

Southwest Regional Mental Health Board, Inc. Lower Fairfield County Regional Action Council RYASAP

Regional Priority Services Report May 2008

Section A: Process Overview

I. Introduction

Every two years, the DMHAS planning division is required to formulate a statewide needs assessment and priority planning process to capture needs and trends on the local, regional and statewide basis. This process is conducted by the five Regional Mental Health Boards (RMHBs) and in the last few years, has been done in collaboration with the Regional Substance Abuse Action Councils (RACs). Information gleaned from this process is used to inform the DMHAS Mental Health Block Grant, DMHAS biennial budgeting process as well as to inform planning and priority setting for each Regional Board.

This year the SWRMHB partnered with two of the three local regional action councils in Region 1, the Lower Fairfield County Regional Action Council (LFCRAC) and RYASAP, to conduct the needs assessment. Through this partnership, services needs, gaps and barriers were explored in regards to both mental health and substance abuse services and areas of focus were identified regarding prevention of both mental illness and substance abuse. These three organizations each have access to a wealth knowledge and understanding regarding service needs and connections to a wide range of local stakeholders in the communities served by Region 1. The partnership allowed for a process that was inclusive and brought the breadth and depth needed to develop a collective vision regarding the mental health and substance abuse services needs in lower Fairfield County.

II. Process:

In Region 1, SWRMHB took the lead in this process and collaborated with the RACs with regards to substance abuse services and prevention services. The three organizations met to determine the scope and process of the needs assessment in accordance with the guidelines set by the DMHAS Office of Program Analysis & Support. In order to ensure a broad based information base, it was decided to use a survey as the primary information gathering tool. Additional information was collected through consumer focus groups, key informant interviews, LMHA responses, meetings, and SWRMHB's Review and Evaluation Process.

Survey:

A web based survey was developed by the partnership that asked respondents to identify and prioritize mental health and substance service needs, to identify service system strengths and to make recommendations to address service priorities (Attachment A). Using

a five-point Likert Scale, respondents were asked to rate 11 mental health service needs and 13 substance abuse service needs ranging from “extreme need” , highest priority, to “not a concern”, lowest priority. Respondents were then asked to prioritize the service needs by identifying the 3 most pressing issues faced by adults living with mental illness and the three most pressing issues faced by adults with substance abuse concerns. Respondents were asked to identify three strengths regarding the services available in lower Fairfield County for adults living with mental illness and three strengths for adults with substance abuse concerns. Finally, respondents were asked to make recommendations on how the identified service priorities could be addressed.

The survey was posted on-line on surveymonkey.com and the link to the on-line survey was sent via email to approximately 200 stakeholders in the following groups:

- Private non-profit mental health and substance abuse service providers
- State-funded mental health and substance abuse service providers
- Town social service directors and health department directors
- Mayors, First Selectmen and other municipal contacts
- Community health centers and hospitals
- Members of law enforcement and criminal justice system
- Consumer and family member groups
- Faith based groups

A total of 50 surveys were completed on-line.

Focus Groups:

Although hard copies of the survey as well as on-line access of the survey were made available to consumers of mental health and addiction services, few surveys were completed by this stakeholder group. In order to ensure sufficient representation of this stakeholder group, three consumer focus groups were conducted. In addition, to elicit additional and clarifying information on the service needs as identified by survey respondents, focus groups were held with mental health and substance abuse service providers and the members of the Catchment Area Councils in Region 1. Focus groups were conducted with the following groups:

- Catchment Area Council 1&2 and 3&4
- 3 Consumer groups at social clubs (Bridge House, Keystone House and Laurel House)
- DMHAS funded service providers

Focus group participants were asked to respond to the following questions:

- What are the most outstanding problems or issues regarding the top five priority areas as identified through the 2008 survey: housing, employment, medical/dental services, services for individuals with co-occurring mental illness and substance abuse and young adult services.
- What is needed to address concerns regarding housing, employment, medical/dental services, services for individuals with co-occurring mental illness and substance abuse and young adult services.
- Are there additional concerns that need to be addressed that were not identified in the 2008 survey?

Additional Information:

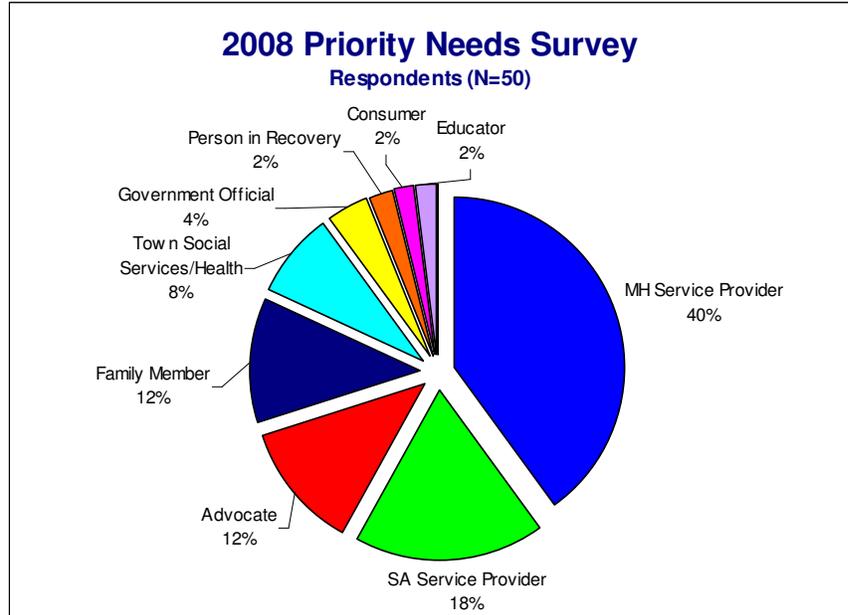
Information on issues, some of which match the priorities identified in the survey, are *collected on an ongoing basis* through various sources as follows:

- Panel presentations at Regional Council meetings. For example, RYASAP and LFCRAC have regional panel presentations from law enforcement in which local and regional issues were identified. There have also been regional panel presentations from school districts.
- Presentations at Mental Health and Regional Council meetings. Some of these presentations have been from Fairfield 08 (housing), Young Adult Services, Co-occurring Service Providers and have included information on needs and recommendations.
- Analysis and presentation of secondary data such as consequential data (e.g. ATOD suspensions, DUIs), numbers receiving service (as noted above) and consumption data (e.g. number of youths drinking alcohol, smoking)
- Participation on various projects and regional initiatives which identify issues related to substance abuse and/or mental health (e.g. Regional Town Hall Forums on Underage Drinking, Greater Greenwich Area Behavioral Summit, Regional Suicide Prevention Forum, Regional Smoking Cessation Supports Initiative)
- SWRMHB strategic planning process
- Lessons learned from SWRMHB Decriminalization Committee, Review and Evaluation Committee, and Education and Advocacy Committee
- “Working Lunch” discussions with key community leaders
- Participation on community needs assessment and funding allocation committees

Ongoing collection of information through these various formats provides supplementary information when identifying priorities in area of Mental Health and Substance Abuse treatment and prevention. It also keeps a “finger on the pulse” of the priority needs for mental health and substance abuse *in relation* to overall community and regional needs.

Section B: Key Findings

I. Survey Results: Of the approximately 200 on-line surveys distributed via email, 50 surveys were completed on surveymonkey.com, which equals a response rate of 25%. Of the 50 respondents, the majority were mental health (40%) and substance abuse (18%) service providers. Family members and advocates accounted for 12% of respondents each. The remaining respondents were town social services providers (8%), government officials (4%), persons in recovery (2%), consumers (2%), and educators (2%).



Feedback from consumer groups regarding use of the survey indicated that this method of information gathering created numerous barriers and resulted in a low consumer response rate, with only 4% of respondents being consumers or persons in recovery. To address this barrier and ensure an adequate level of input was received from consumers, focus groups were held.

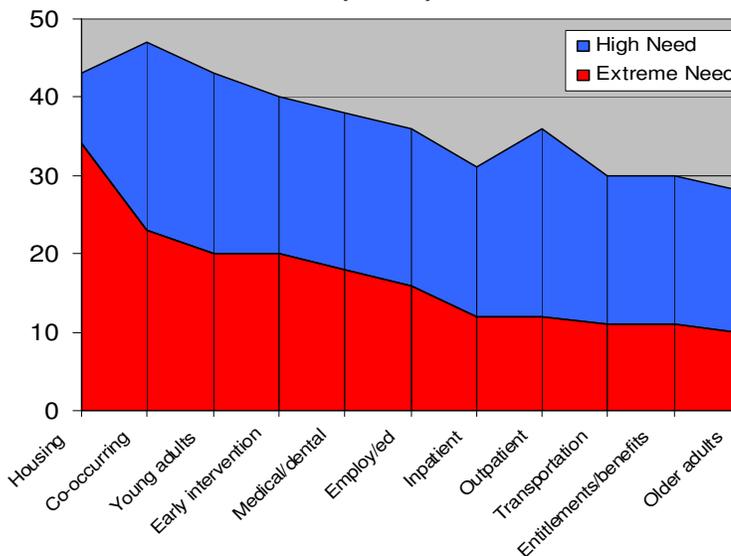
Mental Health Service Needs:

Survey respondents were asked to rate 11 areas of service need as related to adults ages 18

and up living with mental illness. Not surprisingly, most of the 11 identified areas were rated as extreme need or high need which speaks to the critical lack of investment in community based supportive services. The areas rated as the five highest

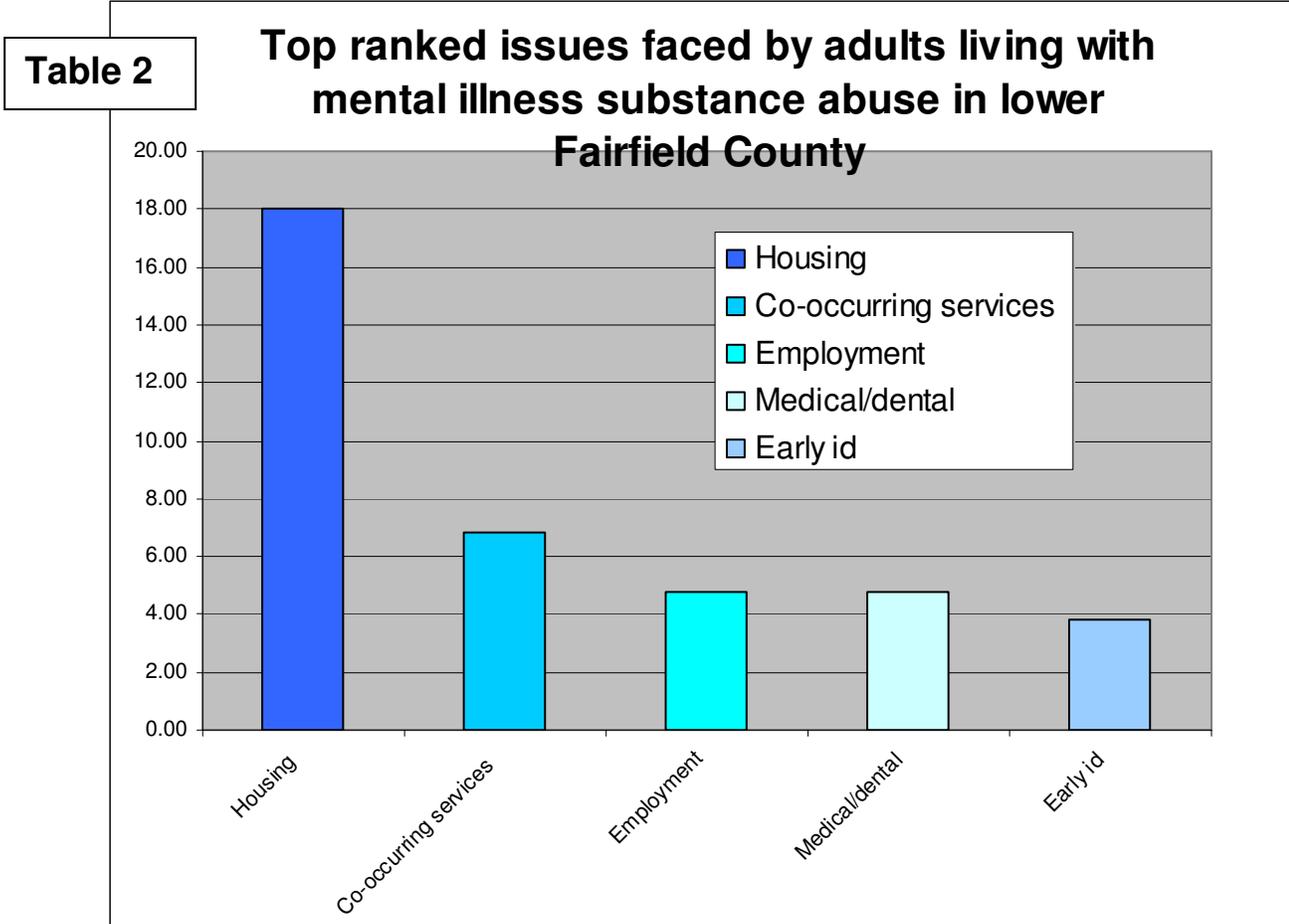
Table 1

MH Services Rated Extreme Need & High Need (N=50)



needs were: housing, services for individuals with co-occurring mental health and addictions, services for young adults (ages 18-25), early intervention services, and medical/dental services (Table 1).

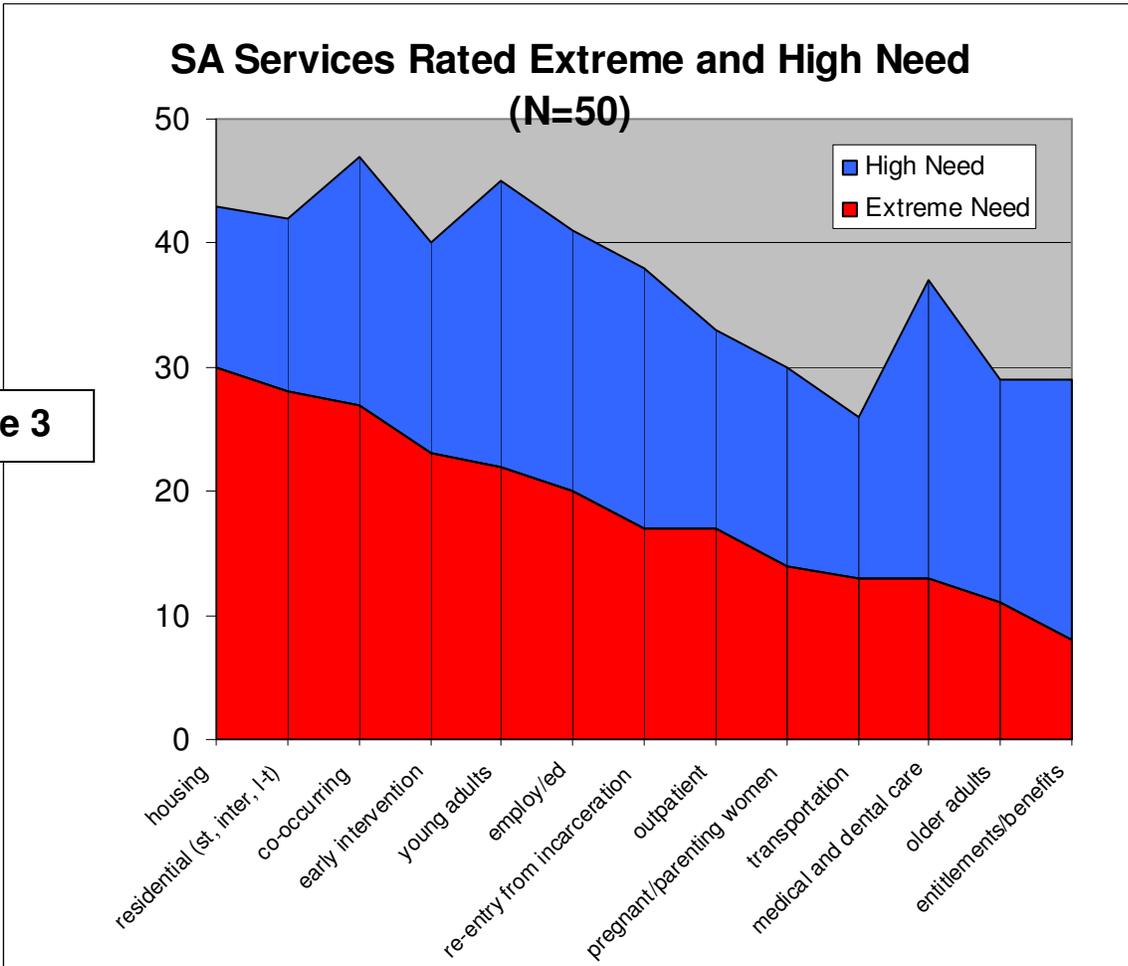
When respondents were asked to prioritize the issues they identified as being needed, it became very evident that housing is the most critical need of all services/supports for persons with mental illness living in lower Fairfield County. By a margin of over 3:1 housing was rated at the most urgently needed service, with co-occurring services, employment, medical/dental services and early identification being the next 4 highly prioritized issues. (Table 2)



Substance Abuse Service Needs

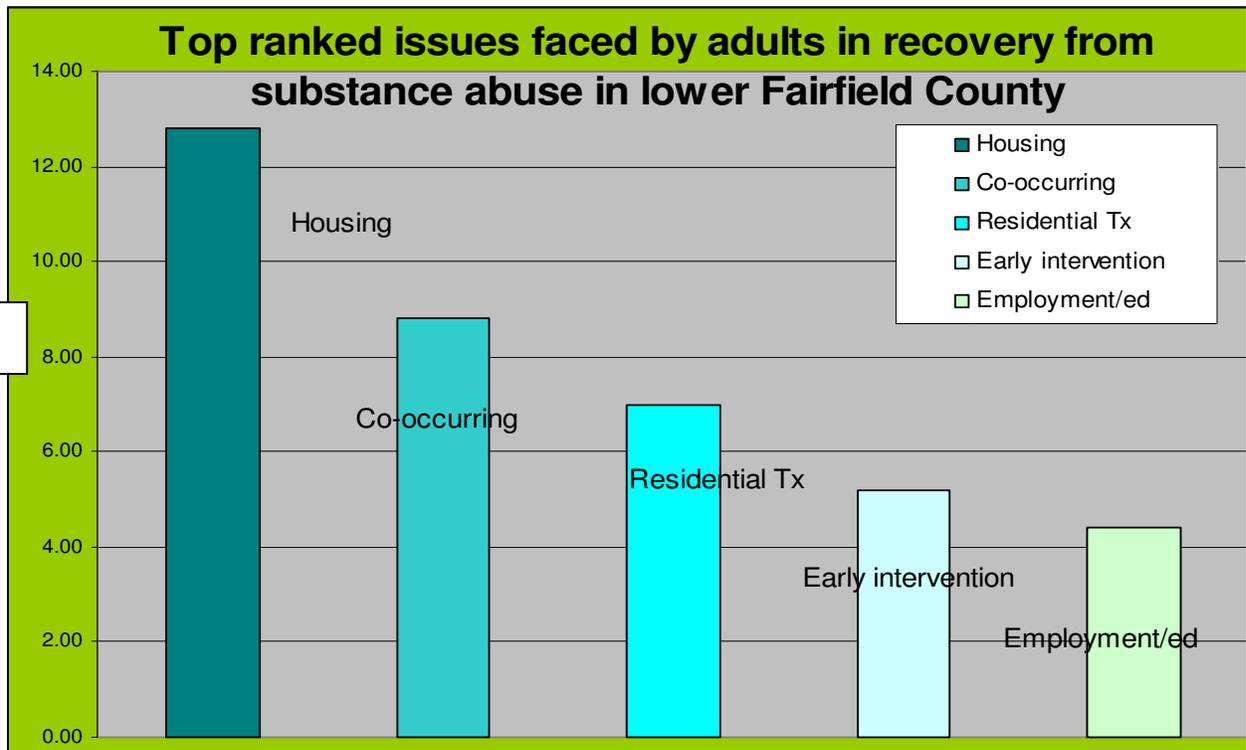
Survey respondents were asked to rate 13 areas of service need as related to adults ages 18 and up with substance abuse concerns. As with the mental health services, most of the 13 identified areas were rated as extreme need or high need which speaks to the critical lack of investment in community based supportive services. The areas rated as the five highest needs were housing, residential substance abuse treatment (short-term, intermediate and long-term), services for individuals with co-occurring mental health and addictions, early intervention services, and services for young adults (ages 18-25). (Table 3)

Table 3



When respondents were asked to prioritize the issues they identified as being needed, once again housing was ranked as the number one priority of all services/supports for persons

Table 4



with substance abuse living in lower Fairfield County. Co-occurring services, residential substance abuse treatment, early identification, and employment/education were the next 4 highly prioritized issues. (Table 4)

II. Summary of focus group/key informant interview feedback

To elicit more specific information regarding mental health and substance abuse service needs, gaps and barriers, and recommendations to address needs focus groups were held with consumers, service providers and members of the local Catchment Area Councils. Discussion focused primarily on the top five priority mental health and substance abuse issues as identified by survey respondents.

Housing:

Overall consumers felt that it was nearly impossible to access stable, safe and affordable housing in Fairfield County. Most of the affordable and available properties are in dangerous neighborhoods, very dirty and poorly kept. Consumers reported that there is a serious a bed bug infestation in Bridgeport Housing Authority properties and other privately held properties.

Even when available housing has been identified, consumers face numerous barriers which include discrimination by landlords who do not want to rent to persons with a history of mental illness, consumers with criminal records that usually relate to minor, non-violent offenses, poor or lack of credit history, very high rents in Norwalk, Stamford and Greenwich, and expensive security deposits. In order to live in a safe and affordable area, consumers have to move farther out of the cities in Fairfield County, which creates an additional barrier – that of transportation. Most consumers do not have driver's licenses or cars and therefore are unable to take advantage of housing in the communities surrounding the cities.

Transitional and supportive housing were both held up as solutions that are working well. There is a need for more investment in these types of housing as there are too few of these units available. Providers stated that having a home coupled with support has been essential to many consumers' recovery. Transitional housing provides a "time buffer" not only in the support provided but allows for the longer time periods needed to find permanent housing.

Possible solutions:

- Educate housing authorities and landlords regarding the myths and realities of mental illness to address the stigma of renting to persons with mental illness.
- Form collaborative relationships with housing agencies to address credit history and establish processes to ensure rent is paid timely.

Employment

The recurring theme heard in the focus groups was related to stigma and the need for employers to become educated about mental illness and its symptoms. For many consumers, their symptoms and/or medication side effects drive away potential employers. Other barriers to employment include gaps in employment history due to hospitalizations or other disruptions in daily life, little or no work experience, and lack of skills, particularly technological skills. In addition, the job market in lower Fairfield County is very competitive and high paced with fewer jobs available that are considered entry

level, especially in Stamford and Norwalk which have many Fortune 500 companies. It is hard for consumers to fit into the fast paced work environment and as a result most consumers end up finding jobs in retail or other service industry jobs. Consumers expressed a strong desire to work, stating that *“we know can be an asset if the employers would be willing to give us a chance.”*

Consumers and providers were both in agreement that supported employment as well as temporary employment programs are effective in helping consumers obtain jobs – consumers stated they feel by their participation in these employment programs *“supported and hopeful about their future.”*

Possible Solutions:

- Build relationships with major employers to increase both entry level job opportunities and opportunities to advance to higher skill level jobs.
- Provide sensitivity training for employers regarding different mental illnesses to help them understand better about what to expect from an employee who might be living with mental illness.
- Provide more supportive employment specialists to aid consumers in obtaining and keeping a job.
- Build relationships with local colleges and universities.
- Connect consumers with computer and other technology training.

Medical/Dental Care

The primary concern expressed is the lack of focus on the physical well-being of consumers. The mental health system is not well trained to identify or focus on medical issues and primary care doctors tend to see the psychiatric illness first, discrediting or overlooking consumer medical symptoms and complaints. Access to medical and dental care is limited due lack of insurance, impact of the Medicaid spend down and low Medicaid reimbursement rates. Low reimbursement rates is especially problematic regarding access to dental care as there are very few dentists that will take Medicaid and there are only a very small number of dental clinics in the region. Consumers experience long waiting lists for dental appointments, difficulties accessing emergency dental care, and have practically no access to reconstructive care, such as bridges, crowns – more often teeth are pulled as consumers cannot afford to pay for the “extras”.

Possible Solutions

- Increase Medicaid coverage for dental care.
- Ensure consumers receive annual physicals.
- Coordinate primary health care with mental health care.
- Co-locate medical and primary health care.

Co-occurring Services

The primary issue discussed was the need to get the mental health and substance abuse systems to work better together; focus group participants felt the whole system needs to be re-evaluated and re-thought on how to deliver services to persons with co-occurring mental illness and substance abuse. There continues to be access to care barriers where it can be difficult for consumers being referred by a mental health agency to access substance abuse services and conversely many substance abuse providers are unwilling to accept a consumer with more serious mental illness (i.e. schizophrenia, major mood disorders) but are comfortable working with those with anxiety and depression.

Possible solutions:

- Increase co-ordination and collaboration between mental health and substance abuse providers.
- More co-occurring capable staff located in both mental health and substance abuse services.

Young Adult Services

With only one DMHAS funded Young Adult Service program (YAS) in Region 1, there is a critical need for additional YAS, especially in the Norwalk, Stamford, and Greenwich areas. Consumers at the social clubs indicated a need for age-appropriate programming in the psycho-social clubs as well as in treatment programs. Young adults stated they do not feel a part of the social clubs as there are few activities that appeal to them and the majority of members are much older than they are. Young adults stated they would get involved in social clubs if the programming met their needs and interests. Most appealing to the young adults are age-appropriate recreational activities as well as assistance in obtaining employment, independent housing, and furthering their education.

Section C: Recommendations

Mental Health Services:

1 Priority: Housing – Increase access to supportive housing

Rationale: Survey results as well as feedback from the focus groups and key informant interviews indicate that housing is the number one service need for persons living with mental illness. When asked to prioritize service needs, survey respondents ranked housing as the number 1 priority by a margin of 3:1 over the next most highly prioritized service need, that of co-occurring services. Fairfield County is known to be one of the highest cost housing markets in the U.S. In a report by the Connecticut Housing Coalition in coordination with the National Low Income Housing Coalition, the Stamford-Norwalk region was identified to be the most expensive rental market in the entire country. A person must earn \$31.58 an hour to afford the rent for a modest two-bedroom apartment; this is significantly higher than the already high rate of \$21.11 an hour that a person must earn to afford rent in the remainder of Connecticut's communities. Bridgeport, the state's most populous and one of its poorest, is increasingly becoming less and less affordable. The city's housing prices and rents have for a long time been considerably lower than the remainder of Fairfield County but this is quickly changing as developers are bringing in large scale projects designed to attract more middle and upper-income residents. As a result, Bridgeport's stock of low-cost rental units is declining. With Stamford and Norwalk being designated as the most expensive rental market in the country and Bridgeport low-cost rentals declining, affordable housing rarely exists in Region 1.

For persons living with mental illness, supportive housing has been shown to be effective in helping individuals to remain stably housed and promote self-sufficiency. The 2006 Supportive Housing State Report from the Corporation for Supportive Housing indicated that slightly more than 80% of the total households were homeless prior to moving into supportive housing, with nearly two-thirds coming from emergency shelters, the street or other places unfit for human habitation. When exploring strategies to address the chronic housing shortage in lower Fairfield County, it became evident that increasing the stock of supportive housing units would have the most impact is both addressing the housing shortage and supporting an individual's recovery and capacity to maintain their housing.

Strategy:

- **Using the Fairfield 08 model, partner for-profit developers with non-profit housing providers to develop supportive housing.**

Fairfield 08 is a non-profit organization made up of four homeless shelter providers in Fairfield County – Interfaith Housing in Westport, Operation Hope in Fairfield, St. Luke's Lifeworks in Stamford and Alpha Community Services/YMCA in Bridgeport. These four organizations have joined together to address the need for permanent supportive housing to eradicate chronic homelessness in Fairfield County. The goal is to create 2000 new units of permanent supportive housing by 2014.

Fairfield 08 is working with large private developers to develop a partnership between the private-non profit providers, for profit developers and for profit property managers.

The developers/property managers would build the units and manage the properties once built and the PNPs would be responsible for providing the support services. Rental subsidies are very important in making this concept work, as they ensure the developers/property managers an ongoing financial stream to pay for the rent.

Fairfield 08 has just started this work and has housed 41 individuals to date. They expect to house 150 in 2008. To successfully implement this model the following is needed:

- Partnerships with willing developers and property managers - Fairfield 08 has met with many large private developers and has not been turned down by any to date.
- The units need to be integrated into the properties.
- Access to rental subsidies need to be secured.
- Commitment from local, strong social service providers who understand their communities and can effectively work with local zoning and planning boards.

#2 Priority: Co-occurring services

Rationale:

With the implementation of mandatory screening in all DMHAS funded mental health and addiction programs, an increasing number of individuals with co-occurring issues will be identified. Although great strides have been made in regards to the Commissioner's Co-occurring Initiative, providers and consumers repeatedly state that the two systems continue to operate in isolation of each other and that there is a need for improved coordination and collaboration to increase access to programs. Programs are beginning to educate and train staff in the importance of identifying and treating those dually-diagnosed with mental health disorders and substance abuse. In SWRMHB's 2006-07 review of DMHAS funded out-patient mental health programs, the Review and Evaluation Committee found that although each program had a portion of their staff receive Integrated Dual Disorder Treatment (IDDT) training, implementation of integrated treatment has been hindered by the lack of adequate clinical supervision as a follow-up to IDDT training and a lack of comprehensive screening/assessment tools for substance use. This need for more training regarding working with individuals with co-occurring services has appeared as a recurrent theme in SWRMHBs 2007-08 reviews of homeless outreach programs, where the percentage of individuals with co-occurring disorders were reported to be above 60%.

Strategy:

➤ Provide on-going clinical supervision and support to promote effective implementation of IDDT

The Southwest Connecticut Mental Health System (SWCMHS) has recognized a need for strengthening the co-occurring capacity of staff in the Region 1 and has hired an "IDDT Champion" to develop services throughout the region. In addition co-occurring experts have been identified throughout the system to assure responsiveness to this population. Collaboration between the private non-profit community and SWCMHS needs to be developed to ensure the training and on-going support provided by the "IDDT Champion" is available to employees not only in the working in the state facilities but in the private non-profits. In addition, DMHAS training should be brought to Region 1 as often DMHAS trainings are held in the Hartford or Middletown area. Traveling to these trainings is burdensome and costly, requiring significant travel costs and release time for staff from lower Fairfield County.

- **Break down barriers between mental health and substance abuse systems**
 - Conduct regular face-to-face meetings between mental health providers and substance abuse providers to identify and address access to service barriers.

#3 Priority: Employment

Rationale:

For many consumers, employment is a key factor in their recovery process. Consumers report on the benefits of working and getting a paycheck as giving them feelings of increased self-esteem and self-confidence to move forward. In lower Fairfield County, the job market is increasing competitive. With the focus on the best practice of supported employment which helps consumers participate as much as possible in the competitive labor market and work in jobs they prefer with the level of professional help they need, consumers are competing with the general population for jobs. In the competitive job market consumers are faced with the challenges of stigma and employer reluctance to hire persons with a history of mental illness, a lack of technological expertise that is required to not only do the job but often to apply for the job as many employers now use web-based application processes.

“Employing consumers can be good business” – as stated by an employer who has collaborated with Laurel House’s temporary employment program for years. This employer stated that at first, her company’s participation was viewed as a “community service” activity but over-time this employer found that employees from Laurel House were a valuable asset to their organization and it was now viewed as “good business” to hire Laurel House consumers. Cultivation of relationships with the business community is a key factor in giving consumers an entry into the competitive job market in Fairfield County as well as education of these prospective employers.

Strategies:

- **Partner with local business, higher education and non-profit agencies** to develop employment opportunities.
- **Computer training** – increase access to existing community-based computer training to increase consumer marketability for entry level office jobs
- **Collaborate with chambers of commerce to provide training** to the business sector to address stigma and myths of employing persons in recovery from mental illness and addictions.

#4 Priority: Medical/Dental Services

Rationale:

According to a recent report by Dr. John Newcomer and Dr. Charles Hennekens in the October 17, 2007 issue of the *Journal of the American Medical Association* people with serious mental illness lose 25 years of life expectancy as compared with the general population, and this loss is due primarily to an increased risk of cardiovascular disease. This alarming statistic emphasizes the need for better coordination and communication between mental-health specialists and primary health practitioners. Aggressive efforts should be made toward **fully integrating primary health care, dental care and behavioral health care services** so that the Medicaid population can have easier access to adequate primary health and dental care. Having access to preventive measures, early intervention and treatment for diabetes, hypertension, and major oral/dental problems is imperative to those suffering mental disorders as research demonstrates the strong and inextricable link between physical and emotional health.

Strategies:

- **Collaborate and coordinate primary, psychiatric and substance abuse care** which includes
 - Transparent process
 - Sharing of clinical information with other providers
- **Integrate recovery oriented behavioral health care into the primary care setting**
 - Co-locate mental health and physical health services

#5 Priority: Young Adult Services**Rationale:**

With only one DMHAS funded Young Adult Service program (YAS) in Region 1, there is a critical need for additional YAS programs, especially in the Norwalk, Stamford, Greenwich area. There is a growing demand for services tailored to meet the needs of young adults ages 18-25 due to the increasing number of young adults transitioning out of DCF needing ongoing, often intensive services; a marked increase in community referrals; and the rise in lower Fairfield County in prescription drug abuse amongst teens and young adults that leads to heroin addiction. Data from SWCMHS indicates that in 2006-07 a total of 217 young adults were receiving services through programs at FS DuBois Center and the Greater Bridgeport Community Mental Health Center yet the YAS program has the capacity to serve only 90 young adults. The remaining young adults receive more traditional services, where staff has little or no expertise regarding young adult issues. Currently, there is only one psychiatrist on staff in SWCMHS who has expertise in adolescent and young adult issues. He works full-time in the YAS program in Bridgeport, but recently has been spending one day per week at the FS DuBois Center in Stamford to address their growing population of young adults.

Strategy:

- **Fund additional YAS programs in Region 1**, especially needed in the Stamford-Norwalk area. To inform program planning and investment of limited YAS dollars, DMHAS should collaborate with the DCF Systems of Care to identify needs, gaps and barriers re: emerging young adult population

Mental Health Prevention**Prevention #1: Community Education**

Rationale: Although much progress has been made in addressing the stigma associated with mental illness, stigma does continue to be a factor that can prevent individuals from accessing timely care, i.e. before a crisis occurs and can negatively impact a consumer's recovery as they seek to obtain housing and employment.

Strategy:

- **Leverage technology to reach a wider audience** – utilize new media (i.e. web casts, streaming videos, podcast etc.) to reach Connecticut citizens to transform prevailing public attitudes towards mental health by providing instant access to real stories that can have a positive impact on the public's perception of and understanding of mental illness. The goal would be to engender greater empathy and caring for our children, our friends, family members and neighbors who are struggling

with mental illness and to broaden the community's understanding of wellness to include both physical and mental health.

Prevention #2: Early Identification

Rationale: 40 out of 50 survey respondents indicate that early identification services were in extreme or high need in lower Fairfield County and early identification was ranked as the fifth highest priority service need. Early identification and early intervention can lead to better outcomes, reduce or eliminate symptoms of mental illness, and prevent future, more costly interventions. Most individuals with depression wait years before seeking help and many do not get help at all. In the cases of elderly who commit suicide, many consult their physician shortly before their death but fail to communicate their despair. For young adults demonstrating early symptoms of psychosis, an effective early intervention program may reduce the duration and intensity of psychotic states as well as the secondary effects of psychosis, such as social and educational or vocational disruption and substance abuse. Primary care physicians can play a crucial role in identifying persons with mental health concerns by conducting routine screening and once identified, connect them to supportive treatment.

Strategy:

- **Conduct physician training** on MH screening and referral sources for MH treatment services.
- **Incorporate standardized screening into routine medical visits** (i.e. adult physical exams, well child visits)

Prevention #3: Increase coordination of services

Rationale:

One of the most recurring themes expressed at Southwest Regional Mental Health Board's CAC meetings and Decriminalization Committee meetings is the challenge of maintaining individuals in the community and breaking from cycle of homelessness or temporary/transitional housing, to incarceration and/or hospitalization. Success will require the collaboration and coordination of services across numerous systems, including law enforcement, the judicial system, Department of Corrections, homeless providers, inpatient facilities, outpatient facilities, housing providers and other support services.

Strategy:

- **Establish a community reintegration collaborative** to ensure smooth transitions from inpatient or incarceration to community

Prevention #4: Collaborate with Department of Corrections

Rationale:

Discussions at SWRMHB's Decriminalization Committee often focus on transition issues for persons with mental illness being released from incarceration. The newly funded specialized mental health parole officers have provided a needed bridge for these individuals, yet there is limited capacity to do this work as there is only one of these officers, based out of Bridgeport, for the entire region. There have been several cases where consumers have been released with their two-week supply of medication and have not been able to access mental health care within this two-week time frame, thus running out of their medications.

Strategy:

➤ **Ensure uninterrupted access to medication upon discharge**

- Facilitate connection with mental health treatment upon release from incarceration.
- Co-locate mental health clinician in the Department of Corrections and the local mental health authority.

Substance Abuse Treatment Services:

#1 Priority: Housing – Increase access to supportive housing *and affordable housing*

Rationale:

As indicated under rationale for housing under Mental Health Services, Fairfield County is known to be one of the highest cost housing markets in the U.S. In a report by the Connecticut Housing Coalition in coordination with the National Low Income Housing Coalition, the Stamford-Norwalk region was identified to be the most expensive rental market in the entire country. A person must earn \$31.58 an hour to afford the rent for a modest two-bedroom apartment; this is significantly higher than the already high rate of \$21.11 an hour that a person must earn to afford rent in the remainder of Connecticut's communities. Bridgeport, the state's most populous and one of its poorest is increasingly becoming less and less affordable. The city's housing prices and rents have for a long time been considerably lower than the remainder of Fairfield County but this is quickly changing as developers are bringing in large scale projects designed to attract more middle and upper-income residents. As a result, Bridgeport's stock of low-cost rental units is declining. With Stamford and Norwalk being designated as the most expensive rental market in the country and Bridgeport low-cost rentals declining, affordable housing rarely exists in Region 1.

Sober Housing is known as supportive housing specific for people in recovery. Supports are provided through peer to peer model that includes day to day informal support and NA and AA meetings. In addition, treatment facilities will also provide outpatient counselor support for the first 6-8 weeks that someone is living in a Sober House. Residents have to be working as they do pay rent in these residences and many stay up to two years or longer.

Sober Housing is an important step in recovery. To reduce the risk of relapse, it is important that a person in recovery can live in the same area where they started their recovery and have built up their supports. Therefore, it is important that the Sober Housing (aka Supportive Housing) is available in that area. In Fairfield County, there is a shortage of this type of housing which can result in a person in recovery moving back to the area where he/she was using drugs and therefore, increases the odds of relapsing.

However, in discussion with one of the key informants, the issue of ***lack of affordable housing*** in our region was more critical. People living in Sober Housing eventually want to move out into their own place i.e. a new phase of recovery but stay in the area where they have employment and supports in place. It was noted the lack of affordable housing in this region continues to be an issue for those who are working full time but many make approximately \$8/hr which is far below the needed hourly wage as noted above.

Strategies:

- Partner for-profit developers with non-profit housing agencies to **increase Sober Housing** – i.e. Fairfield 08 model
- **Extend Long-term transitional housing**

#2 Priority: Co-occurring services

Rationale:

Treatment agencies are seeing more clients diagnosed with co-occurring disorders. Staff in treatment agencies are now being trained in co-occurring and intake assessments include

questions to screen for mental health issues. However, as these numbers increase, training more staff and strengthening relationships with mental health providers is important.

Strategies:

➤ **Break down barriers between MH and SA systems:**

- Conduct regular face-to-face meetings between mental health providers and substance abuse providers to identify and address access to service barriers.
- Provide half day forums on best practices and COD bringing together MH and SA front-line service providers.

#3 Priority: Residential Treatment

Rationale:

Treatment as a service faces a number of challenges for a number of reasons:

1. According to the Treatment Research Institute, most people using drugs are not addicted but fall into the category of misusing or abusing. In addition, we know that simple screening and brief intervention can have a significant impact on these people. However, screening and early intervention is not a billable service.
2. Insurance company requirements for clients receiving outpatient but who need inpatient services is so extensive, to the point where the time required is too long and the client has relapsed or left outpatient services.
3. There are many clients who do not have insurance but require treatment. How are their needs met?

In addition, according to the Treatment Research Institute, there is a difference in treatment practices in private versus non profit treatment agencies. For example, Paul M. Roman, Ph.D., Lori J. Ducharme, Ph.D. and Hannah K. Knudsen, Ph.D. summarize key findings of an organizational comparison of two large samples of treatment programs in “Patterns of Organization and Management in Private and Public Substance Abuse Treatment Programs.” Among their findings: pharmacological therapies are more likely to be used in private centers, while voucher approaches are more likely in public centers. We know that sharing information on effective practices is important to continued effective treatment outcomes, therefore, it is important that private and non profit treatment agencies have an opportunity to share their knowledge on “what works”.

Strategies:

- Include **Screening and Brief Intervention as paid service** provided by Treatment Agency.
- **Address insurance challenges** to accessing residential treatment.
- Investigate capacity to **meet need of those with no insurance**
- **Examine best practices** in both private and non profit Treatment Facilities.

#4 Priority: Employment

Rationale:

DMHAS recognizes that employment is crucial to recovery. In Fairfield County, one may be able to find employment but it is difficult to find a job that is close to a livable wage based on the cost of living in this region. Upon closer examination of this issue, there are a number of factors that come into play:

- Skill level needed for a livable wage job
- Supports needed to prepare, secure and keep a job

- Lack of relationships with companies who hire at higher wages
- Addressing these factors requires employment support and employment marketing.

Strategies:

- **Ensure adequate resources for employment support and marketing.**
 - **Strengthen employment support** to include both pre-hire and post-hire support – to promote job retention.
 - **Computer training** - increase access to existing community-based computer training to increase consumer marketability for entry level office jobs.
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Substance Abuse Prevention Services

#1 Priority: Community Awareness

Rationale:

Research shows that change in the 4 core measures actually reduces youth ATOD use. However, research also shows that a focused strategic effort is needed to impact any or all of these areas. For example, using the SPF-SIG framework that includes provision of resources that could be used at the local level would strengthen community awareness and prevention to address underage drinking.

Strategies:

- **Implement a statewide, cohesive public education and awareness campaign focused on one of the 4 core SA indicators**
 - Perception of risk by young adult or student
 - Perception of risk by parent
 - Age of onset
 - Thirty-day use

#2 Priority: Early intervention

Rationale:

Many adolescents abuse substances but are not medically “addicted” to drugs. According to the Treatment Research Institute, “ it can be difficult for them to get treatment in an era when cost containment has raised admission criteria for treatment programs to include only the most severe cases. Progress toward expanding treatment availability could take a step forward if greater use were made of a form of counseling growing in popularity called Brief Intervention (BI). With many schools now using counselors to staff in-school clinics, drug prevention programs or drug assessment and intervention programs, the relatively short, non- intensive BI therapy could become a more appropriate response for mild or moderate users who would otherwise not meet admission criteria for other forms of treatment. (Winters 2005 TRI)

We also know positive impact of early intervention for employers. According to a research group at the George Washington Medical University, companies’ return on alcohol screening- 215 percent and related to savings from increased productivity, lower medical costs and fewer days of work missed due to alcohol problems. American Journal of Preventive Medicine 2008;34 (2) published the results of a study in which the U.S. Preventive Services Task Force (USPSTF) recommended screening and behavioral counseling in primary care to

reduce alcohol use. In January, an article in JoinTogether indicated that there are now screening codes for physicians, however in Connecticut there are no designated funds to pay for these billable codes.

Strategies:

- **Train primary care physicians and pediatricians to routinely screen** and refer for ATOD
- **Secure funding attached to the billable codes**
- **Include BI as a billable service** for treatment agencies

#3 Priority: Strengthen collaboration and communication between prevention and treatment services

Rationale:

DMHAS has identified a continuum of services that includes prevention, intervention, treatment and aftercare. RACs are mandated to identify gaps and develop resources to address these gaps. Based on common gaps identified by RACs in their areas, and the fact that many treatment agencies serve more than one RAC catchment area, it is more time, cost and resource effective to have a Fairfield Treatment Committee, co-facilitated by all RACs in this region.

Strategies:

- **Convene a consortium of Region 1 SA providers and RACs**, including both PNPs and for profit providers for networking and to identify best practices

#4 Priority: Education and Outreach

Rationale:

Prevention involves changing the conditions under which substance abuse and misuse occurs. Focusing on these conditions through education and outreach; the latter of which involves addressing the conditions continues to be a priority to reduce ATOD use across the lifespan.

Strategies:

- **Ensure ongoing education about substance abuse** using local resources and venues.
- Continue to **identify the local and regional conditions** that affect substance abuse/misuse.
- **Support existing or develop new initiatives that address the conditions.**
- **Use the media** to keep education at the forefront.

#5 Priority: Relapse Prevention

Rationale:

Recovery is a process and often referred to as Relapse Prevention. According to the Treatment Research Institute, relapse prevention rates for other chronic conditions have improved when aftercare support is consistent. In substance abuse recovery, this can include NA and AA meetings and consistent monitoring support such as CCAR telephone recovery support.

Strategies:

- **Address high relapse rate** – conduct analysis of issues around relapse and identify what is need to reduce relapse rate.
 - Increase number of persons who access CCAR Telephone Recovery Support and develop policy that requires agency to connect person to this service
 - Explore relapse results with those enrolled in an existing extended care model, “Focused Continuing Care” or “FCC” (used at Betty Ford system) which has been standardized to simplify training and improve client engagement. The frequency of post-discharge telephone contact was increased with more emphasis on follow-up contact rates. Other changes engage clients and their families in the recovery process by providing graphic reports illustrating clinical progress and “next steps” toward recovery. Development of a data collection/reporting infrastructure allowing Betty Ford counselors to assess results of future FCC changes is underway.