recreational activities” are a vital part of treatment.

CULTIVATE PROVIDER-CONSUMER RELATIONSHIPS

Many financial limitations, impacted by state funding gaps and health insurance issues, continue to prevent people from accessing the healthcare services they need. While outpatient programs with Medication Assisted Treatment (MAT) may be less expensive than residential stays, programs are ineffective without the human connection component.

The first problem with MAT is we heard that there are not enough outpatient services offering this program, so residential rehabilitation providers are reluctant to start clients on this treatment without the assurance that they can get support after discharge to continue accessing MAT. Moreover, people who struggle with MAT talk about feeling like a number. They describe being shooed out of doctors’ offices after 15 minutes and offered a pill to “fix” their symptoms. This is a system-wide issue that points to a need for more outpatient program supports that offer MAT and cultivate human connections.

Similarly, people who struggle with residential stays talk about feeling isolated from friends and family, and feeling like they have no options after discharge from the program. Since residential beds offer a short-term solution, we must look at the entire system of care and ensure that patient-centered care is a focus throughout treatment.

The use of peers can be an empowering part of this focus. For example, strong alumni engagement and use of a recovery house were cited as effective motivators for people in recovery. These are cost-effective solutions that foster human connection.

SUPPORT RESPONSIVE CARE:

The effectiveness of any particular residential rehabilitation program depends on how well they address the needs of people who seek help. This also relates to how programs can foster community and how much staff empower clients to build human connections. For example, family involvement was treated differently by each residential program we reviewed. The involvement of family and friends in one's recovery is key. Throughout our reviews, we saw the impact of a "recovery community" and peer-to-peer supports on people in rehabilitation programs.

PROMOTE PEER SUPPORT

Peer support services are delivered by individuals who have common life experiences with the people they are serving. These services leverage empathy and empowerment to support recovery. Peer support is an essential element of successful communities and is integral to recovery. Residential rehabilitation programs should offer peer support with clearly defined, meaningful roles.

One model program to consider is CT Community for Addiction Recovery (CCAR) Recovery Coaches, which is a peer-to-peer model that effectively addresses addiction crises in Emergency Rooms (ERs). CCAR's connect-to-care rate is 97%. This means that most people who are paired with a Recovery Coach in the ER make an immediate healthcare plan to address their behavioral health problems long-term and to avoid returning to the ER. CCAR uses the "recovery coaching" model which empowers anyone to become a counselor.

Beyond the ER, Advocacy Unlimited's Community Bridger program meets people in locations most convenient to them in their communities. In contrast to CCAR's Recovery Coaches, Community Bridger uses the Recovery Support Specialist (RSS) model, which requires that a counselor have lived experience in mental health or addiction. The RSS model promotes the theory that people with lived experience of mental health or addiction issues can offer uniquely valuable support to one another. Community Bridger also uses Intentional Peer Support (IPS). Both programs listen to people and build their recovery supports on cultivating trust and human relationships.

To address addiction issues, let's look to the programs where human connections are well developed and promote these models. We must continue to invest in recovery with the full expectation that this is a long-term, chronic issue. Moreover, while the opioid crisis has been in the media, alcoholism continues to be the most prevalent addiction concern. In a 2018 study done by CCAR, opioids represent 24% while alcoholism represents 69% of ER patients. We must cater our programs to fit the ongoing needs of our communities.

CONCLUSION:

The overall healthcare system currently lacks adequate supports for people with chronic illnesses. Recovery is a long-term process that can take months or years to address. In order

to promote stability and recovery, we need to prioritize programs that focus on developing the human connection. This way, people can find recovery supports within residential programs and beyond. The most effective rehabilitation programs help people trust their healthcare providers, cultivate supportive relationships, and create a thoughtful plan for how to tackle the addiction long-term.

INTERCOMMUNITY PROGRAM REVIEW

OVERVIEW OF INTERCOMMUNITY

Intercommunity (IC) has a mission to help people improve their quality of life by providing physical, mental health and addiction services for optimum health and recovery. IC is unique as a FQHC-LA (Federally Qualified Health Center Look-Alike) that offers primary care and behavioral health services. Hence, they can connect clients with other specialty services as needed and when appropriate. For example, when their residential clients need dental services, IC can bring them to a local provider. IC aims to provide whole-person care.



The Intensive Residential treatment program is a 14 to 28-day program, focused on intensive treatment of Substance Abuse and Mental Health Disorders. Clients attend seven (7) psychotherapy groups a day, addressing relapse prevention, self-awareness, Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, trauma, coping skills and life skills. IC supports all medication assisted treatment (MAT), not just methadone. Individual therapy is also provided at least once a week. Family Education is provided for clients and family during visits.

SUMMARY OF KEY FINDINGS

Our Review and Evaluation committee, comprised of CAC members across our region, conducted a site visit to IC to review their 28-day Rehabilitation Program. The IC staff led the committee on a tour of the Detox and Rehab facilities in Hartford. Then the committee met with Rehab clients and staff separately in two focus groups, and administered surveys to clients. Our key findings are below:

- **Merits:**
 - a. **Excellent alumni engagement:** Alumni Friday is a good way to invite back alumni, so current clients can interact with people who have passed through the program, and cultivates mentoring relationships. Alumni Friday is a good practice to help engage and motivate people.
 - b. **Recovery House offers helpful transitions:** The Recovery House helps people coming into rehab and people being discharged. The Recovery House has 56 beds. If someone is waiting for an inpatient bed, they can go to Recovery House and find people who have been recently discharged from inpatient to mentor or guide them, to seek support, and to prepare for the program. When

people are discharged from a local rehab program, they can also go to Recovery House while waiting for a more extended rehabilitation placement or securing options for a safe return to the community. Recovery House naturally offers peer-to-peer support for motivated participants. The relationships formed at Recovery House seemed to help people with their recovery.

- c. **A family of caring staff:** According to clients, the staff accessibility is better at IC than in other programs. The IC staff was notably ebullient and positive. From speaking with staff, reviewers got the impression that programmatic improvements were already under way. One client was especially impressed that staff noted her dental issues and helped her address them while in the program.

Clients felt physical and emotional safety in the program, and a strong sense of security. R&E reviewers noted the family-like support and camaraderie between staff and clients. Staff described a “familial dynamic” in their program. Clients expressed feelings of “safety and protection”. Clients noted that regardless of what counselor was “assigned” to them, all staff were accessible, responsive, and attentive to address any concerns that arose. Staff reported that a daily briefing keeps the clinical team aware of all client treatment concerns and updates. The staff attitude was optimistic regarding recent transitions and current management structure.

- d. **Post-discharge follow-up:** IC seems to care a lot about clients even after they graduate from the program, especially with discharge to Recovery House and Alumni Fridays. IC staff asserts that relapse is considered part of recovery, which helps people feel welcome to stay in touch and come back to seek help as needed.
- e. **Grievance policy posted:** IC’s grievance policy and patient rights were posted in an open and accessible area, directly across from the entrance.

- **Unmet Needs Noted:**

- a. **Private insurance’s refusal to pay for certain treatments presents gaps in care:** IC has less flexibility to offer clients extended stay due to limits in private insurance. This means that clients are discharged when the commercial insurance company deems appropriate, not when clients are actually ready and able for discharge. Moreover, clients with commercial insurance cannot be assured of services unless they meet the criteria for certain levels of care. This is frustrating and speaks to the need for state-funded supports, to offer flexibility in treating clients when commercial insurance falls short.
- b. **Staff wanted more knowledge about outside programs:** Staff wanted more exposure to outside providers and community programs and services in order

to better understand available community resources for their clients. Staff would like to go on field trips to community programs to learn about resources “out there” beyond IC’s rehab program.

- c. **Paucity of self-help books and twelve-step programming:** Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) resources were lacking. Clients wanted manuals and twelve-step books readily available. Overall, the patient survey indicated an interest in “more programming.”
- d. **Lack of fresh air:** Since the program is located on the 9th floor of a hospital, there is a need for more access to fresh air for clients. People wanted more outside time.
- **Concerns:**
 - a. **Rules and regulations:** Some clients reported that they did not get a printout of rules and regulations, and claimed they were forced to sign that they did. This perception should be addressed since IC is passionate about cultivating a culture of trust. When we shared this with staff and the program director, they thoughtfully responded and affirmed that they will work on this issue to ensure that clients gain familiarity with program rules and expectations during the admission process. Moreover, the program director noted that client rights are clearly posted, and the client rules are printed and available in 3 binders on the unit in an area accessible to everyone.
 - b. **Minor concerns:** Clients had some minor complaints about the food. They also complained that some court-mandated people hold back others from recovery due to their bad attitude. Finally, some women said only one TV is available, so the men tended to control it. Perhaps this speaks to the gender disparity in residential rehabilitation programs. Being a female in a rehabilitation program where most residents are male could be challenging. We wonder what kinds of programming could help address these dynamics. Clients want a system where either two TVs are available, or to get staff help facilitating use of the remote control so that everyone can have a chance to watch what they want.

RECOMMENDED ACTION STEPS

Based on the data collected, here are our recommended action steps:

- Think “transition” rather than “discharge.” The review team suggests calling the “discharge” plan a “transitioning” plan to further drive the point that graduating from the program is just one more step towards recovery, but if there’s a relapse, people are welcome back.
- Connect clients to free Narcan from the Greater Hartford Harm Reduction Coalition (GHHRC). Narcan is a lifesaving tool for overdose, and all clients should have access

to this drug, especially upon discharge. Our reviewers recommend that IC connect with GHHC weekly educational events to offer Narcan to clients.

NEXT STEPS FOR REVIEW AND EVALUATION TEAM

Share results of review with legislators concerned with mental health funding and budget cut recommendations:

We need to fund IC and other mental health and addiction services, especially during this opioid crisis. People with mental health concerns and dual diagnosis continue to need help, and alcohol addiction continues to be the biggest reason for inpatient rehabilitation.

As of February 2018, IC is dealing with major cuts. Over 5% is already cut across all programs at IC, amounting to \$628,000. Additionally, targeted cuts eliminated 2 programs: the HIV/AIDS awareness, and senior outreach (affecting about 100 people). This also cuts two staff for those two programs. IC will nevertheless try to continue some reimbursable services via their FQHC-LA, which has a higher reimbursement rate.

The reality of inpatient residential care is that funds have been stagnant for decades and costs continue to rise. The 28-day program is slated to lose \$75,000 this year. To offset this issue, IC doubled the capacity of Recovery House and ABH paid for 10 beds. Recovery House is not at a deficit due to this additional ABH funding and due to new participant fees. IC recently instituted a change where people now can pay extra to stay longer at Recovery House – for up to 6 months total. These new participant fees help offset costs for IC's rehab programs, but they lengthen the waitlist for Recovery House.

Unfortunately, residential programs like IC's 28-day rehabilitation program all run at a deficit. For example, Coventry House runs at a \$50,000 per year deficit, but it serves moms with children, so IC continues to run it to fulfill a community need. Because IC is a larger private non-profit, it was able to avoid the 5% cut from Coventry house by taking the funding from outpatient services so that IC's FQHC can absorb the cuts. However, smaller private non-profits will not be able to absorb the cuts, and our state will lose residential programs if

we continue to cut mental health funding from behavioral health programs. This will leave many of our most vulnerable residents at risk of relying on ERs for crisis care.



BLUE HILLS PROGRAM REVIEW

OVERVIEW OF BLUE HILLS

Blue Hills Hospital is part of the Connecticut Valley Hospital (CVH), Hartford Campus. At CVH, individuals receive services that assist them to better manage their illnesses, achieve personal goals, and develop skills and supports that lead to living the most constructive and satisfying lives possible. CVH's vision statement is "Inspiring Recovery through collaborative, compassionate, and culturally competent care and treatment."



As the only completely state-funded and state-run inpatient detox program in our region, Blue Hills plays an important role in our spectrum of care. The hospital is made up of primarily two distinct units, the Acute Unit, which is a 21-bed, coed, medically-monitored detox program for alcohol, opiate, and benzodiazepine detox. The average length of stay is 5-7 days, but is individually driven. The Rehab unit is a 21-bed coed intensive rehabilitation program, specializing in treatment of co-occurring disorders, with an average length of stay of 28 days; however, this is based on individual needs and recovery. The population served is primarily individuals with co-occurring disorders, or those with substance abuse issues along with psychiatric and medical co-morbidities.

SUMMARY OF KEY FINDINGS

Our Review and Evaluation committee, comprised of CAC members across our region, conducted a site visit to Blue Hills to review their 28-day Rehabilitation Program. The Blue Hills staff led the committee on a tour of the Rehab facilities at Blue Hills. The committee met with Rehab clients and staff separately in two focus groups, and then administered surveys to clients. Our key findings are below:

- **Merits:**

- a. **Extensive resources:** Blue Hills offers comprehensive supports, including but not limited to medical doctors, nutritionists, a recreational therapist, occupational therapists, and physical therapists. Unlike other rehabilitation programs, Blue Hills has a lot of mental health staff – two psychiatrists and two therapists, as well as substance abuse staff. Due to their staffing, Blue Hills can also meet the level of care for complex medical and probate referrals.

The Review Team was surprised at the diversity of recreational activities people engaged in. The facilities offer yoga, an art room, an equipped gym, and a court

yard. Blue Hills clients are getting a lot of fresh air compared to other rehab programs. Clients visit the local park, see horses, and regularly go on walks. The review team was particularly impressed that clients are getting out a lot in the winter.

Clients raved about the food at Blue Hills. Moreover, it is evident there are many helpful groups based on client discussions. One client complained about sitting all day but it meant she was engaged in groups from morning until evening. Some books offered were outdated, but clients get new books when they request them.

- b. Flexibility regarding the 28 days:** Blue Hills does not discharge their clients without a suitable safe place to live. The flexibility around discharge is invaluable as it ensures people can find community supports needed to maintain recovery.
 - c. Availability for walk-ins:** Blue Hills's location in the heart of Hartford's North End make it easy for people to take public transportation or simply to walk to get help. Some clients said they walked or took bus to Blue Hills. The facility also offers resources across generations for local residents. The facility has been around for a long time, and walk-ins are welcomed, making Blue Hills an incredible community resource. Also, staff often check in with people on the waitlist. One client said he got a phone call from Blue Hills staff while he was on the waitlist, which helped him avoid drinking during the Super Bowl.
 - d. Connection to in-house and community 12-step programs:** Clients repeatedly raved about Blue Hills's strong connection to 12-step programs. Several people stated this was why they chose Blue Hills. Blue Hills sets itself apart by offering both an in-house 12-step program, and connections to community 12-step programs. Staff regularly bring clients to local 12-step programs to create a pathway for people in recovery after discharge.
 - e. Grievance policy posted:** Blue Hills's grievance policy was clearly posted and many clients in our focus group confirmed they were well-aware of the policy and that staff were responsive to grievances raised.
- **Unmet Needs Noted:**
 - a. Cannot take commercial insurance:** Blue Hills offers many comprehensive supports, and the amount of care is incredible compared to what private non-profits can offer. However, Blue Hills is reserved for the most vulnerable community members, and as such, only takes Medicaid insurance. This limits other community members' ability to access this facility.
 - b. Reduced access to Recovery House:** Blue Hills has limited access to Recovery House, which is a useful transition place where people waiting for inpatient rehabilitation beds can stay, and where people can be discharged to after completing the 28-day program. Recovery House has proven to be especially helpful in connecting people in recovery so they have peer mentors and role

models to help with the difficult recovery process. Blue Hills's clients would benefit from more availability at Recovery House.

- c. **No Peer staff:** Blue Hills currently does not employ any people in recovery from mental health and addiction as peer staff. This could limit their ability to connect with clients in an effective way.
- **Concerns:**
 - a. **Family visits:** The way family visits are organized may be a barrier to family members. Clients reported that Blue Hills's family engagement program felt onerous to families. The current policy is every time a family member visits, they must sit through an hour-long educational session. Blue Hills staff thought they were offering new and useful information each time, but family members felt that the pre-visit education sessions were redundant and took away from visitation time. This ultimately deters and reduces family visits for clients.
 - b. **Message that relapse is an indication of failure:** Even though many residential rehabilitation programs face recidivism, Blue Hills's message to clients upon discharge is "I hope we never see you again!" This message infers that relapse is an indication of failure, and could prevent people from seeking help at Blue Hills again. This may deter people from accessing services or encourage them to seek help at other agencies that may not have adequate resources.
 - c. **No alumni engagement:** Unlike other agencies, Blue Hills does not engage alumni on a weekly or monthly basis. In fact, Blue Hills hopes clients will not return after discharge. Lack of alumni engagement may inhibit Blue Hills clients from seeing progress after discharge. People need mentors to help them on their recovery journey. Alumni engagement has been shown to be helpful to both clients and alumni. People are more motivated to be sober if they are seen as a role model, and they benefit from the reminder of the journey they took in rehab.
 - d. **Only one Medication-Assisted Treatment (MAT) available:** Blue Hills only inducts with methadone, but not Suboxone. Staff cited a perception that there is a lack of Suboxone providers. Perhaps challenges exist for providers to prescribe Suboxone in Hartford. Nonetheless, given the wide interest in MAT, Blue Hills should consider offering induction with Suboxone as well.

RECOMMENDED ACTION STEPS

Based on the data collected, here are our recommended action steps:

- **Create position for peers:** Peer staff have been proven to help programs connect with people struggling with mental health and addiction crisis. Peer staff can cultivate efforts to engage with alumni and to promote recovery beyond the program. The return on investment for peer staff is high. Peers' specialized knowledge and ability to empathize with clients comes from life experience rather than formal education.

- **Address concerns regarding family visits:** Family members should be able to prioritize seeing their loved ones when they visit, instead of having to sit through an hour-long, repetitive educational session each time. Family members often come from afar and must take time off work to be able to visit, so their time is valuable. On the other hand, family education helps create support for people in recovery. Engaging family is an important part of the recovery process. Building some flexibility into scheduling for family visits helps family members prioritize seeing their loved ones and learn about how to best support their recovery.
- **Calculate costs for care in case services must be privatized:** Figure out the costs of care for Blue Hills, so that private non-profits have a good understanding of what it takes to provide the staffing and resources needed at this agency. These costs of care will help legislators, policy makers, and other agencies understand whether it is feasible to privatize inpatient rehabilitation programs.
- **Create a centralized intake for efficiency:** Staff brought up the issue that if the intake process was coordinated with CVH, then people would not have to call two places to find out about availability. Blue Hills seemed genuinely interested in developing a centralized intake process and we hope this can be prioritized.

NEXT STEPS FOR REVIEW AND EVALUATION TEAM

Share results of review with legislators concerned with mental health funding and budget cut recommendations: Blue Hills's budget cannot withstand any more cuts, and we should avoid the closure of this facility. Blue Hills offers comprehensive services to the most vulnerable residents of the Greater Hartford region, and closing it down will mean that we will lose a significant resource.



Private non-profits cannot fill the gaps left by Blue Hills. Our members found a contrast between state-operated and private non-profit programs when comparing Blue Hills to other agencies. As a state-operated program, Blue Hills is well-resourced and is uniquely positioned to help the most high-needs clients. Our members thought that Blue Hills's focus on 12-step programs was unique and helpful to clients, since the biggest problem in rehab is still alcohol addiction.

Legislators and policy makers should work with Blue Hills to figure out the real costs of inpatient rehabilitation services. If policy makers want to privatize this service, they must understand what is at stake and invest adequate resources to meet the level of care needed. Cutting Blue Hills's budget or closing the facility will cause irreparable harm to our state's

ability to tackle the opioid crisis and ongoing crisis care issues. We need the level of care that Blue Hills can currently provide.

FARRELL PROGRAM REVIEW

OVERVIEW OF FARRELL

Farrell Treatment Center is an inpatient, residential drug and alcohol rehabilitation program for men based in New Britain, CT.

Msgr. Joseph Farrell started the Farrell Treatment Center in 1972 at Saint Mary's convent as a shelter for homeless alcoholic men. The center offers three main types of services:

- 1) inpatient residential program for men,
- 2) co-ed intensive outpatient programs, and
- 3) outpatient treatment for group, individual, or family therapies.

The 28-day inpatient rehabilitation program for men includes group and individual counseling, and is reputed to be one of the best in the area. David Borzellino, the executive director of the center, stated "There isn't one way to recovery. There are multiple paths and we work with our clients to meet their needs." What sets Farrell Treatment Center apart from other centers is the staff who are trained in trauma therapies and who works with all their clients. "Everyone compliments us on how our staff gets to know clients individually. Farrell doesn't feel like an institution." Borzellino is proud of his team of 23 full-time and eight on-call employees who assist clients at all hours of the day. The staff is always up to date and trained on the latest practices. Clients liked that some staff can offer peer support since they are in recovery from addiction and have been through the residential rehabilitation program. Farrell has one medical internist and three psychiatrists, including one who offers Medication Assisted Treatment (MAT) onsite. A medical doctor is at Farrell daily. Four staff are licensed alcohol and drug counselors and other residential counselors are working toward their certification.



SUMMARY OF KEY FINDINGS

Our Review and Evaluation committee, comprised of CAC members across our region, conducted a site visit to Farrell Treatment Center to review their 28-day Rehabilitation Program. The Farrell staff led the committee on a tour of the inpatient rehabilitation facilities in New Britain, which was a warm and well-maintained old Victorian house. The building felt non-clinical and welcoming. The committee met with Rehab clients and staff separately in two focus groups, and administered surveys to clients. Our key findings are below:

- **Merits:**
 - a. **Diverse array of engaging groups and recovery-oriented healing environment:** Farrell is located in a non-institutional, attractive space that was a converted church. People loved the range of groups offered, which

include “biology of addiction,” yoga, and meditation. People appreciated the fact that they couldn’t hide at the program – that they were engaged the entire day. Clients also appreciated having an available gym, outside time, and expressed enthusiasm about the nutritious meals available. Everyone takes on chores and does their own laundry. Many of the moderators, or staff who oversee the residential program, are also people in recovery and some have graduated from Farrell. Therefore, moderators can offer peer support, empathy, and compassion while helping with medication management.

b. The staff responsible for transitions is passionate about her work and cultivates community partnerships to help people find places to land:

Before discharge, each client devises a plan with the staff responsible for discharge. This staff caters to people’s geographic preferences to find an appropriate next step, whether it be a more extended rehabilitation placement, or securing housing options, or finding a job or volunteer opportunity for clients. The clients’ relationship with this staff play an integral role in them moving forward with sobriety.

c. A family of caring staff: The staff accessibility is unparalleled. Clients’ living quarters are on the same floor as staff offices, and even the Executive Director of Farrell has an easily accessible office right in the middle of the building with an open-door policy.

- “Warm-hand offs” are noted in every stage of treatment and continues beyond discharge. Staff are invested in getting people seeking treatment into the program as quickly as possible, and in ensuring safe transitions.
- Genuine interest and investment in client success before, during, and after treatment was evident. Clients seemed to feel respected and appreciated for their efforts.
- People in recovery felt that the staff genuinely care about their physical and emotional safety. Family-like support and camaraderie existed between staff and clients.
- Staff and clients talked about people in the house as a “family”. Clients expressed feelings of “safety and protection”.
- Clients noted that regardless of what counselor was “assigned” to them, all staff were accessible, responsive, and attentive to address any concerns that arose.
- All staff participate in morning goals and evening wrap-up groups, which help develop relationships and ensure that staff know about clients’ progress.
- The diversity of areas of expertise and style among staff means that each client can connect with someone or some mode of recovery offered

d. Post-discharge follow-up: After discharge, clients always feel welcome to call for support, or to come back to the program if they need another stay. Alumni

come back to lead groups. The annual holiday party brings back graduates of the program.

- e. **Grievance policy posted:** Farrell's grievance policy and patient rights were posted in an open and accessible area in the main hallway, near the front entrance. All the clients in the focus group said they knew their rights and remember signing a form that indicated their awareness of the grievance policy.
- **Unmet Needs Noted:**
 - a. **Need more funds or support for housing upon discharge:** "Basic Needs Beds" is a temporary allowance for housing funded through DSS. Basic Needs Beds can pay for a month at the YMCA, two months at a Sober House, but does not cover the costs of a hotel. Farrell specified that their Basic Needs Beds funding was reduced from three months to one month at the YMCA
 - b. **Need more program funding:** Farrell offers a comprehensive program on a shoestring budget, and the program loses \$100,000 per year by offering this valuable service to the community. The program just lost two beds due to funding cuts, which is a big loss for people seeking residential rehabilitation treatment during this opioid crisis. Without more funding, Farrell will be forced to close its doors.

RECOMMENDED ACTION STEPS

Based on the data collected, here are our recommended action steps:

- Share Farrell's best practices with the community and other service providers. Farrell's practice of mandating staff to participate in groups along with clients is laudable. This practice to integrate staff and clients humanizes the recovery process, fosters mutual respect among providers and clients, builds genuine relationships, and diminishes stigma barriers that delay the establishment of necessary trust. This is a simple practice that should be standard.
- Farrell staff noted that the intake process could be tweaked to help even more people get in more efficiently. To do this, the agency could better educate the front desk about how to better respond to intake calls, since a client's self-report is not always accurate. The process is currently first come first serve, and priority should be given to clinically-appropriate people.
- Our staff survey showed that staff's knowledge of Culturally and Linguistically Appropriate Services (CLAS) standards was low at 37% out of 100%. Farrell serves a big Polish population but also serves a linguistically-diverse community in New Britain. One client noted it might be helpful to offer services in different languages. Perhaps Farrell can offer training on cultural competency and language access to staff.

NEXT STEPS FOR REVIEW AND EVALUATION TEAM

Share results of review with legislators concerned with mental health funding and budget cut recommendations:

We need to fund Farrell and other mental health and addiction services, especially during this opioid crisis. As of 2017, Farrell is dealing with major cuts. Residential programs like the 28-day rehab program run at a deficit, even with a lean budget like Farrell's. Our state will lose residential programs if we continue to cut mental health funding. This will leave many of our most vulnerable residents at risk for relying on Emergency Departments for crisis care. The reality of residential care is that funds have been stagnant for decades and costs continue to rise. Farrell's residential rehabilitation program is slated to lose \$100,000 this year.



MERRITT HALL PROGRAM REVIEW

OVERVIEW OF MERRITT HALL

Merritt Hall offers comprehensive 28-day rehabilitation programs for substance abuse that includes gender-specific treatment for men and women ages 18+. Merritt provides intensive substance abuse treatment as well as psychiatric and medical care. The individualized length of stay for Merritt's inpatient rehabilitation program averages 36 days. Additional services include individual, group, and family counseling. Merritt also offers 12-step support groups, vocational



rehabilitation, recreation and leisure activities, and many other psycho-educational and supportive services. There are three units total, two for men, one for women, with a 30-bed capacity in each. Beds are always full. The rehab stay is 30-45 days with 90-day outlier stays. Merritt Hall is staffed with a Nurse, two Addiction Counselors, one Recreational Therapist, one Clinical Psychologist, and Social Workers. Merritt also has a Psychiatrist and Medical Doctor on site, who are available to see patients every day. Each unit has two Psychiatrists and two Psychologists, a Neurologist, and a bevy of Substance Abuse Counselors.

SUMMARY OF KEY FINDINGS

Our Review and Evaluation committee, comprised of CAC members across our region, conducted a site visit to Merritt Hall in late June to review their 28-day Rehabilitation Program. The Merritt Hall staff led the committee on a tour of the facilities in Middletown. Then the committee met with clients and staff separately in two focus groups, and administered surveys to clients. Our key findings are below:

- **Merits:**
 - a. **Flexibility regarding the 28 days:** Merritt does not discharge clients without a suitable, safe place to live.
 - b. **Extensive resources:** As part of Connecticut Valley Hospital, Merritt has extensive resources including a doctor, dietician, and other staff. The psychologist can assess for neurological issues that have never been previously diagnosed. Merritt also has a dialysis unit, HIV care, C-PAP, Oxygen, and offers recreational, physical, and occupational therapy (RT, PT and OT). Merritt offers services to people who are visually impaired, and always has interpretation available for monolingual clients. Merritt also has religious leaders, such as a chaplain, rabbi, and imam.

Merritt Hall can also meet the level of care for complex medical conditions, offer detox from a combination of substances, and support people with arson and sexual assault histories. Induction with either methadone or suboxone are available. A large intake set-up helps get people help they need more efficiently.

Merritt can offer excellent after-care planning for people who graduate from the program. No one is released without a place to go. Clients can get vocational services, help with pardons, completing their education, job training, and GED.

- c. **Recovery-oriented environment:** From the beginning, clients are welcomed with full supports. A new admissions ritual in the women's program includes a welcome with a song and assignment to a big sister, who helps mentor the client in her recovery, and every week of sobriety results in a recognition star. The men's program has similar welcoming ritual. This is well liked by the patients.

Wall murals and comfort rooms help clients recover better. Clients also liked the daily process group, which is a mutual support group that does not require skill-building.

Clients feel very much respected by the administration. On a scale of 1 to 10, clients surveyed at Merritt Hall rated respect by administration at a 9. Clients also believe that staff will follow up with them after discharge from the program to make sure they are okay. Staff share that they generally do not follow up, but will respond if clients call for assistance. The Annual Alumni event was discussed by clients – peers are welcomed back to share their recovery stories.

- d. **Grievance policy posted:** Merritt's grievance policy and patient rights were posted in an open and accessible area.

- **Unmet Needs Noted:**

- a. **Long waitlist:** Merritt has a 2 to 3-week waitlist. Getting into Merritt is more difficult than other facilities because it is always full. Merritt has capacity for 20 inpatient co-ed detox beds, and 30 beds in each of the three rehabilitation units – two for males and one for females.
- b. **Efficiencies:** The staff and administration would like to find efficiencies. One idea is to integrate Blue Hills and Merritt referrals.
- c. **Lack of Providers at Discharge:** Staff find that it is more difficult to get clients discharged to a suboxone program and there is a scarcity of suboxone providers available for follow-up. Methadone has been easier; however, the Hartford Dispensary recently changed their structure such that induction

process lasts 6 months and people have to report to a hub center for intake and continuation of services. This creates new transportation barriers. Homelessness is a barrier to certain clients to get discharged and to have supports to recovery.

- **Concerns:**

- a. **Family psycho-education program:** The way family psycho-education is addressed may be a barrier to family visits. After a long drive to CVH, family members must go through an hour of psycho-education for a half hour visit. This often results in lack of visits. If family members want to drop off belongings, this should happen on a separate day and time. Often, the choice for clients is between receiving belongings or getting a family visit.

The R&E team addressed this concern with administration during our exit interview. The problem is that checking for contraband requires two staff to sign off. This is difficult for staff to manage when also conducting family visits. Contraband is taken seriously since contraband recently resulted in an overdose death.

- b. Clients would like improvement for recreation. They lost their pool because of the cost of maintenance. Clients want weight room equipment. Merritt lost library staff during recent budget cuts, and clients miss having access to a library. Clients also would like to re-open the Valley View café, where they can work and connect with others in recovery, and have an opportunity to advertise clothing drive needs to the community.

RECOMMENDED ACTION STEPS

Based on the data collected, here are our recommended action steps:

- Address concerns regarding family visits.
- Proceed with efforts to streamline intakes.

NEXT STEPS FOR REVIEW AND EVALUATION TEAM

Share results of review with legislators concerned with mental health funding and budget cut recommendations:

We need to fund Merritt Hall and other mental health and addiction services, especially during this opioid crisis. People with mental health concerns and dual diagnosis continue to need help, and alcohol addiction continues to be the biggest reason for inpatient rehabilitation. Even as CT Valley Hospital undergoes extensive scrutiny due to the issues at

Whiting, Merritt Hall continues to be an important resource in our community for the most vulnerable, complex health clients.



CLIENT SURVEYS

The following charts represent only clients who chose to participate in our client focus groups. Due to the small sample size, please note that these numbers are **not representative** of the entire client population at these service agencies. The charts are included to give readers information about those who shared feedback for the report in our focus groups.

Treatment programs could be improved if... (Choose ONE)

Answer Choices	Blue Hills		IC		Farrell		Merritt	
They have shorter wait lists	27%	4	0%	0	0%	0	43%	3
There were more programs	60%	9	100%	4	33%	2	28%	2
They offered services in more languages	13%	2	0%	0	17%	1	0%	0
Other: Answers include, “need increased funding”; “more programs”; “want improved client to counselor ratio”; “want staff to sit in on NA/AA meetings to ensure conversation is focused on recovery efforts”; and “perfect the way it is”	0%	0	0%	0	50%	3	28%	2
Answered		15		4		6		7
Skipped		2		0		1		1

Our Focus Groups’ Level of Education?

Answer Choices	Blue Hills		IC		Farrell		Merritt	
Some Elementary or Middle School	25%	4	0%	0	0%	0	0%	0
Some High school	6%	1	0%	0	67%	4	25%	2
High School Graduate/passed GED/High School Equivalency Exam	44%	7	50%	2	17%	1	37%	3
Some College	13%	2	25%	1	17%	1	37%	3
College Graduate	13%	2	0%	0	0%	0	0%	0
Graduate School (advanced degree)	0%	0	25%	1	0%	0	0%	0
Answered		16		4		6		8
Skipped		1		0		1		0

Our Focus Groups’ Age Range	Blue Hills		IC		Farrell		Merritt	
20-39	44%	7	25%	1	83%	5	50%	4
40-59	31%	5	50%	2	17%	1	50%	4
60-79	25%	4	25%	1	0%	0	0%	0

COMPARISON DATA

Unless otherwise noted by asterisks, these numbers are self-reported by the agencies.

	InterCommunity	Blue Hills	Farrell	Merritt
Program funding (FY 16-17)	\$1,513,182	\$2,259,514*	\$1,100,000	\$4,286,570*
DMHAS Funding	\$411,442 (this is probably a blend of BHRP dollars & grants) ¹	100%	\$0 grants and 100% BHRP dollars ²	100%
Capacity (number of beds)	28	21**	24 (men only)	30** (women) 60** (men)
Est. unduplicated client count (FY 16- 17)	567	Not reported	276	Not reported
Total number of current active clients	28	21	24	90
Full Time Employees	17	26	15	105
Part Time Employees	3	2	5	5
Peer Support Staff	2	0	1	3 shared with CVH

*Source: <http://transparency.ct.gov>

**Source: <http://www.ctaddictionservices.com/index.php>

¹ DMHAS funding is split into:

- 1) Grants - a pot of money given ahead of time to the program to help with uninsured clients.
- 2) Behavioral Health Recovery Program (BHRP) dollars - money reimbursed to programs after a determination that Husky D patients need the level of care.
 - a. This determination is made by Advanced Behavioral Health (ABH), and programs must invoice ABH for reimbursement for the days clients spend in residential treatment.
 - b. Medicaid does not fund residential treatment, so BHRP fills this gap.
 - c. BHRP is a set-aside pot of funds (which is a mix of federal and state dollars) to support non-Medicaid programs.

² Farrell gets no DMHAS grant money but 100% BHRP dollars.

DMHAS FY2017 Annual Statistical Data

Race	N	%
White/Caucasian	68,125	64%
Black/African American	16,651	16%
Other	22,130	20%

Our Focus Groups' Ethnic, Racial, Cultural Background:

Answer Choices	Blue Hills		IC		Farrell		Merritt	
Asian/Pacific Islander	0%	0	0%	0	0%	0	0%	0
Black/African American	25%	4	25%	1	0%	0	25%	2
Hispanic/Latino	19%	3	25%	1	0%	0	13%	1
White/Caucasian	56%	9	50%	2	100%	6	62%	5
American Indian or Alaska Native	0%	0	0%	0	0%	0	0%	0
Other (please specify)	0%	0	0%	0	0%	0	0%	0
Answered		16		4		6		8
Skipped		1		0		1		0

DMHAS FY2017 Annual Statistical Data

Gender	N	%
Male	62,890	59%
Female	43,473	41%
Transgender	12	0%

Our Focus Groups' Gender	Blue Hills		IC		Farrell		Merritt	
Female	19%	3	75%	3	0%	0	37%	3
Male	81%	13	25%	1	100%	6	63%	5
Other (please specify)	0%	0	0%	0	0%	0	0%	0
Answered		16		4		6		8
Skipped		1		0		1		0

DMHAS FY2017 Annual Statistical Data

Level of Care	Unduplicated Client Count
SA Residential Rehab	10,370
SA Outpatient levels of care	50,008

Primary Drug at MH or SA Admission – SFY17 Admissions	N	%
Heroin/Other Opioids	18,755	38%
Alcohol	17,615	35%

DMHAS FY2017 Annual Statistical Data:

Substance Abuse Inpatient and Residential

Eleven thousand eight hundred fifty-two (11,852) clients received Substance Abuse Inpatient and Residential services. Most (88%) of these clients were in the **residential** Level of Care. There were 20,581 admissions to SA inpatient or residential programs and 20,495 discharges during this timeframe.

Substance Abuse Residential	Bed Capacity	State Avg. Utilization
SA Intensive Res. Rehabilitation 3.7	147	96%
SA Intensive Residential - Enhanced	43	99%
Transitional/Halfway House 3.1	93	93%