

**REGION V  
PRIORITY PLAN  
2007- 08**

**Prepared by the  
Northwest Regional Mental Health Board  
Housatonic Valley Coalition Against Substance Abuse  
Central Naugatuck Valley Regional Action Council**

**I. Purpose of Regional Priority Setting Plan**

The purpose of this report is to inform the DMHAS needs assessment and planning process, inform the general public and legislature, and advise planning efforts in the region. The findings and the process of data gathering promote coordination and collaboration.

This report is inclusive of the input of many sources through all three of the organizations listed above. These sources included:

- Focus groups of providers of DMHAS mental health and addiction services.
- Focus groups of consumers.
- Interviews with key informants, consumers, family members, community representatives, police, government officials, faith-based community leaders and more.
- Regional Action Council meetings and committees (the Housatonic Valley Coalition and Central Naugatuck Valley RACs).
- The Regional Mental Health Board (NWRMHB)
- Catchment Area Councils (CACs 20, 21 & 22).
- Consumer Action Group.
- Local Prevention Councils and their committees.
- Meetings with the Northwest CT Area Agency on Aging.
- Evaluations conducted on an ongoing basis by the Regional Board/CACs including assessment of unmet needs.
- Findings of reviews.
- An online needs assessment survey. Respondents included a strong cross-section of all stakeholders, including mental health and substance abuse providers, advocates, educators, consumers/ people in recovery from substance abuse disorders, family members, town social workers, clergy, business leaders, and government officials.

**Sections:**

- A. Overarching issues**
- B. Service and treatment issues and needs**
- C. Prevention**
- D. Region V System and service strengths and progress**

**Report format:**

This report integrates the sectors of treatment and prevention of both mental illness and substance abuse wherever possible, in recognition that these pieces do not

operate exclusive of each other, and prevention and early intervention are really along the continuum of treatment.

The process noted above yielded a wealth of information. Some updated the state of the region in terms of needs that had been identified in prior years (i.e. transportation, housing, voc/employment, prevention/early intervention and co-occurring disorders). Other new and emerging issues were also identified. Trends were noted to have both developed and in some cases, reversed. Themes and some over-arching issues were observed. These are organized by issue below.

#### **A. OVERARCHING ISSUES:**

- Capacity
- Private-not for profit funding
- Funding barriers to service

##### Capacity:

**Simply and alarmingly, the entire mental health and substance abuse system in Region V is operating over capacity.** Where this does not appear to be the case it is deceptive: the shrinking resources have left many agencies unable to operate at their contracted capacity. Many operate even over that. Many clients are served “off the record.” The pressures of the system have “encouraged” their discharge, but intermittent needs send them back to the providers and staff they know. Rather than go through the whole admission process and the paperwork involved, the short term needs may be met on an informal basis. But this also uses resources of an overstretched system.

**Outpatient services were ranked in the top five service needs in the online survey.** The outpatient services in the greater Waterbury area are particularly bad in this respect, with waits of weeks to months to get an appointment.

Some populations – e.g. Psychiatric Security Review Board (PSRB) clients – are a challenge as they are required to have 24-hour care even when it may no longer seem needed. This ties up resources that are needed by others.

##### Private-not for profit funding:

***This has become an overarching issue that affects many if not most other issues.*** This sector has experienced what is by now a critical level of erosion of their resources by years of funding shortfall. Without the necessary funds to hire and retain experienced staff, they have an increasingly young and inexperienced staff, staff vacancies and shortages, and no time left for staff training (which is doubly counter-productive as it makes the staff person more attractive to be hired away from the agency, often to state services which pay anywhere from 40-100% more). Services have effectively been reduced as many agencies are only able to balance their books by leaving staff vacancies unfilled. Other positions have been unfilled as the agencies are unable to find willing applicants for the salaries available. In one instance, an agency was down eight people. At one point a single (sub-regional) system was short 20 staff across the PNPs. The agencies may be forced to hire people below the quality desired. “It has become a quality assurance problem.” To make ends meet,

some of the PNP staff are working second jobs and extra shifts, with routine 50-60 hour weeks. This leads to burnout and poor decisions.

Staff turnover also means more recruitment and training costs.

The complexity and risk of the consumers coming into the system is increasing. Where adequate resources would facilitate flexibility, and the time and creativity to meet specialized client needs, this can no longer happen and the list of specialized services needed continues to grow. Agencies and staff are able to focus only on the tasks and needs of the clients already and most immediately before them.

As is noted regarding services for Older Adults below, these issues also impact client care more directly. Where the PNP staff are overwhelmed by need without resources, staff are not adequately trained, charting suffers, which in turn can adversely impact reimbursement, and the financial picture worsens further.

As this region has many services provided by the private non-profit sector, these issues are felt especially acutely here. In one forum it was described as “the safety net has become threadbare – people now fall through.”

The budget approved by the legislature provides a zero percent increase for the PNPs for FY 08-09. Possible scenarios in response to this could not be positive, but without a crystal ball it is impossible to know what might happen. The agencies have already stretched, they have already been “creative,” they have already had staff vacancies as they cannot find people to work for the pay, they have cut administrative and supervisory positions, they have already shown amazing dedication. We are deeply concerned that clients, their families, and the communities will suffer, even as the cost is shifted to hospital emergency departments, homeless shelters and the prison system.

Funding barriers to service:

There are situations where the services are there, but cannot be accessed by individuals due to their payor source (or lack thereof). Some specific situations:

- “Undocumented aliens” – Individuals and families who are in the country without the proper documentation have presented a challenge; the numbers of these individuals in Region V are high. Such persons have difficulty in accessing routine health care, and when the need becomes acute, they present at the hospital emergency department. Hospitals are required to serve them regardless of ability to pay, and this represents an additional drain on hospitals’ already stretched resources. Additionally, such individuals may avoid services or be reluctant to accept help when needed due to fear of arrest or deportment. Even people who are in this country legally but are not citizens are ineligible for Medicaid and thus are ineligible for many services where Medicaid is the payor.
- Unstable residence: Several cities in the region have experienced a challenge when individuals move out of state abruptly, or go back and forth. There is not reciprocity between CT and New York or Massachusetts. With each move there must be a re-application for benefits; this can be a long and difficult process.
- Young adults: Medicaid is managed differently for many individuals under age 21. Most fall into a managed group where behavioral health services are carved out, and they do NOT qualify for the Medicaid Rehab Option, which is now in place in

the group homes. This has presented a challenge for serving young adults (under 21) who fall into that category.

- Spend-down: One unforeseen side effect of the Medicare Part D program was its impact on spend-downs. Hundreds if not thousands of DMHAS clients were thrown into spend-down status and have experienced weeks and months without Medicaid/Title XIX coverage. This has left the individuals unable to afford medication or medical appointments, and has rendered them uncompensated clients in any Medicaid Rehab Option program. Prior to the implementation of the Medicare Part D program (which is Federal), medication costs (which were covered by the state at no cost to the clients) counted as an expense for the clients' determination. As the cost is now covered by the Federal government, it can no longer be counted as a medical expense. The too-low income limits for disabled persons to be Medicaid eligible were masked for years. Clients now find themselves ineligible for Title XIX for long periods. Without the income to cover the medical expenses, needs go unmet. Efforts to have the state legislature change the income guidelines have not been successful.
- Managed care: Managed Medicare and Medicaid authorizations have become increasingly difficult and limited. Providers have had to divert more resources to fighting limitations and refusals. This includes medications (antipsychotic and antidepressant prescriptions have shorter than needed authorizations) and duration of treatment. More preauthorization and paperwork are required. Managed care treatment reports may need to go to different organizations, and there is no standardization of forms or reporting. The demands of the paperwork and managed care process divert staff resources away from client care, or require hiring more staff, increasing the cost of services.

The medical model employed is often a black-and-white one, in a world where the human needs are usually in shades of gray. This is also a client issue. Individuals may not have the necessary expertise to make a good decision about a managed care company when they are required to choose. Last summer, a particular Medicare provider held a recruitment fair on the green in Waterbury, signed up many people, and then became very restrictive in their authorizations. Seniors can get a lot of help through their connection to the Western CT Area Agency on Aging; DMHAS consumers do not generally have access to that resource.

The DMHAS system can be as bad as many of the managed care companies. One provider noted that she counted, and that it took 67 pieces of paper to open a chart. There were papers for insurance and payors, authorizations, tracking, those required for accreditation, licensing, releases, etc. This is overwhelming for both staff and clients. Money resources are going to bureaucracy, not people. One small agency chose to no longer participate in one of the substance abuse initiatives because the paperwork demands were becoming overwhelming and would have required hiring additional staff just for that paperwork.

- Unforeseen Medicaid Rehab Option (MRO) effects:  
The MRO has effectively excluded certain groups from services they may have been able to access before (e.g. Young Adults in the behavioral health carve out, people who are too ill to meet the programming demands). Of concern is how the increased use of certain fee-for-service models will shape service availability and design. The adage "Follow the money" can be tweaked: the services will follow the

money, and the design may not be as preferred. For example, case managers used to deliver medications. The responsibility and cost was shifted to VNAs, who could bill for this, outside of the DMHAS budget. If case management becomes billable, will this function revert back to them? What will happen to transportation of clients, which is not billable? In a culturally competent system of care, work with families and in building relationships in the Latino communities is essential. That is also not a billable service. How will this be protected from being lost, or more realistically, encouraged to be developed?

- See also under "Older Adults" and the relationship of funding inadequacy and the PNPs to adverse and critical incidents.

## **B. SERVICE AND TREATMENT ISSUES AND NEEDS**

- Housing
- Transportation
- Co-Occurring disorders
- Specialized Services
  - Older adults
  - Medical needs for persons with mental illness
  - Eating disorders
  - Young Adults
- Barriers to healthy living
- Emergency Departments (ED) issues
- Workforce development
- Cultural/ ethnic/ language issues
- Multi-departmental / system Transformation
- Substance abuse treatment and trends
- Vocational/Employment
- Smaller but important issues
  - Pet care
  - Moving and storage
  - VNA services

### **HOUSING:**

**Housing was listed as one of the top five needs in the online survey.**

Despite the slump in the housing market, the need for safe, affordable housing is essentially unchanged or worsened. Affordability is still the biggest issue in Danbury, where the Housing Subsidy program has been essential in enabling people to move into housing.

The Region has active and effective Continuum of Care groups which have worked to bring in more resources, but the pace of implementation can be slow.

A felony conviction, not uncommon among people with certain substance abuse histories, is a barrier to Section 8 housing. While there is now an appeals process, it is very hard to win.

The downturn in the economy with the loss of many jobs and home equity can be expected to cause an increase in homelessness among individuals who were previously stable. People who were obtaining jobs at \$8-\$16/hour are having increased difficulty finding and maintaining employment.

**RECOMMENDATION:** More units of safe, affordable housing should be developed in both cities and smaller communities.

### **Supervised apartments:**

While not strictly "housing," this is listed here as there are many consumers in the system for whom an apartment setting with staff available in the immediate area 24/7 is the only safe or appropriate setting. The wait lists for Supervised Apartments are extremely long, from months to even years.

Stigma in the community continues to be a hindrance to developing new and better supervised living situations for consumers. In one community, the effort to site a program for troubled youth led to efforts to add zoning barriers; the proposed program application was withdrawn, but the zoning initiative has continued. This has had a chilling effect.

RECOMMENDATION: Additional DMHAS resources specifically for supervised apartments.

#### Residential Services:

**The need for more residential services was listed as one of the top five needs facing people with substance use disorders in the online survey.**

One positive development has been that “transitional” housing for people in recovery from substance abuse is on the radar. Faith-based initiatives are enhancing these services. The Christian Community Outreach Ministries, overseen by the Jericho Partnership in Danbury, will be opening an eight unit, 16 bed living facility in a matter of months. They have consulted with St. Francis Hospital as well as other providers in Connecticut. They anticipate that support services will provide a flow of consumers from one level of care to another, with stays at the “transitional” facility providing housing for twelve months per individual. This is also an example of a cultural minority initiative that has moved forward without DMHAS involvement.

RECOMMENDATION: Increase DMHAS support of residential treatment services for people with substance use disorders.

#### TRANSPORTATION:

**Transportation was listed as one of the top five needs in the online survey.**

The state of public transportation varies greatly in the region. Danbury has the best services, with some nights and weekend service, maps and bus stop signs. In Torrington and Waterbury, resources are much more restrictive. The last bus in Torrington is not late enough to get people back home from their jobs. The local (Northwest) Transit Authority has been receptive to ideas, and there has been some willingness to add routes, but three people are required for every route. It becomes a “chicken and egg” dilemma. In the suburbs and rural areas, public transportation is close to non-existent.

People using the para-transit systems often experience long waits and unreliable service. Long waits for it to arrive can mean lost employment or missed medical appointments. While complaints persist in Torrington regarding Logisticare, their staff have demonstrated willingness to meet with consumer groups.

While consumers try ride shares, and providers provide transportation, the demand of these resources far exceeds the supply. The local clubhouse reduced the rides they offered, and that increased ridership on public transportation but there are real limitations.

RECOMMENDATION: More public transportation is needed: more routes, more times, with better signage/publicity about routes and times available. This could include regular buses and/or coordinated para-transit. Transportation to and from

suburbs and rural areas is needed to enable people to live outside of cities, and to be able to get to and from jobs and treatment resources.

**RECOMMENDATION:** One suggestion from the consumer groups has been the development of technology to meet some needs. This could include video-conferencing for meetings outside of the local area. Video stations could be established in each LMHA for this. The increase in gas prices makes this particularly attractive.

### **CO-OCCURRING DISORDERS:**

**The need for co-occurring services was cited as one of the top five needs by survey respondents.**

Despite the need being cited for over a decade, there is still no inpatient service unit for people with severe mental illness and severe substance abuse issues. It is unconscionable that such a service does not exist within the facilities of the Department of Mental Health and Addiction Services, where those two silos merged over a decade ago.

**RECOMMENDATION:** An inpatient service unit for people with severe mental illness and severe substance abuse issues should be developed and publicized.

Most of the clients now coming through the doors of substance abuse treatment programs have co-occurring mental health needs/issues. As there are long waits for people to access psychiatrists/medication management from hospitals (the primary resource in this region), substance abuse treatment programs have had to hire their own psychiatrists. The expense for this is not covered by grants nor fully by the billing process.

**RECOMMENDATION:** Grants to Substance Abuse treatment programs should take this new expense into account when calculating grant funds, supporting the DMHAS emphasis on best practices in serving people with co-occurring disorders.

While there is considerable emphasis on “co-occurring disorders,” in fact the characteristics of the population now entering the system are more difficult and complex than those of ten years ago, and becoming more complex for those again within the system. Individuals may have multiple disorders, and medical complications are becoming major factors in consumers’ lives.

**RECOMMENDATION:** A paradigm shift from “co-occurring disorders” to an “Integrated recovery model” which encompasses wellness.

### **SPECIALIZED SERVICES:**

#### **Older Adults and people with increased medical needs:**

Services are needed for older adults that are geared to their specific needs. This population is growing. It is noteworthy that Southbury, one of the towns in this region, has the highest percentage of elderly persons in the state. Some demographic reports indicate that Region V will lead the state in the percentage of more elderly citizens over the next decade.

Working in collaboration with the Western Connecticut Area Agency on Aging, several problems affecting the elderly have been identified. These included the increased needs of elderly persons living alone, elderly persons developing mental illness,

physical losses resulting in mental deterioration or functioning, and those who have lost the natural supports that had enabled them to function well with an existing illness. Issues include substance abuse and dependence, hoarding, severe environmental problems, problems with the community or their neighbors, isolation, depression and suicide. As individual needs increase, there are not adequate resources for simple care integration and support, and individuals end up being routed into unnecessarily high levels of care.

**RECOMMENDATION:** More outreach and services should be developed to meet these specific needs, and ongoing collaboration between those services and organizations traditionally serving the elderly (AAAs, Elder Protective Services, etc.) and mental health services and resources (DMHAS, mental health providers) should be fostered.

Medical needs in people with mental illness: For people with mental illness, “old age” appears to appear earlier, as this group is reported to be dying on average 25 years younger, and this group is observed to have increasingly complicated and compromised medical conditions. More individuals have metabolic syndrome, cardiac conditions, diabetes, COPD, are on kidney dialysis, have Hepatitis B or AIDS. These are added to the group of actually older individuals and all of the medical issues that increase simply due to advancing years. This has led to a need for more medical focus, expertise and time for monitoring and coordination of multiple medical needs. Medical care needs to be coordinated with mental health care and substance abuse treatment.

Some individuals’ medical needs make home care no longer appropriate, but they still need appropriate mental health services/support. In the Waterbury area, there is one skilled nursing facility that is heavily used (Abbott Terrace) and many individuals go to board and care homes as an intermediate step. But there was a concern that people become lost to monitoring and oversight once they enter such facilities. “The Money Follows the Person” will not help this group; it only applies to people who need a *lower* level of care. One community location was cited as positive – The Elton – on the green in Waterbury, where people have been observed to do well. Many supportive services are provided.

**RECOMMENDATION:** Develop residential programs with higher levels of resources and staff expertise, and additional medical supports built into programs.

This is juxtaposed against the services able to be provided by the PNPs, which are so stretched that the time needed to provide the necessary coordination is simply not available. The analysis of Critical Incidents has found insufficient collaboration as a contributing factor in an increasing number of incidents. Drug interactions are being missed, or caught late. The increased risk is to both consumers (health) and providers (liability).

Eating disorders:

Eating disorders are prevalent, and the disorder may be co-occurring with other psychiatric conditions. There are no programs specifically for adults with eating disorders anywhere in the entire region.

RECOMMENDATION: At least one regional eating disorders program(s) based on the co-occurring model. They should be accessible to people on Medicaid/Medicare/SAGA, emphasizing engagement and harm-reduction, using a team approach. It should be attached to a clinic or hospital to address the concurrent medical issues.

Young Adults:

Young adults with early (or even an early history of) mental illness are the “new” DMHAS clients. Their needs are often more complex, and there are more high-risk behaviors, including drug use, gang involvement and both planned and unplanned pregnancies. Heroin use continues to be a serious problem. Young adults are subject to all the trial and error that is normal in their age group. But the same challenges are also potential strengths as this population has the opportunity to avoid the focus on disability and build recovery.

Aggressive work with this population by the Homeless Outreach team in Danbury has noted that the length of time that it takes Young Adults to assimilate into the “culture of homelessness” is much shorter than for the older adult population. In this case early treatment is prevention. One positive observation by the Homeless Outreach Team was that there are no longer the numbers in the shelter of former DCF clients either discharged or who ran away from services as soon as they turned 18.

RECOMMENDATION: Specialized services with staff trained and ready to work with this age group is essential. Services need to address their lack of life skills. This resource is fully operational in only one part of the region, just starting in the second, and needed in the third.

**BARRIERS TO HEALTHY LIVING/WELLNESS:**

- Nutrition: Consumers have cited the challenges to a healthy diet of low income and the fact that the less expensive grocery chains are not located in or have even moved out of the inner city community (Waterbury) where they were more easily accessed by consumers. The Nutrition Training Initiative conducted by the Northwest Regional Mental Health Board in conjunction with the UCONN School of Nutritional Sciences a few years ago continues to have impact in the focus on nutrition throughout the region’s mental health programs, but it is not enough. Obesity and diabetes continue to affect high numbers of consumers in the mental health system.
- Exercise: Some forms of exercise require more funds either for getting there (car) or membership fees (health clubs, YMCA). Even the free resource of walking at the malls has been sharply reduced (Waterbury). Outside exercise such as walking may be limited by weather, traffic or safety considerations.
- Smoking: Many consumers in the DMHAS system still smoke. Nicotine replacement is not covered by Medicaid, Chantix is not on most Medicare Part-D plans and smoking cessation programs are not yet widely available. At this time there are few specialized smoking cessation programs for persons with mental illness or substance use disorders. While for the general public, the best practice standard has been identified as a combination of supportive therapy and nicotine replacement, best practices specifically tailored to people with mental illness or substance use disorders are still in the “emerging practices” stage.

#### RECOMMENDATIONS:

- Healthy living supports should be implemented throughout the DMHAS system.
- Education in nutrition, shopping, menu planning, portions, and cooking on a limited budget should all be part of the educational opportunities provided to consumers.
- Exercise should be supported and facilitated in all DMHAS-funded centers. Smoking cessation support groups should be nurtured.
- DSS and the legislature should allocate funds to have nicotine replacement therapy (NRT) a covered expense on Title XIX.

#### **EMERGENCY DEPARTMENT (ED) ISSUES:**

New difficulties have been reported on both “sides” – consumer and Emergency Department (ED).

- The EDs are reporting more problems in the both regular Emergency departments and special behavioral health EDs, including aggressive behavior, fights, people getting hurt in restraints, and injuries to staff and patients. One ED reported that over 50% of the people coming into the EDs for mental health problems also have substance abuse as an issue. The young adults who are presenting at/being sent to the local EDs are particularly volatile and challenging. One hospital had to increase staff seven days a week to deal with behavioral health problems.
- Consumers have reported having physical concerns not properly treated; they are “psych patients.” Concerns about being “sent to the [psych inpatient] floor” have kept people from seeking help for real physical needs. Once there, pressured staff combined with an inability to clearly articulate symptoms have led to poorer outcomes.
- People with disclosed histories of substance abuse and addiction are routinely sent out of emergency departments with supplies of addictive pain medications.

PROGRESS: There is a major initiative already underway in this region to address these issues. In a process initiated by the Consumer Action Group, this group in collaboration with representatives from the three major hospitals of the region have begun meeting. Core issues are being identified, as are the barriers and opportunities. While this process is still in the early stage, there is commitment to finding solutions, with buy-in both from consumers and the hospitals. The plan is to begin at one hospital (Waterbury Hospital) and then expand once there is success. Staff within that facility have already begun their own meetings to begin work.

#### **WORKFORCE DEVELOPMENT:**

In an effort to find staff for PNP agencies, a workforce development outreach was made at WestConn in Danbury. They found very few people going into human service fields as students discovered that there is no money in it. Over time, this situation will become even worse, as the pool of potential employees continues to shrink. Nurses and social workers had already been difficult to hire and retain. Having DMHAS advertising directly to individuals in those professions has made the situation more challenging, as these staff are siphoned out of the PNPs. Vocational providers noted that where they used to see more retail jobs advertised in the papers, now they are social service jobs, and the ads are there week after week.

**RECOMMENDATION:** PNP providers should be funded adequately to be able to hire, adequately compensate and retain appropriate employees.

Good medical providers are becoming increasingly scarce, both those who will accept Title XIX and even those who accept regular insurance and Medicare. UCONN Health Center is now virtually the only place that will accept Medicaid clients with a need for advanced care. Issues include the high “no show” rates for the DMHAS population and the low reimbursement rates.

**RECOMMENDATIONS:** The medical trade organizations should approach its members requesting that all practitioners accept some regular insurance and Title XIX patients.

DMHAS providers should educate consumers about their responsibilities in health care, and provide the necessary supports to reduce the no-show rate in the system. The legislature should support legislation to provide adequate fees for services provided.

American psychiatrists are becoming an endangered species. The vast majority that remain in community practices have moved to cash-only practices. Billing and managed care demands have driven other private mental health practitioners out of private practice, shifting more of the demand to hospital and clinics.

**RECOMMENDATION:** The American Psychiatric Association should approach its members requesting that all psychiatrists accept some regular insurance and Title XIX patients.

**Staff training:**

DMHAS training, which has been an essential resource as it is free, is not provided locally as it once was. Much is now conducted at CVH. This represents a barrier of time and transportation, especially for the PNPs who cannot afford the expense of staff coverage. Web-based training is a good resource, but does not work for some areas such as CPR, BMS, and First Aid, etc. There has been less willingness to conduct onsite training for the PNPs even as they are less able to send staff out.

**RECOMMENDATION:** DMHAS should resume the practice of providing training in the regions, and develop more web-based training.

**CULTURAL/ ETHNIC/ LANGUAGE ISSUES**

**Language barriers:**

While all parts of the region have either some Spanish-speaking staff or programs, these are not adequate to the need. Hiring the appropriate staff is not generally possible within the PNPs due to the competition for suitable candidates and the lack of resources to get and keep them. There is a very large Latino community in Waterbury, most of whom (over 700) receive services from a single hospital psychiatrist in one hospital who is bi-lingual and bi-cultural. He is elderly and could retire or leave his position at any time. This would result in an immediate service crisis for the Latino community. The other major resource, Catholic Charities, is always full and at the time of this assessment was closed to new admissions.

Latinos are still under-represented in the DMHAS system. An innovative new initiative with three locations has developed in Danbury serving the Latino population with several recovery-support services. From January 2008 – April 2008 they served over 1000 people. They collaborate with other (DMHAS-funded) substance abuse service

providers. Interestingly, however, this initiative itself receives no DMHAS funds. How and why did such necessary services develop without that support? Does the DMHAS structure and system pose an exclusionary cultural barrier to programs that are developed by and appropriate to some ethnic groups? Should the “non-traditional” providers be expected to change to fit the system, or should the system develop new approaches that fit other cultures’ evolving services?

Asians are very under-represented in the region’s DMHAS service system. A review of the ethnic data from DMHAS indicates *zero* Asian clients. Where are they? There is a substantial Asian population in the region.

Many individuals speak other languages and come from other cultures. There are over 57 languages and dialects spoken in the Danbury school system, and there are substantial minority groups speaking Portuguese, Spanish, Albanian and Chinese, and new groups appear regularly. A group of Karen (from Southeast Asia) were recently resettled in Waterbury, and Danbury has a large Brazilian population (both legal and illegal). Inroads have been made in the development of relationships, but much more is needed, and development of relationships takes time and investment. The immigration crack-down has had a negative impact on this. There are also alternative systems which have developed in certain groups. For example, in Danbury, prescription drugs are dispensed by women without licensure or certification, and the origin of the drugs is unknown. However, this is for some the sole source of needed medications (primarily birth control).

#### RECOMMENDATIONS:

- Members of minority groups should be encouraged to enter the human services fields.
- Providers of services to minority populations should be interviewed to determine what services are needed, and how they are structured to be welcoming to and effective with these cultural/ethnic minorities. Potential barriers within DMHAS’ structure should be identified and eliminated.
- Technology should be developed to enable the system to maximize the expertise across more ethnic groups and languages across the state, using tele-conferencing and remote services.

Differences in physiology: There are differences in the ability of certain ethnic groups to metabolize alcohol. Stakeholder reports indicate that certain Central American populations are in this category which suggest that both prevention and treatment strategies would benefit from adaptation.

### **MULTI-DEPARTMENTAL / SYSTEM TRANSFORMATION**

Issue: Barriers to recovery for clients returning to the community from the Department of Corrections:

**Re-entry services was listed as one of the top five needs for adults with substance abuse concerns.**

Some improvements have been noted in this area. For example, it has been years since people were brought to the LMHA in shackles. However:

- Individuals are discharged without sufficient prescription medication to last until an Outpatient Services appointment in the community, which can be a wait of as long as 4-12 weeks.
- Unless there is a re-entry program (not currently available in any part of Region V) people with mental health and substance abuse needs simply show up in the community without identification, housing, entitlements, a place to stay, substance abuse or other services arranged.

#### RECOMMENDATIONS

- Develop a mechanism to assure that individuals being released from prison have 1) an appointment for psychiatric outpatient services arranged well before leaving prison **and** 2) release with medication sufficient to last until that appointment.
- All prisoners should have shelter and treatment arranged, and identification when leaving.

### **SUBSTANCE ABUSE TREATMENT AND TRENDS**

It seems an important use of this report to also identify trends and changes as they have been noted.

Alcohol – is still the most highly and widely abused substance.

Methamphetamines: Prevalence is still not a major issue in this region, with use reported only sporadically.

Heroin: Use is high and the purity of the heroin on the market has resulted in accidental overdoses in several communities. Use of this drug has been noted within the young adult population. Many begin with abuse of prescription narcotics (usually oxycontin) and graduate to heroin, attracted by the cheaper price and availability.

Prescription drug use:

While not a new issue, the abuse of prescription drugs is foremost in the minds of the Local Prevention Councils (LPCs), schools, parents and substance abuse providers. However, parents and schools are only now beginning to address this in a pro-active manner. Major contributors to the supply of mis-used prescription drugs are doctors in the emergency departments, dentistry and physicians who send patients home with a 30 day supply of addictive medications for pain control. These drugs then work their way into other hands for illegal use. Oxycontin is the biggest problem and has led to an increase in heroin addiction. Also commonly abused are diazepam (Valium), Vicodin, Percoset, Concerta, Ritalin and Adderall.

RECOMMENDATION: Collaboration with state-wide medical organizations should be forged to develop new and different prescription protocols related to potentially addictive medications, how they are prescribed, and mechanisms to support people in maintaining their recovery.

### **VOCATIONAL/EMPLOYMENT**

Despite the shrinking economy, it is perhaps a mark of system strength that this area did not appear within the top five needs in the online survey. This region has strong vocational providers, growing collaboration with the Bureau of Rehabilitation Services (BRS) and several consumer-driven initiatives which have continued the focus on employment.

There are still challenges. A substance abuse history with a felony conviction remains a major barrier to employment. The construction trades are historically open to people

with substance abuse histories, but these positions are often lower paying within that field and without health benefits. It is also noteworthy to consider some of the factors that can create a pressure on individuals to begin or return to drug sales. As a result of the downturn in the housing market, many of these jobs have been lost. There is a concern that without income, the temptation to return to the sale of drugs will be strong. Persons released without identification by the correctional system are also at higher risk of returning to drug sales as an income source.

RECOMMENDATION: Vocational and employment services that allow persons with a felony conviction history realistic opportunities for education and career development, and that are protective against recidivism.

**SMALLER BUT IMPORTANT ISSUES:**

Pet care:

For some consumers, their pet is their only “family.” Resources are needed for when consumers go into the hospital or lose their home or apartment.

Moving and storage:

There are no resources to help consumers when they move, and no storage for furnishings when they are hospitalized or lose their apartment.

VNA services:

The system has shifted many tasks formerly done by case managers to the VNA, to free up DMHAS resources. This includes medication assistance and monitoring. However, in rural areas the ‘no show’ situation (which can reflect the symptoms of the illness) results in clients being dropped as there is no VNA reimbursement if the client is not there.

## **C. PREVENTION:**

### **PREVENTION/ EARLY INTERVENTION:**

**Early intervention was listed as one of the top five needs in the online survey.**

**Stigma:** While the topic of stigma for people with mental illness is a key issue, it is well-known and has considerable attention within DMHAS. The stigma against people with substance abuse disorders is in some ways even more severe. They are often seen as “bad,” “unworthy,” “a waste of time,” a “nuisance” – not as *a person with a disorder who needs help to achieve recovery*. This results in poor treatment or even rejection from treatment in hospital emergency departments and other services.

**RECOMMENDATION:** Instead of seeing the “frequent flyer” as a nuisance, the staff need to recognize that they and the system have gotten another chance for a successful intervention.

**Education:** Through the activities of the RACs a fair amount of education takes place about substance use and abuse, but there is little in the curricula to help students understand what is happening to them or their friends as first symptoms of mental illness appear.

With substance use/abuse by youth in the schools, there is a tension between intervention and expulsion where the former has led to the latter, leaving people hesitant to intervene. There have also been some racial disparities noted here, as teachers (who are predominately white) view who one child as just needing some “intervention” and another as needing expulsion. There is also inequality with regard to consequences that are dealt to students who are guilty of infractions. A National Honor Society student may suffer no repercussions for bringing alcohol to school, when a lower-performing student may be suspended or expelled.

Though the Connecticut School Health survey does gather information on a biennial basis, the data collected is generalized for the state, and cannot be identified specific to individual communities. This can enable a school or community to maintain the illusion that they have no problems, and believe (or attest) that it only happens “over there” or in “the other school.” This reluctance has hampered efforts to identify or quantify the problem(s) and where they exist, and makes it impossible to accurately assess the needs and efficacy of interventions.

**RECOMMENDATION:**

- There is a **need for an enhanced relationship between the Department of Education and DMHAS**. This is also a system transformation issue.
- A single survey, implemented in all schools grades 6-12, and funded by the state, to assess substance use/abuse and key behavioral data (bullying, violence and problem gambling).
- Consistent reporting of outplacements, suspensions, incidents, and re-entry information. While this data may be collected by individual schools it is not shared.
- Improve education in the schools about mental illness.
- Address the conflict between identification of needs and disciplinary action in the schools.
- Additional intervention staff capacity in schools to address bullying, violence, disciplinary issues, mental health issues and substance abuse. These positions

are often the first to be cut in budget reductions but are essential for prevention activities.

**Community sales compliance:** Resources that impact prevention are vulnerable in each budgetary round. Efforts at cost-shifting go on between local, state and federal funding, and between different departments, but the net effect can be that no one does it. For example, due to reductions, the State Liquor Authority no longer conducts compliance checks on underage liquor sales. The responsibility has been shifted to the police. However, their individual officers are more likely to be known in the towns, they do not have the resources to do this nor do they have the authority to pull the liquor license, which is the fast, simple and effective strategy belonging to the State Liquor Authority.

**RECOMMENDATION:** Increased staff at the State Liquor Authority and resumption of State Liquor Authority compliance checks.

#### **D. REGION V SYSTEM AND SERVICE STRENGTHS AND PROGRESS:**

- **Young Adult Services:** the programs in the Torrington area have been in operation for years, and – recently reviewed by the NWRMHB – are of excellent quality. A new program is just at its inception in the Waterbury area.
- The **Guardian Ad Litum program** is innovative and effective. It is well-regarded by its clients and its effectiveness documented in the NWRMHB review process.
- **Trauma-sensitive treatment** is a focus throughout the region.
- **Evidence-based models** are widely used, including IDDT for co-occurring disorders.
- There are **positive relationships and honest collaboration** among the providers in the mental health system, between Mental Health and Substance Abuse treatment programs and services, and between state-operated and PNP providers.
- There are **active Continuums of Care** in all three parts of the region, and these collaborations have brought in many housing resources including 15 more units of Shelter + Care in the Waterbury area alone.
- **New leadership and direction at the GWMHA** is well-regarded.
- **DMHAS training** – especially when offered at the local level – is useful, accessible and most important for financially-strapped PNPs: free. There is a new series of Friday training at the GWMHA which is well-regarded. These classes are 1 ½ hours long and utilize “local talent.”
- There are **several positive vocational initiatives**, including the Voc S.O.C.I.A.L. group in Danbury, the Recovery Works group in Waterbury, and the “Making Work Work” group in Torrington. The NWRMHB Work Incentives Committee continues to be a force which advances vocational issues on a local, state and national level. It has been instrumental in moving forward the relationship between DMHAS and BRS across the region through a series of very well-attended special Roundtable Discussions called “Meeting of the Minds- DMHAS and BRS.”
- Improvements in **substance abuse outreach:** MCCA has developed a Senior Outreach program, and there is an outreach program to Latinos.
- Strong availability of **self-help and consumer-driven groups** such as AA, NA, Al-ANON and in Danbury, such groups for Young Adults as well. It was noted that key to building such resources for young adults was having one at a college campus with on-campus housing.
- **Recovery and Wellness Program:** is a recovery-oriented and innovative format as an alternative to “groups” for skills education.
- **Environmental changes and spreading awareness and use of best practices in prevention** in communities, through educational systems, schools, community forums and strategic planning. Many environmental changes such as ongoing educational and family support workshops to prevent underage alcohol use, coupled with efforts to change the social norm from “some use is benign” to “no use until of legal age and/or when the adolescent brain has fully matured” is becoming socially accepted and more widely implemented in schools and communities.
- **There is an increasing focus on wellness** including stress-management, smoking cessation, nutrition and reducing obesity, healthy lifestyles, meditation and yoga. All of these build resilience and are preventative factors for addiction and mental illness.

- **Parents are beginning to seek support and education** in their skills, roles and responsibilities as parents, and to increase their awareness of risks to youth in all areas of prevention, not just surrounding alcohol use or early prevention of mental health issues.
- **Increased availability of bupenorprhine/ Suboxone treatment.** There are now multiple agencies and private practitioners who offer this resource in the region.
- **Substance abuse providers are beginning to participate** in service-system wide meetings, improving collaboration and sharing resources. While not yet inclusive of all DMHAS-funded substance abuse providers, there has been noteworthy progress.
- **Consumer and recovery-oriented services:** A proactive process to have more recovery-oriented outpatient services become the norm is already happening with panels of consumers going into area hospitals – now at their request – and conducting educational focus groups with hospital staff on consumer issues including the meaning of “Recovery.”

a: final draft Region V Regional Needs Assessment and Priority Planning report/m