EASTERN REGIONAL MENTAL HEALTH BOARD
REGIONAL PLAN

Presented to the Department of Mental Health and Addiction Services
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SUMMARY OF RECOMMENDATIONS

Under the imperatives and opportunities of the Transformation grant,

1: DMHAS should advocate as strongly as possible with the Governor and the Secretary of the Office of Policy and Management for a permanent mechanism to increase non-profit resources (See above, p.1).

2. DMHAS should work with other state agencies to improve the mental health work force (p.2-5) by

a) Promoting curricular reform and internships in MSW, psychology and psychiatry programs,
b) Increasing inservice training for psychiatrists in recovery based services (p.5).
c) Advocating for *Mandated* Crisis Intervention Team (CIT) training for *all* police departments and ambulance services (p.2),
d) improving training and *certification* for school and college health services assessment for major mental illnesses, and
e) Advocating for training, reimbursement, and co-location of mental health and primary care services, especially for pediatric and geriatric practices.

3. DMHAS should increase outpatient capacity through grants and by supporting Medicaid rate increases (p.3-4).

4. DMHAS should continue its present course of increasing resources for and sensitivity to trauma victims (p. 3-4), family collaboration (p.7), and people in later stages of recovery.

5. **DMHAS should study the feasibility of merging adult and juvenile *crisis* services.**

6. DMHAS should assure continuation of its present high level of service by

a) enforcing its mandate that crisis services serve everyone in a behavioral health crisis, regardless of diagnosis or insurance (p.2,8), and
b) funding agency transportation programs (p.4).

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Our discussion was guided by four principles. Our recommendations should be **Recovery oriented**, i.e., promoting integration into society and consumers' control of their fate. They should be **boundary stretching**, taking into account related agencies and systems like children's mental health, criminal justice, housing, transportation, and Medicaid and Medicare policies. They should be **sensitive** to consumers' culture, age, gender, and personal history. And they should address implication for the **reorganization** or rebidding of services in the next few years. This report also incorporates the results of Regional Board evaluations, advocacy, and other community and consumer inputs.

While we coordinated our effort with the substance abuse Regional Action Councils, it was not practical to integrate our findings, so this report will cover only mental health programs and co-occurring disorders.

Overarching issues: Capacity and non-profit funding

We have always aimed for recommendations based on professional trends and best practices that we can implement ourselves without major funding. Knowing the state budget process, this strategy limits our disappointment. However, the fiscal situation of **non-profit agencies** has reached the point that we cannot leave it to individual and trade association lobbying.

Non-profit wages have risen less than inflation for 18 of the last 22 years. Staff have lost purchasing power. They are working their way *down* the ladder of success. Many people leave the field. Non-profit training costs soar and consumers must adjust to and come to trust new staff members with depressing frequency.

DMHAS agrees with these arguments. We believe that the commissioner has argued a forcefully as he can with the Governor and OPM. However, our primary recommendation this year is that he go farther. With rising fuel and insurance costs, the issue has reached crisis proportions. Both agencies and staff need more resources to maintain stability, and ***stable agencies mean stable clients.***

Our second recommendation also cuts across agency boundaries and service types. We need more **capacity in outpatient and case management** programs. We discuss this in detail below, but the bottom line is that ***people get worse on waiting lists***. Opportunities are lost. Readiness fades. Relapses and arrests force people to start over again later, . . . and again later. Whether through supplemental grant funding or further increases in Medicaid reimbursement rates, providers need to add staff so that consumers can start and stay on the road to recovery.

PREVENTION: Crisis Services: service planning, early diagnosis and assessment.

The first principle of crisis treatment is crisis *prevention*, through better service plans, advance directives, and self-monitoring protocols such as Wellness Recovery Action Plans (WRAP) and Dialectical Behavioral Therapy (DBT). Of course, providers are part of these approaches, which means repeated *continuing education* by DMHAS and client advocates.

Primary Care practitioners are a weak link in early diagnosis. People rarely go to a mental health practitioner first—indeed, insurance often requires a referral. Yet few pediatricians, internists and geriatricians are trained to assess behavioral health problems and usually cannot bill for the assessment—though they dispense at least half the medications for anxiety and depression. The first Transformation Work Groups recommended an elaborate program of training, co-location, consultation, and insurance reform which has recently been revived. We urge DMHAS to pursue them with vigor.

We also suggest special attention to ***high school and college health services***. Because major mental illnesses often surface in these years, campus mental health services must expand their focus to include voices, paranoia, mania, and major depression. While most students drink as part of social life, some do so to quiet voices or racing thoughts. While most adolescent depressions pass, some deepen. While natural chemicals fuel most bursts of energy, some are manic.

Practitioners need to identify this minority of cases before they emerge as psychoses and addictions. They also need stronger referral networks and reentry programs. Too often, campus rules amplify the stigma of mental illness through punitive residential and reentry policies. *Disabilities advisors* also need special training in the needs of people with cognitive and behavioral issues and monitoring to assure that treat such people with the respect that we have come to expect from DMHAS.

When crises do occur, Mobile Outreach programs must be mobile and responsive. The only alternatives are arrest and hospital emergency rooms. More police now have **Crisis Intervention (CIT**) training, but many do not. Some who do have retired or been reassigned by new leaders who do not see de-escalation as a priority. We strongly support the current attempt to extend CIT training to State Police, Probation and Parole officers and Emergency Medical Technicians. Departments without this training still routinely make crises worse, sometimes with tragic results. Because public safety services are a *de facto* adjunct of the mental health system, we cannot afford consumers who fear the police and ambulance staff. Neither can we afford police and EMTs who make consumers' less safe.

Our sense was that SMHA's Mobile Crisis and United Services' Emergency Services did well with conventional crises, but we have heard complaints from atypical groups. Crises generally override target population boundaries, but *youth, elderly, and addiction services* have reported difficulties in getting Mobile Outreach to come to their clients. (Because United Services Emergency Service serves multiple client groups this may be less of an issue there.)

As most people's first point of contact with the mental health system, crisis services have a special responsibility. A positive experience with a crisis program makes it more likely that a family will seek further help when needed. A bad experience simply furthers their prejudice and their reluctance to get help. We urge crisis services to be generous in judging whether a request is an emergency or not.

This is complicated by the proposed reorganization and rebidding of ***DCF crisis services***, which will increase the service area and thus reduce the local knowledge of crisis responders. Nowhere are the two missions of DCF more confused than in crisis intervention. Both Child Protection and Mental Health services are important, but they often require opposite approaches.

Since DMHAS seems to have a much better developed protocol for crisis intervention, it may make sense for DMHAS to take over this service. This would further the Transformation goal of interagency cooperation and the rebidding goal of more rational and efficient service *without* requiring the full scale merger of child and adolescent mental health services into DMHAS. We understand that this is an extremely sensitive issue, but we urge DMHAS to consider this limited step and to begin discussions with DCF.

Recommendation 1: DMHAS crisis services should enforce its mandate to serve everyone in a behavioral health crisis, regardless of diagnosis or insurance.

Recommendation 2: DMHAS should facilitate mandatory training and *certification* for primary care physicians and for school and college health services to assess for major mental illnesses.

Recommendation 3: MandatedCrisis Intervention Team (CIT) training for *all* police departments and ambulance services.

Recommendation 4: DMHAS should consider merging adult and juvenile crisis services.

Outpatient services and case management

Inadequate **outpatient therapy capacity** frustrates both staff and clients in eastern Connecticut. We have few providers and they have too few staff. The Medicaid rate increase of last year helped, but they say that the reimbursement rate is too low for them to hire additional staff. (Two of our clinics are hospital based and always have a net loss because they must pay a share of hospital overhead, but both say that their administrators do not expect them to make money, only to limit their losses.)

The clinics have extended capacity by using groups, increasing the time between appointments, and creating specialized services, but they have reached the limit. Consumers at a recent Catchment Area Council meeting told us that their clinic's new policy of scheduling only two visits and not giving them the same time slot each week has made them less stable. One said that therapy helped him control his intermittent explosive disorder and that he was afraid of doing something that would land him back in jail. Another said that a regular schedule helped her order her life and it was harder for her, as a trauma survivor with trust issues, to build trust with her new therapist. Clearly these are DMHAS priority cases.

Continued training in trauma therapies is warranted until we have made up for the long period of inattention to these issues. The increasing number of DCF and other young adult referrals, returning veterans, and the increasing awareness of the role of trauma in other mental illnesses all point to a continuing increase in demand. DMHAS has made a good start in training for awareness as well as therapy, but there is more to do in both addictions and mental illness programs.

There may also be quality and efficiency issues with therapy. Given the shortage, clients usually get the first available slot rather than matching with a person best trained in

his or her problem. Treatment goals and plans probably also need fine-tuning. We should continue to explore targeted therapies and groups for special populations, collaboration between therapist and client in planning, and "homework" improves outcomes and accelerates progress. We should continue to support ***Warmlines*** and other *peer supports*. ***Family education*** is a stress management resource for both consumers and families as well as a good thing in itself. We should continue to explore technological staff-extenders like internet-based support groups and "*telepsychiatry*."

However, there is no substitute for more therapists. The workforce development part of the Transformation process should look at modernizing curricula, increasing internships, and other methods for capturing more and better candidates for our clients. The DMHAS Training Center gets uniformly high marks from our constituents, but we need to reach out to *professional schools* that traditionally train people for other kinds of practice. ***Interns*** who have positive experiences with the people we serve are more likely to continue to work with them. At the least, they are less likely to perpetuate the stigma that makes our lives harder.

The **Medicaid Rehabilitation Option (MRO)** has had the good effects of bringing outpatient and case management programs closer together, improving service planning, and revitalizing our attention to growth, skills, and recovery. Some say that we have the advantages of the MRO without the disadvantages, since we do not have to consider billability in allocating staff time.

We expect the MRO to take effect eventually, so we must plan for the disadvantages. As the last state to adopt the MRO for community support, Connecticut has a better system in many ways. We should not give up our advantages to fit a funder's mold. Especially in rural areas with no public transit, we cannot expect consumers to transport themselves. DMHAS must ***fund agency transportation*** services in some form.

We must also improve delivery of **"drop-in" or intermittent case management** for people whose needs fall below the MRO threshold of billability. We have had several reports of glitches in re-establishing services for people dropped from case management. Consumers see this as punishment for doing well, or "the curse of the high functioning." One person called her case manger from ten years ago (who now had another job) for help in a crisis because she could not get what she needed from her old agency.

People generally like their case managers and therapists. We often get spontaneous testimonials about them. However, we also get occasional reports of staff using **HIPAA** as a shield against talking to family members (in one case even a conservator) and it is still common to have service planning meetings without the client. Agencies almost always correct such problems when we bring them up and there is no question that DMHAS programs are far ahead of DCF and DDS in this regard, but we still have work to do. Staff should routinely ask consumers to sign releases for families at intake and should attempt to *repair* ruptured relations when possible. The new Transformation grant to the Regional Boards for Continuous Quality Improvement may raise awareness of this need.

Vocational services

The Individual Placement and Support (IPS) model has taken hold in this region. Staff all support individual choice and increased awareness of consumer behavior in work outcomes. However, clients do not always see the difference between the old and new models. Perhaps we should use *dis*satisfaction with vocational services as a positive measure of recovery.

Research often finds that staff believe they are more progressive and skilled than objective measures indicate. The fidelity scales that come with the New Hampshire programs are a useful correction, but *only* when done by outsiders. Otherwise staff give themselves credit for what they *think* they are doing rather than what the consumer experiences.

Traditional jobs still predominate, perhaps because *consumers* retain traditionally low horizons and still fear losing benefits. While people will always have to start at the bottom, we would like to see more people on clerical or other white collar ladders. At the other end of the spectrum, we would like to see more activity in compensating for the cognitive deficits of schizophrenia, whether by bypassing or compensating for them.

Most case managers and therapists believe that work helps people manage stress in the rest of their lives. The money marginally improves their economic situation and work negates the hated and counterproductive Medicaid **spend-downs.** The activity and productivity improve self-esteem and give some the strength to deal with other stresses.

Psychiatrists are the last group to get this message. At least two of our most productive consumers (among others) were discouraged from working during temporary stresses despite telling their doctors (in different agencies) that it helped them feel better. We urge DMHAS to teach all agency psychiatrists to consider whether work helps or hurts in each individual case, rather than relying on obsolete stereotypes. Recovery means *managing* stress, not avoiding it. Work can be a major tool in doing so.

Housing

Supportive housing answers many of these problems. It addresses stigma by coopting local governments and developers. It subverts homelessness by providing services in a less threatening manner and giving residents a reason to accept them. The privacy of scattered sites bypasses the harm-reduction issue, albeit at some cost of group cohesion.

Not surprisingly, barriers remain. Rehabilitation is expensive. The Governor supports the idea, but rejected additional units. While supportive housing stabilizes neighborhoods and often catalyzes redevelopment, local governments often try to isolate developments in stigmatized or protected settings.

In this region, for example, the mayor of Norwich has become an enthusiastic supporter of supportive housing, but he wants to put it on the grounds of an old tuberculosis hospital, which is already home to many mental health and human service agencies that were encouraged to leave downtown. Recovery advocates argue that this is not

community integration. People who need supportive housing need the resources of neighborhoods as well as targeted services. They need neighbors, recreation, and stores. Putting them on a reservation with other "programs" promotes stigma and low self-esteem. Our advocacy is already a constant in local thinking. An outside force could tip the balance. ***DMHAS officials should add its moral and professional authority with local officials.***

Affordable housing in any form is scarce in this region because thousands of new casino workers (and the recent loss of 150 units to fire) have absorbed the existing stock, often raising rents out of the reach of people with disabilities. People with addiction issues risk relapse in the areas where housing is still available. While staff have built good relationships with landlords in the cities, transportation and local resistance continue to limit efforts in the rural towns and in the far northeast to the extent that legal advocates have become involved. We encourage local agencies to continue to **buy property** as the only practical way to increase resources in the near term.

Mental health agencies were active in creating Ten Year Plans to End **Homelessness** in both northeast and southeast. Norwich has an interagency Community Care Team that works exceptionally well together and has found stable housing for *half* of the residents of the winter shelter in the last two years, 87% of whom have mental health or substance abuse issues.

New London, Willimantic, and the far northeast have tried to replicate this model, but some First Selectmen deny that there are homeless people in their towns yet have also created special rules to discourage them. Some agencies reject the multi-agency, but functionally specific, release of information form that makes interagency service planning possible. ***An authoritative legal opinion from DMHAS would help***. Since few towns still have their own human service agencies, temporary case management often falls to mental health agencies. We applaud Norwich Human Services and Reliance House for aggressively seeking supplemental grants to serve the homeless.

Recommendations

5. Increase outpatient capacity through grants and Medicaid rate increases.
6. Encourage more white collar jobs and compensation for cognitive deficits.
7. Revise DMHAS family policy to improve family collaboration.
8. Promote curricular reform and internships in MSW and psychology programs.
9. Fund agency transportation programs.
10. Monitor and improve re-entry to services for people with episodic service needs.
11. Increase inservice training for psychiatrists as partners in recovery based services.
12. Support interagency communication with functionally specific multi-agency release of information forms

Young adult services

Young adults are a priority for service increases here as well as elsewhere. The one existing program in eastern Connecticut has gotten good marks from outside reviewers. It is adding a residential component in the greater Norwich area. A new program with residential services is also just starting in the northeast.

It is too early to say anything about these programs except that need still exceeds supply. They seem to be aware of the issues that have arisen elsewhere such as girls intentionally getting pregnant. The Regional Board is about to evaluate these programs and will have more to report soon.

Relations with families

DMHAS has demonstrated its commitment to the importance of the consumer and family role in policy and programs with a Transformation grant. The grantees will develop new ways to sample new groups of consumers and families, beyond those organized into recognized groups. These new participants will need to be convinced that attitudes have changed since the experiences that alienated them in the past. The real evidence for that change will come from providers' response to individual attempts to participate.

To start, case managers and therapists should always ask intake the consumer to sign a release for their families at intake. If the consumer refuses, the staff person should ask why, and attempt to repair relations as it becomes appropriate during treatment. At the least, at periodic reviews of the service plan staff should ask again if the consumer is ready for family contact. In any case, staff should *always* respond to family inquiries, even if they can only speak in generalities about the illness. Even if staff cannot talk, they can always *listen* to families' reports of consumers' behavior or needs.

At the same time, providers should offer periodic public presentations on mental illnesses and family roles. Providers use NAMI provider courses to sensitize staff to family perspectives and the NAMI Family-to-Family course is an excellent resource, but family roles are not yet a regular part of mental health services. Families need *evidence* of staff commitment to them. DMHAS has made this commitment at the top level. It must now implement it through family-contact measures in staff evaluations.

Older people with mental illnesses

For several years the Regional Board chaired a committee of the local Area Agency on Aging on services for older people with mental illnesses. We found the usual barriers to service for atypical clients, especially an unfamiliarity with DMHAS procedures by staff in nursing homes, home care agencies, and housing authorities. They did not know that Mobile Outreach or United Services did assessments— or they were turned down when they asked for one. The Mental Health Association has found the same thing statewide.

Our providers report no recent incidents of conflict between people with disabilities and older people in public housing, though our state senator remains committed to separating the two groups. Dementia assessment resources are scarce in this area, especially since *several psychiatrists have stopped accepting new* ***Medicare*** *patients*. It is hard for an untrained person to distinguish between dementia, depression, and other health problems affecting memory and behavior. Thus, DMHAS-funded crisis assessments are a crucial part of our relationship with people in parallel systems in the community.

Transportation

Transportation has always been a major barrier to employment, autonomy, and recovery in eastern Connecticut. The southeast has busses that run every hour or two hours so that a simple appointment may take most of the day. Except for Willimantic, the northeast has no public transit at all.

Given the lack of alternatives, the recent decrease in staff transporting clients is unworkable. You cannot teach someone to ride the bus if there is no bus. While we support the Medicaid Rehabilitation option (MRO), we strongly urge DMHAS to fund transportation services in some form. Some agencies have a ride service, but it is hard to hire good drivers at the available wage and the vans wear out. The MRO does not fit all circumstances and DMHAS and its contract agencies must resist the temptation to trim services to fit reimbursement.

Consumer participation and advocacy

Our agencies do not know how many consumers they have as staff because they do not ask. They feel strongly that they should not treat people with mental illness any differently than other employees. Supervisors should be sensitive to performance issues and should refer to Employment Assistance program (EAP) services if needed, but the administrators rejected special coordination with clinicians, for example.

This works well for many people. However, if we want to increase the number of consumer-staff, we must also consider **a larger group, not as far along in their recovery**. This group works episodically, usually part-time at fewer hours than needed to qualify for health insurance or even EAP. They may still receive vocational services from agencies in the system, though most will not employ their own clients. We should offer training to sensitize supervisors, vocational counselors, and therapists to the special needs of people in this marginal situation, often aggravated by colleagues who do not accept or trust them.

This issue has surfaced recently in the attempt to create a special job classification for consumers. Having a mental illness confers special empathy and ability to draw clients into services, but we cannot assure that consumers will get these jobs. Our providers felt strongly that such classifications are stigmatizing. Consumers worry that a separate track will prevent them from moving to regular career tracks when they are ready. We eagerly await the results of the Workforce Development studies funded by the Transformation grant.

CO-OCCURRING DISORDERS

1. Harm-reduction vs. abstinence

The co-occurring disorders initiative is one of DMHAS' great successes. As more cross-trained people replace single-silo staff, more programs will become dual-diagnosis capable. Two frontiers remain to be crossed. First, we need to embrace the **harm-reduction** revolution. The pioneering "Transitional Living Community (TLC) program here reaches clients who fail at abstinence based programs. However, it is an extremely labor-intensive program, demanding near constant staff reframing of client behavior to increase awareness of the consequences of addictive behavior for the client's goals. Motivational interviewing has proved an invaluable tool, but it requires more practice than most staff get.

Most staff-- and perhaps most consumers as well-- prefer traditional highly structured abstinence-first residential programs. The structure and clear expectations make it easier for both groups, though many know that they will fail eventually. In practice, harm-reduction principles have infiltrated traditional programs, as staff try to interpret the meaning of a lapse and give extra chances.

Still, abstinence requires compliance more than understanding. Traditional programs clearly work for people who can learn their triggers and vulnerabilities from groups and self-awareness. Harm-reduction usually has the same goal and requires the same knowledge, but begins before the person is able to stop using. It uses "using" as a tool, just as IPS uses job loss as a tool for self-awareness. There will always be a place for both kinds of programs, but the role of harm-reduction programs must grow if we are to reach those who repeatedly fail at abstinence programs.

2. Billing and licensing regulations

Secondly, funding **regulations** remain a barrier to full integration. DMHAS is aware of the problems in cross-licensing, staffing, and billing. Again, working with the Departments of Public Health and Insurance is a major unrealized goal of the Transformation process. We have not seen these Departments participate meaningfully.

3. Integration and collaboration

DMHAS has made great strides in integrating mental health and addiction services since our last report. We expect continued support for providers to improve their co-occurring competencies. We applaud the dual screening protocol in DMHAS provider contracts and urge its extension under the Transformation Grant to school and college health services and to federally qualified health centers. The Regional Action Councils made this their first priority.

4. Health promotion and wellness

The RACs have found that emphasizing health and wellness inhibits substance abuse among youth. Teaching alternative forms of stress management, whether yoga, reiki, meditation, or other self-awareness program, makes people less likely to use alcohol and drugs for that purpose. Self-esteem and assertiveness training makes it easier to resist peer pressure. Increasing physical demands on oneself makes the debilitating aftermath of some substance use less tolerable.

Paradoxically, generalized programs seem to reach youth more effectively than making them choose a reference group that may acquire a stigma in the all-important peer social system. However, for older people, support groups within clubhouses or day programs may be more effective. Pets also improve adults' focus on responsibility and health.

5. Transitional programs for youth and young adults.

Co-occurring disorders are the norm for youth in our system. Thus, special approaches are needed that address the way young people communicate. Internet relationships, especially involving pictures and unregulated contact pose special risks, but ordinary cell phone use, texting, blogs, and videos also provide private ways to subvert public agreements.

PREVENTION: Crisis Services: service planning, early diagnosis and assessment. (adapted from the mental health section above)

1. Training in self-monitoring and self regulation

The first principle of crisis treatment is crisis *prevention*, through better service plans, advance directives, and self-monitoring protocols such as Wellness Recovery Action Plans (WRAP) and Dialectical Behavioral Therapy (DBT). Of course, providers must cooperate with these devices, which will require *continuing education* by DMHAS and client advocates.

2. Case-finding

a) Primary Care practitioners are a weak link in this system. People rarely go to a mental health practitioner first—indeed, insurance often requires a referral. Yet few **pediatricians**, internists and **geriatricians** are trained to assess behavioral health problems and usually cannot bill for the assessment—though they dispense at least half the medications for anxiety and depression. The first Transformation Work Groups recommended an elaborate program of training, co-location, consultation, and insurance reform which has recently been revived. We urge DMHAS to pursue them with vigor.

b) High school and college health services also need increased attention. Because major mental illnesses often surface in these years, campus mental health services must expand their focus to include voices, paranoia, mania, and major depression. While most students drink as part of social life, some do so to quiet voices or racing thoughts. While most adolescent depressions pass, some deepen. While natural chemicals fuel most bursts of energy, some are manic.

Practitioners need to identify this minority of cases before they emerge as psychoses and addictions. They also need stronger referral networks and reentry programs. Too often, campus rules amplify the stigma of mental illness through punitive residential and reentry policies. ***Disabilities advisors*** also need special training in the needs of people with cognitive and behavioral issues and monitoring to assure that treat such people with the respect that we have come to expect from DMHAS.

This is complicated by the proposed reorganization and rebidding of ***DCF crisis services***, which will increase the service area and thus reduce the local knowledge of crisis responders. Nowhere are the two missions of DCF more confused than in crisis intervention. Both Child Protection and Mental Health services are important, but they often require opposite approaches.

3. Crisis intervention

The proposed reorganization and rebidding of ***DCF crisis services*** will increase the provider's service area and thus reduce the local knowledge of crisis responders. Nowhere are the two missions of DCF more confused than in crisis intervention. Both Child Protection and Mental Health services are important, but they often require opposite approaches.

Since DMHAS seems to have a much better developed protocol for crisis intervention, it may make sense for DMHAS to take over this service. This would further the Transformation goal of interagency cooperation and the rebidding goal of more rational and efficient service *without* requiring the full scale merger of child and adolescent mental health services into DMHAS. We understand that this is an extremely sensitive issue, but we urge DMHAS to consider this limited step and to begin discussions with DCF.