

# **REGION IV**

## **SERVICE PRIORITIES AND RECOMMENDATIONS**

**Report in Follow-Up to  
Presentation to DMHAS June 30, 2010**

**Submitted by:**

**North Central Regional Mental Health Board  
East of the River Action for Substance Abuse Elimination  
Substance Abuse Action Council of Central Connecticut  
The Capital Area Substance Abuse Council**

## Table of Contents

<b>I.</b>	<b>Section I: Introduction to Regional Priority Setting Process .....</b>	<b>1</b>
	<b>Purpose.....</b>	<b>1</b>
	<b>Process/Data Sources.....</b>	<b>2</b>
<b>II.</b>	<b>Section II: Provider and Referral Organization Survey Results.....</b>	<b>4</b>
	<b>A. Availability of Mental Health and Substance Abuse Services.....</b>	<b>4</b>
	<b>B. Wait Time .....</b>	<b>8</b>
	<b>C. Barriers.....</b>	<b>10</b>
	<b>D. Challenges and Solutions/Strategies.....</b>	<b>15</b>
	<b>E. Strengths.....</b>	<b>23</b>
	<b>F. Use of Standardized Assessment Tool.....</b>	<b>26</b>
<b>III.</b>	<b>Section III: Focus Group Results .....</b>	<b>27</b>
	<b>A. Service Priorities.....</b>	<b>27</b>
	<b>B. Challenges/Solutions/Strategies.....</b>	<b>29</b>
	<b>C. Strengths.....</b>	<b>32</b>
<b>IV.</b>	<b>Overview of Findings.....</b>	<b>33</b>
<b>V.</b>	<b>Overview of Process.....</b>	<b>35</b>

## Section I. Introduction to Priority Setting Process

### Purpose

The 2010 Priority Setting Process was designed to provide information requested by the Department of Mental Health and Addiction Services (DMHAS) that is “important to the regional needs assessment and ultimately to DMHAS’ development of the next biennial budget.” Information was gathered from many perspectives using a variety of methods to gain a general understanding of how well the DMHAS service system is or is not meeting the needs of the DMHAS population (adults 18 and older).

The process included the perspectives of people in recovery from mental illness and/or substance abuse, their families, concerned citizens, mental health and addictions service providers, and community service providers (non-mental health/substance abuse providers, such as town social service providers, shelter providers, police, etc.) who observe the needs of people with psychiatric disabilities and/or addictions. Because they often refer individuals for services, they are also called referral organizations.

### Local Perspectives

During the spring of 2010, local perspectives in Region IV were gathered by the North Central Regional Mental Health Board (NCRMHB) and the three Region IV Regional Action Councils (RACs) – East of the River Action for Substance Abuse Elimination, Substance Abuse Action Council of Central Connecticut, and The Capital Area Substance Abuse Council. Information was collected in online surveys completed by providers and referral organizations, as well as focus groups consisting of people in recovery (or consumers) from mental health and/or substance abuse, family members, referral organizations, and providers.

### Proposed Use of the Report

This report describes information gathered in surveys and focus groups conducted for this process, as well as other relevant information gathered throughout the year by NCRMHB and the three RACs. No one source of information tells the whole picture. The report gives guidance, but, more important, it provides a starting point for dialogue and systematic examination of challenges and solutions or strategies. The recommendations should also be reviewed along with recommendations of other key planning information so that DMHAS can develop a consolidated strategic plan with selected priorities and track progress on each priority.

While the statements gathered in open ended survey questions and focus groups were identified as critical needs by individual respondents, specific service observations or recommendations are listed as presented by individuals and may not necessarily represent a widespread consensus of opinion. Recommendations are offered for further review by DMHAS and for selection of those recommended actions that can be pivotal, cost effective, and implemented given current or anticipated resources.

### Follow up to Report

Participants were pleased to provide input into the Regional Priority Setting Process, and many individuals thanked us directly for including them in the process. Participants would like to receive feedback about the data collected and see action steps unfold as a result. Participants recognize that some service recommendations listed are not easy to implement in a system that many people believe to be under-resourced. They also want to acknowledge that during this process they identified many achievements within the DMHAS system as indicated in this report.

**Process/Data Sources**

Information was gathered in a variety of ways to capture a picture of mental health and substance abuse service needs and possible priorities for funding, as any one piece of data may not give the full picture. Online provider and referral organization surveys and focus groups conducted as part of this process are described below. Brief summaries of content, findings, discussion points, and recommendations are presented in shaded areas throughout the report.

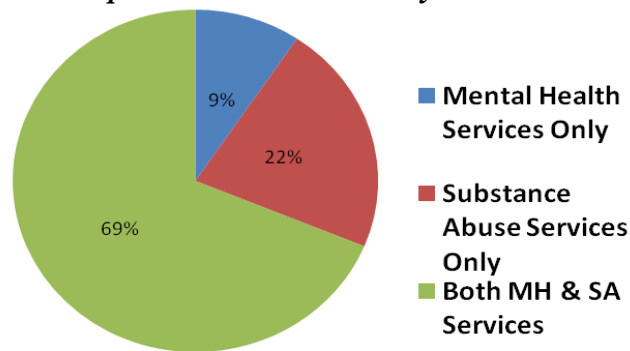
**A. Provider Survey**

The questionnaire for providers was designed to capture the informed knowledge of DMHAS mental health and addiction services providers. This included their direct knowledge of providing a service or referring clients to other services not delivered through their agency. Agencies were to answer “don’t know” if they did not have knowledge of a particular question. Providers were asked to rate selected items to capture specific knowledge about (1) service availability including estimated wait times, (2) barriers to treatment, and 3) open ended questions regarding the strengths, challenges, and suggested solutions/strategies to address challenges.

Surveys were sent online to the chief administrator of mental health and/or substance abuse service providers funded in Region IV and identified by DMHAS. Surveys were completed by 34 agencies. Emailed reminders from NCRMHB and a follow up call from ERASE urged agencies to complete surveys.

Agencies were asked to identify the type of treatment services they provided (including DMHAS funded and non-funded programs). The majority (69%) of DMHAS funded service providers that completed surveys provided both mental health and substance abuse services. Of the remaining agencies, 22% provided substance abuse services only, and 9% provided mental health services only as shown below.

*Participants in Provider Survey*



**B. Referral Organization Survey**

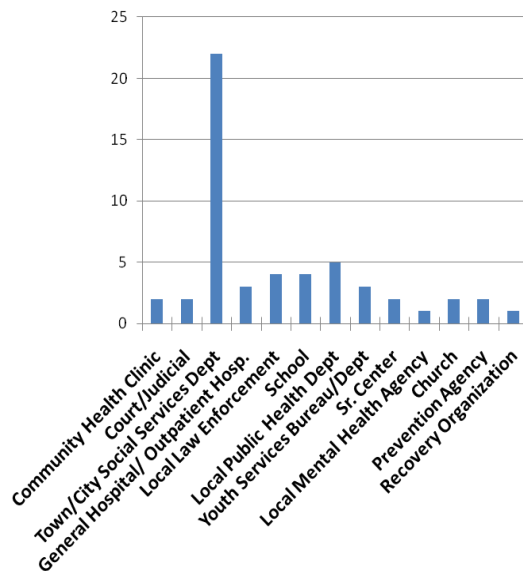
A questionnaire for referral organizations was designed to capture the perspective of municipal and nonprofit agencies that interact with the services that DMHAS either directly operates (e.g. CT Valley Hospital) or funds, such as community based nonprofit providers. Respondents were instructed to “answer only those questions that you or your staff have some first-hand knowledge of.”

As in the provider survey, respondents were asked to rate specified items, as well as respond to open ended questions.

Surveys were sent online to referral organizations and individuals in the community identified by the North Central Regional Mental Health Board and the three RACs. These organizations and individuals serve people in their community and see people who need the help of state mental health and addiction services, interact with and make referrals to DMHAS funded service providers, and observe how people were or were not helped.

Surveys were completed by 59 respondents. Respondents represented thirteen categories of referral sources. Town/city social services departments provided the largest number of responses (38.6 %), with local public health departments (8.8%), local law enforcement (7%), and schools providing the next highest number of responses. Thirteen categories of referral organization respondents were identified as shown in the graph below.

**Referral Organization Survey Responses**



Organizations were asked to identify their level of interaction with the mental health service and substance abuse system in your area “such as referring persons for treatment”. With regard to the mental health service system, over a third (35.1%) interacted either very often (14%) or often (21.1%). An additional 61.4% reported that they interacted occasionally; only 3.5 % reported not at all. With regard to their level of interaction with the substance abuse service system, over a fourth (26.8%) reported that they interacted very often (8.9 %) or often (17.9%). An additional 62.5% interacted occasionally and only 10.7% not at all.

**Brief Summary: Referral Organization Participation**

Referral organizations are an important constituent or “customer” in referrals to both DMHAS funded mental health and substance abuse service systems, as indicated by the level of interactions they reported with provider agencies. Interactions were more frequent with mental health providers than substance abuse providers. Over a third reported that they had interacted often or very often with the mental health system, and over a fourth had interacted often or very often with the substance abuse system. Only 3.5% reported that they never interacted at all with the mental health system and 10.7% never interacted with the substance abuse system. As shown later in the report, referral organizations

often provided extensive comments to open ended questions, showed concern and caring for people with mental illness and substance abuse, and thanked us for asking them to respond.

### C. Focus Groups

Six focus groups were held, one at each of NCRMHB's six Catchment Area Councils (CACs) which includes a membership of consumers, family members, community referral organizations, and providers. In addition to regular CAC members, providers were asked to attend and bring additional consumers and family members. There were a total of 80 participants – 34 consumers, 18 providers, 18 community referral organizations, and 10 family members.

Participants were given flip charts with the 24 categories of mental health and/or co-occurring substance abuse services listed by DMHAS in the provider survey questions regarding availability of services. On separate flip charts, consumers, family members, referral organizations, and providers placed colored dots on the three categories of services that they rated as the “most needed services to fill current gaps” in the mental health service system.

Discussion followed regarding differences among the responding groups, and current strengths, challenges, and recommendations (suggestions, strategies) to address challenges. Individual comments were written on flip charts as presented, and sorted into categories of response.

A later focus group was held with 8 mental health providers to help interpret what appeared to be divergent information gathered in the CAC focus groups and the provider survey.

### D. RAC Surveys: CT 2010 Readiness Survey and RAC Community Needs Assessment Workgroup

RACs also conducted surveys independently and reported their findings to DMHAS in a separate document.

## **Section II: Provider and Referral Organization Survey Results: Availability, Wait Times, Barriers, Challenges, Solutions/Strategies, Strengths Mental Health and Substance Abuse Service Systems**

### **1. Availability of Mental Health and Substance Abuse Services**

In both provider and referral organization surveys, respondents were asked to report on availability of mental health and substance abuse services, although with different reporting formats. Providers were asked to rate specified items, while referral organizations were asked to provide an overall rating of general availability.

#### A. Provider Survey Results

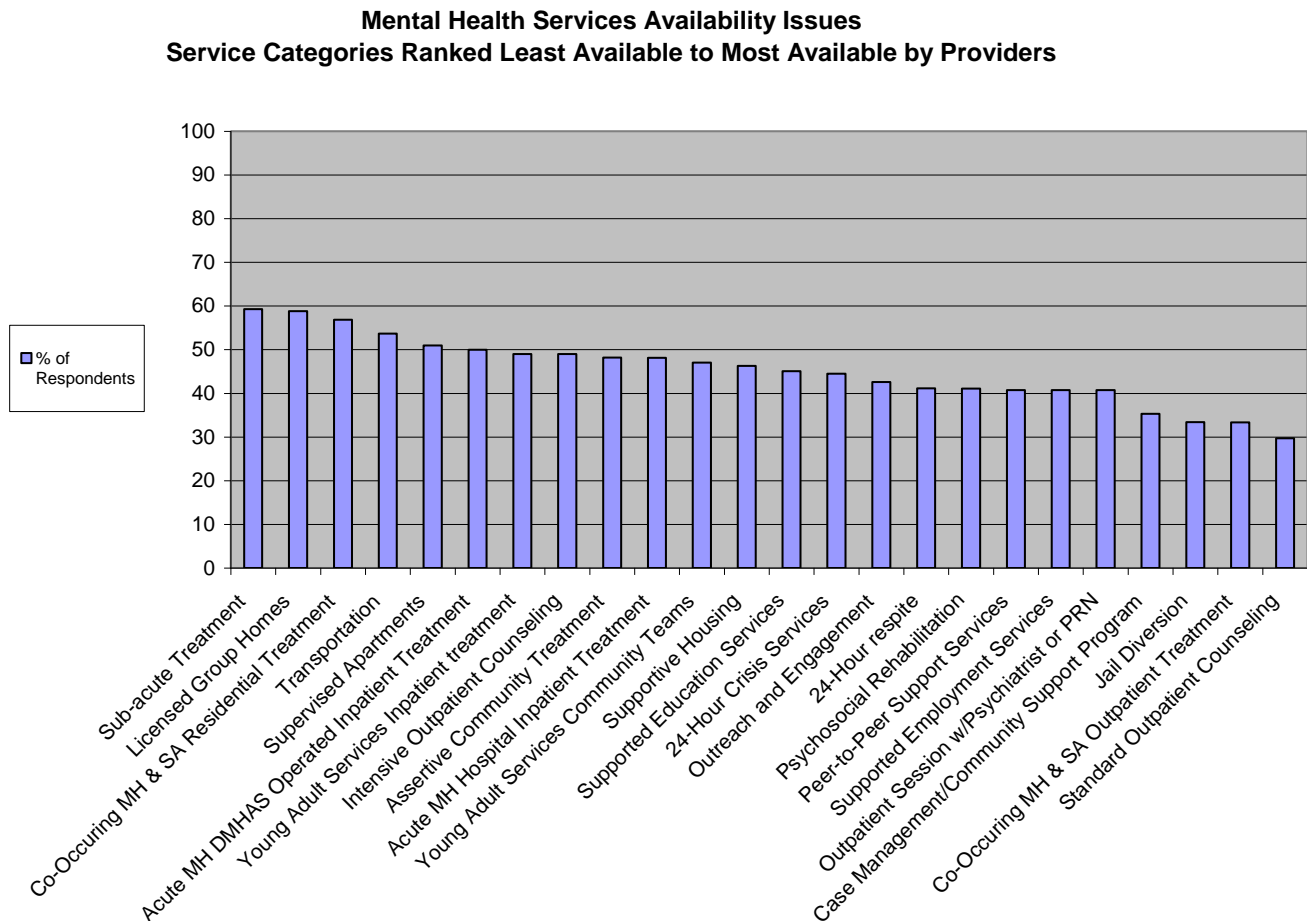
With regard to **availability of mental health services and substance abuse services**, providers were asked to rate services “by how available they are, based upon your experience with clients you serve directly within your agency and/or refer outside your agency.” There were 24 items selected by DMHAS for the mental health service system and 25 items for the substance abuse service system.

Providers were instructed to rate the services as “not”, “sometimes”, “often”, or “always” available and to answer “don’t know” if they were unfamiliar with the service.

In the graphs that follow regarding availability of mental health and substance abuse services, the ratings for each service category were combined using a weighting ranking system for ease of interpretation. “Not available” percentages were multiplied by 3, “sometimes” by 2, “often” by 1. The weighted percentages in each service category were added together and divided by 3 in order to produce a weighted percentage score. “Don’t know” ratings were not weighted and were not included in the calculations for weighted percentage scores. “Always available” ratings were not weighted and were not merged into the weighted percentage scores. It should be noted, however, that the services most often identified as “always available” were also the services identified as most available in the weighted percentage rankings.

### Availability of Mental Health Services

The graph below presents the relative rankings by DMHAS funded service providers regarding availability for 24 categories of mental health services:



It should be noted, however, that over 10% respondents indicated they were unfamiliar with 13 out of the 24 service categories listed, including jail diversion and young adult inpatient services (29%); assertive community treatment, 24-hour respite, young adult community services, and supported education services (22%); acute Mental Health DMHAS operated inpatient treatment, and outreach

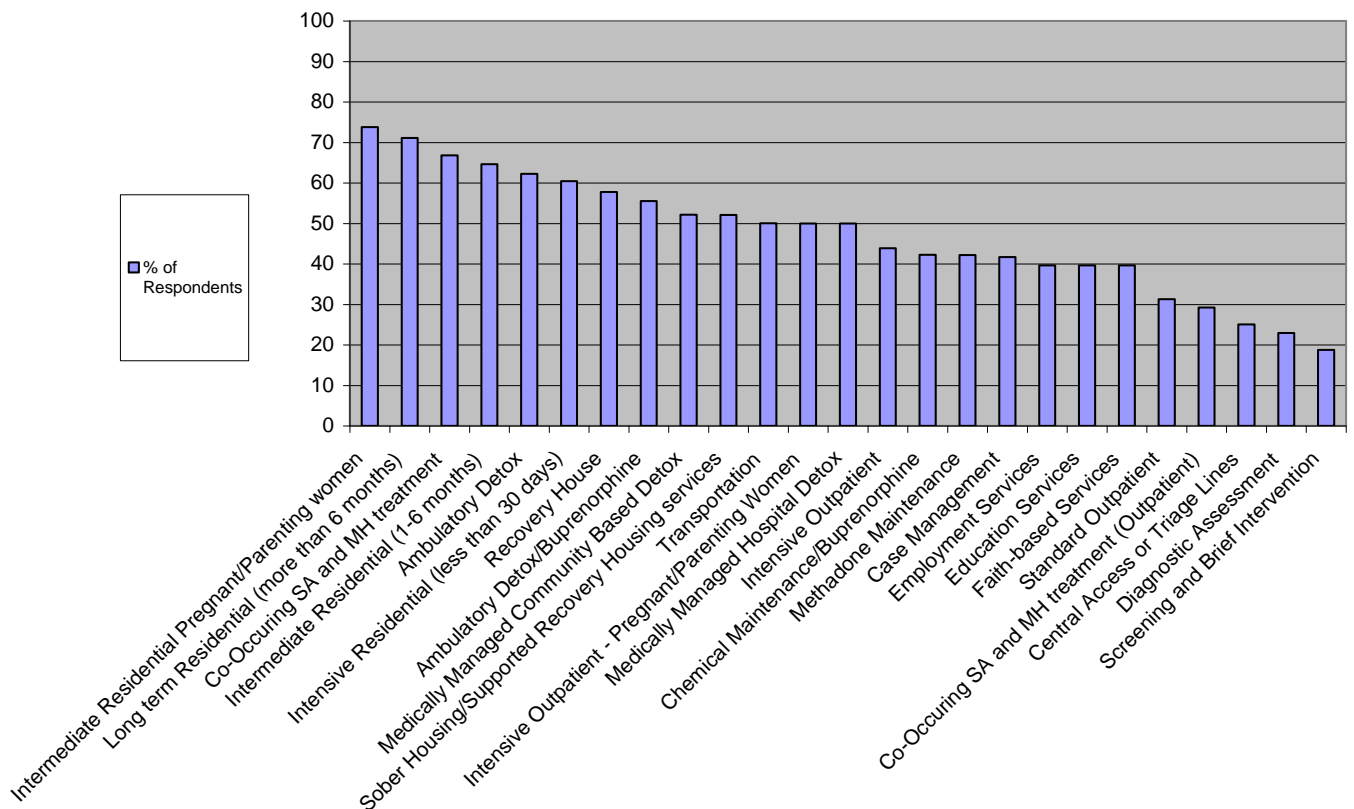
and engagement (17%); co-occurring MH & SA residential treatment, licensed group homes, and supervised apartments (12%); and supportive housing (11%).

With regard to the mental health service system, half or more of the DMHAS provider respondents identified the following six services as least available: Sub-acute treatment (59%), licensed group homes (59%), co-occurring mental health and substance abuse residential treatment (57%), transportation (54%), supervised apartments (51%), acute mental health DMHAS operated inpatient treatment (50%). Close behind were the following services: young adult services inpatient treatment (49%), intensive outpatient counseling (49%), assertive community treatment (48%), acute mental health hospital inpatient treatment (48%), young adult services community teams (47%), supportive housing (46%), supported education services (45%), 24-hour crisis services (45%).

### Availability of Substance Abuse Services

The graph below presents the relative rankings by DMHAS funded providers regarding availability of 25 categories of substance abuse services:

**Substance Abuse Services Availability Issues**  
**Service Categories Ranked Least Available to Most Available by Providers**



Providers were asked to rate 25 categories of substance abuse services based on their experience with clients served directly within their agency or referred outside their agency. It should be noted that over 10% respondents indicated they were unfamiliar with 14 out of the 25 service categories listed, including faith-based services (28%); employment and education services (22%); central access or triage lines, intensive outpatient services for parenting or pregnant women, case management, and transportation services (17%); ambulatory detox, ambulatory detox/buprenorphine, chemical

maintenance/buprenorphine, and recovery house services (12%); diagnostic assessment, screening and brief intervention, medically monitored community-based detox and sober housing services (11%).

With regard to the substance abuse system over two thirds of DMHAS provider respondents identified the following three services as least available: intermediate residential pregnant/parenting women (74%), long term residential (71%), co-occurring substance abuse and mental health treatment (67%). An additional ten services were identified by half or more of the respondents. These were intermediate residential (65%), ambulatory detox (62%), intensive residential (60%), recovery house (58%), ambulatory detox/buprenorphine (56%), medically managed community based detox (52%), sober housing/supported recovery housing (52%), transportation (50%), intensive outpatient for pregnant/parenting women (50%), and medically managed hospital detox (50%).

#### *Brief summary: Provider Reports on Availability of Services*

In ratings for both mental health and substance abuse services, the least available services tended to be the most intensive, restrictive, and focused on clients with a high level of need. Transportation was a notable exception in both mental health and substance abuse services. Transportation was much less available, however, in the mental health service system (rated the 4th least available service) than in the substance abuse service system (rated the 11<sup>th</sup> least available service).

A focus group was held with eight mental health providers to better understand the need for these intensive, restrictive services. The providers reported that they are seeing consumers who have very serious needs and cannot access intensive, supervised settings. Providers identified aging clients, for example, who have diabetes, have to go off clozaril, and can no longer get into a nursing home. They noted that there have been “life cycle changes” among the people they serve. Many more consumers are aging, people are dying 25 years younger than the general population, and some clients have dementia. In previous discussions, providers have also reported that they are serving more clients who are coming from the corrections system, and this factor also needs to be examined. There may be other groups of people whom providers feel need these high intensive services.

Providers reported that they are straining to serve consumers who cannot access these more intensive, restrictive settings. For example, since sub-acute treatment at Capitol Region Mental Health Center closed, other providers are serving these individuals in their regular community services without the benefit of increased staffing, a restrictive setting, etc. As Cedarcrest Hospital was reducing its number of patients, many providers were anticipating a need for higher levels of care in the community, but follow up can determine if the current new services in place are meeting their needs.

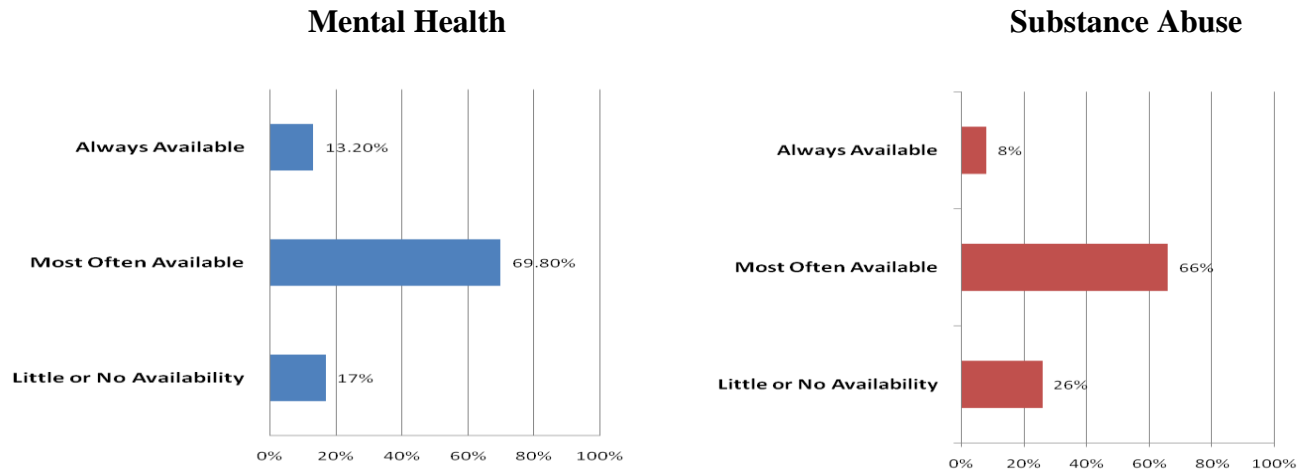
There was also a cautionary view that lack of availability for a service does not necessarily mean that you need more of it. There needs to be further investigation of the types and numbers of people who are considered in need of the intensive services identified in the survey as least available, whether there needs to be increased availability of some or all of the least available services, or whether alternative services can best meet their needs.

#### **B. Referral Organization Results**

Referral organizations were asked “When referring persons to mental health or substance abuse treatment in your area, how available are services?” Organizations were asked to rate whether services were always available, most often available, or little or no availability.

The graphs below present referral organization ratings of availability of mental health and substance abuse services in their area:

### Availability of Services Referral Organization Responses



With regard to availability of mental health services, 13.20 % of respondents rated services always available, 69.80 % most often available, and 17% little or no availability. With regard to substance abuse services, 8% respondents rated services always available, 66 % most often available, and 26 % little or no availability.

#### *Brief Summary: Referral Organization Reports on Service Availability*

With regard to **availability of services**, referral organization respondents reported that mental health services were more available than substance abuse services. Over one fourth (26%) of respondents reported little or no availability for substance abuse services, compared with 17% for mental health services. The majority of respondents, however, reported that both mental health and substance abuse services were most often available.

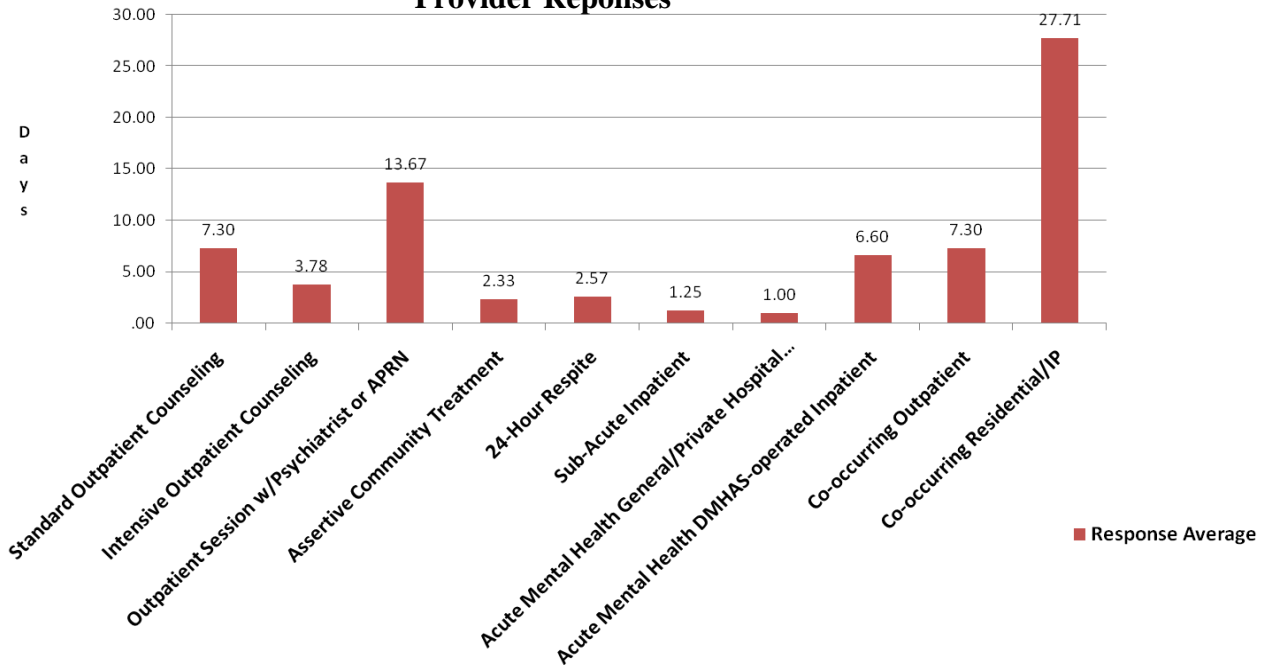
## 2. Wait Time for Mental Health and Substance Abuse Services

In addition to rating availability of services, DMHAS funded providers were asked to rate another set of specified items on length of wait times for services. Results were reported for average number of wait time in days.

### A. Provider Survey Results

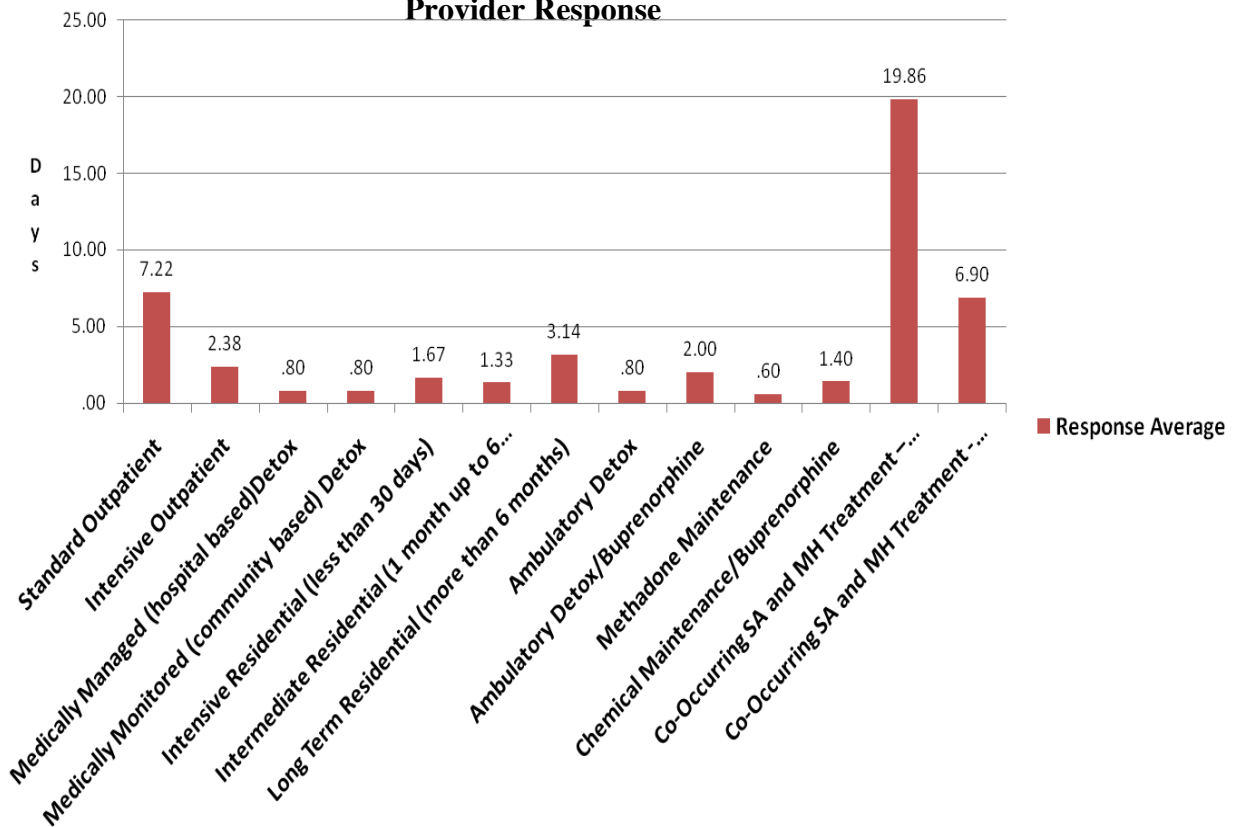
With regard to wait time for services, DMHAS providers were asked to rate services by thinking of those mental health or substance abuse “clinical services your agency provides, of those persons admitted within the most recent month, how long (on average, in days) of a wait was it for them to be admitted?” There were 11 items for mental health services and 13 items for substance abuse services. Average wait times identified by DMHAS funded providers are presented in the graphs that follow for mental health and substance abuse services:

### Mental Health Services Wait Time Provider Responses



With regard to **wait time for mental health services**, the service identified with the longest wait time was co-occurring residential/inpatient services with an average wait time of 27.71 days. The next largest wait time was for outpatient sessions with psychiatrist or APRN (13.67 days); followed by co-occurring outpatient counseling (7.30 days) and standard outpatient counseling (7.30 days), and acute mental health DMHAS-operated inpatient services (6.60 days). Intensive outpatient was next with 3.78 days.

### Substance Abuse Services Wait Time Provider Response



With regard to **wait time for substance abuse services**, the service identified with the longest wait time was co-occurring substance abuse and mental health residential treatment with an average wait time of 19.86 days. The next longest wait time was for co-occurring substance abuse and mental health outpatient treatment (6.90 days), followed by standard outpatient services (7.22 days), and long term residential- more than six months (3.14 days). Intensive outpatient was next with 2.38 days.

#### *Brief Summary: Provider Reports on Wait Times for Services*

When rating **wait times for services** in both the mental health and substance abuse service systems, there was **agreement among providers that the longest wait times were for co-occurring residential and outpatient services** (an average of 27.71 days for residential/inpatient in the mental health service system ratings; 19.86 days for residential treatment and 6.90 days for co-occurring outpatient treatment in the substance abuse service system ratings).

There was also agreement in both the mental health and substance abuse service systems that the **second longest wait times were for outpatient treatment** (for mental health service system ratings were wait times of 13.67 days for outpatient sessions with psychiatrist or APRN and for substance abuse service system ratings wait times were 7.22 days for standard outpatient services).

The third longest wait times in the mental health service system were for **acute mental health DMHAS-operated inpatient services** (6.60 days) and in the substance abuse service system were for **long term residential- more than six months** (3.14 days). **Intensive outpatient** was fourth with 3.78 days for the mental health service system and 2.38 days for the substance abuse service system.

### **3. Barriers to Mental Health and Substance Abuse Care**

DMHAS funded providers and referral organizations were both asked to report whether specified items were barriers. Providers were asked to rate more items than referral organizations, although all of the items included for the referral organizations were also included for providers.

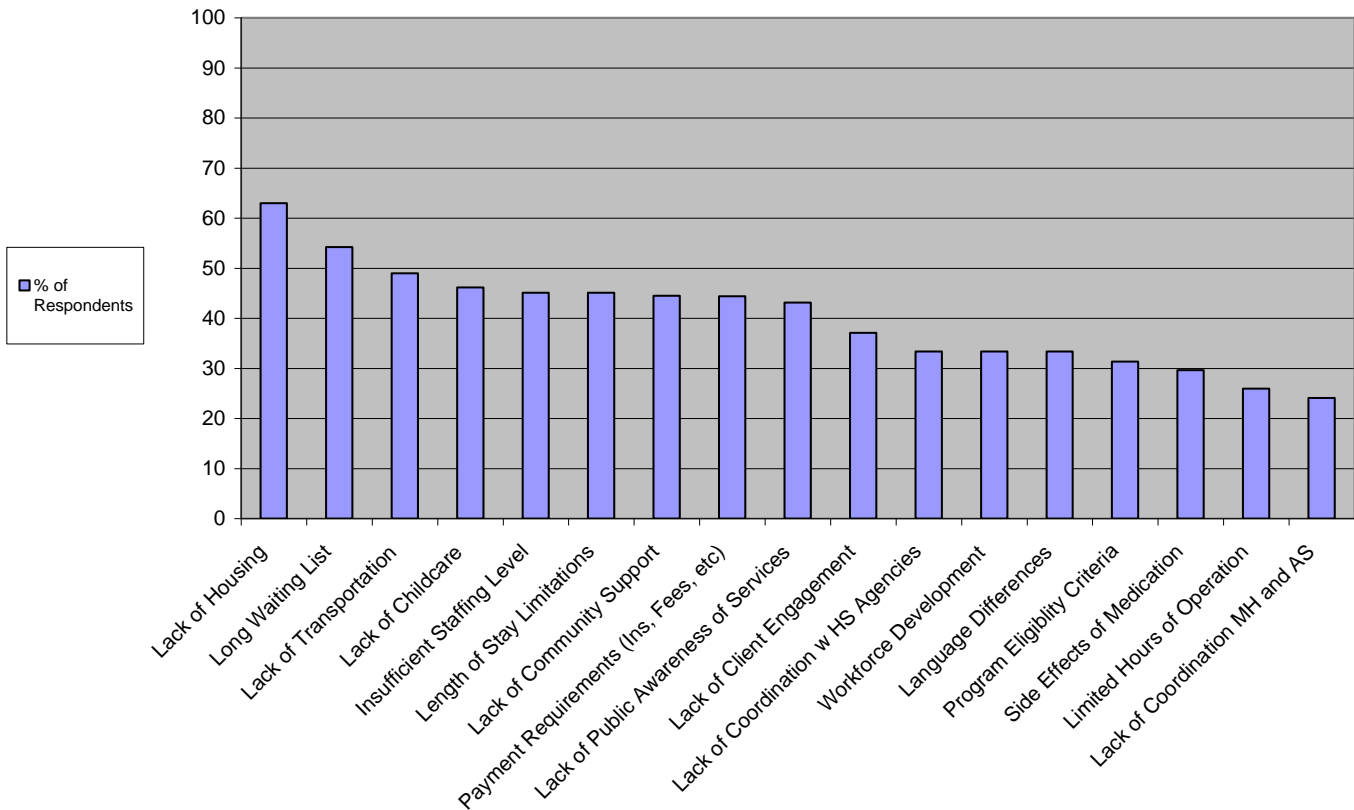
#### A. Provider Survey Results

Providers were asked to think of those things which hinder people from getting or continuing mental health and substance abuse services and rate how often the items were a barrier to care. Providers were asked to rate the 17 items which appear on the chart below as “not”, “sometimes”, “often”, or “always” a barrier to care. They were instructed to answer “don’t know” if they were unfamiliar with the service. A weighted ranking system as described on page 5 was used for ease of interpretation.

#### **Barriers to Mental Health Services:**

Relative rankings by DMHAS funded providers for mental health services are presented in the graph that follows:

**Barriers to Mental Health Services  
Issues Ranked Greatest Barriers to Least Barriers by Providers**



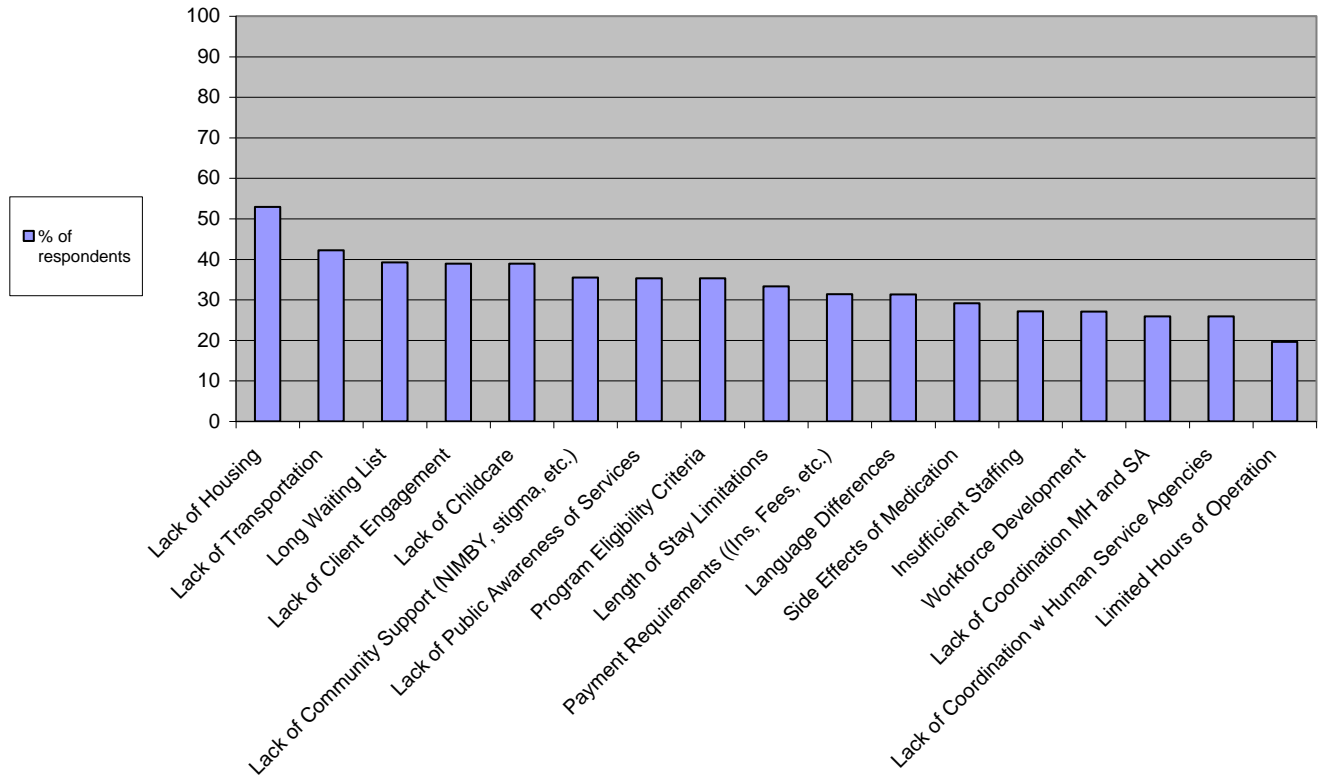
It should be noted that over 10% of respondents indicated they were unfamiliar with 4 out of the 17 barrier issues listed, including payment requirements (17%); lack of childcare (13%); long waiting list (11%).

With regard to the mental health system, over half of the respondents identified two items as barriers – lack of housing (63%) and long waiting list (54%). Close behind were the following services: lack of transportation (49%), lack of childcare (46%), insufficient staffing level (45%), length of stay limitation (45%), lack of community support (45%), payment requirements (44%), and lack of public awareness of services (43%).

**Barriers to Substance Abuse Services:**

Relative rankings by DMHAS funded providers regarding barriers to substance abuse services are presented in the graph that follows:

**Barriers to Substance Abuse Services  
Issues Ranked Greatest Barriers to Least Barriers by Providers**



It should be noted that over 10% of respondents indicated they were unfamiliar with 7 out of the 17 barrier issues listed, including lack of childcare (28%); language differences (13%) lack of transportation (12%); lack of community support, side effects of medication, insufficient staffing, and lack of coordination between substance abuse and mental health services (11%).

With regard to the substance abuse system, the only barrier identified by over half the respondents was lack of housing (53%). Over one third of the respondents identified the following as common barriers: lack of transportation (42%), long waiting list( 40%), lack of client engagement (39%), lack of childcare (39%,) lack of community support (36%), lack of public awareness of services (35%), program eligibility criteria (35%), and length of stay limitations (33%).

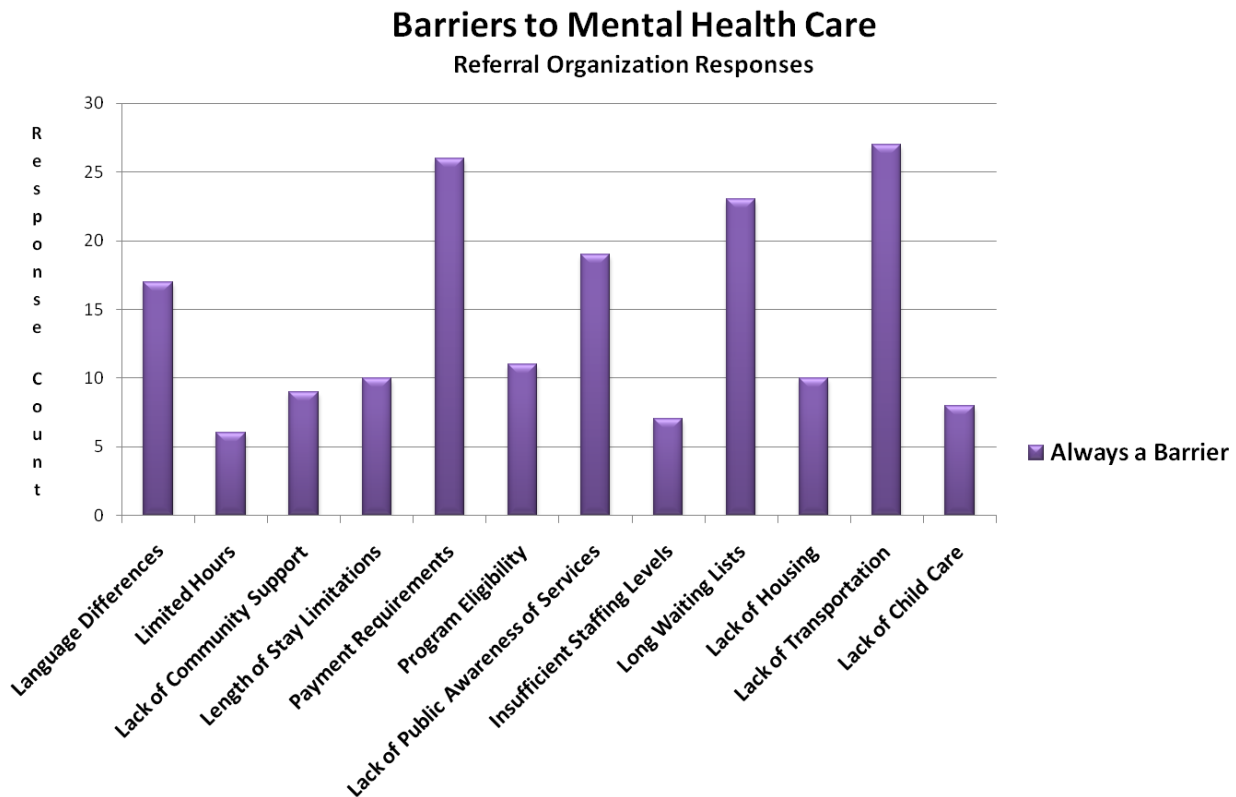
**Brief Summary: Provider Report on Barriers**

For both mental health and substance abuse systems the same three items were ranked as the top three barriers - lack of housing, long waiting list, and lack of transportation. Half of the providers identified all three items for the mental health service system and lack of housing for the substance abuse system. It should be noted that long waiting lists and lack of transportation were also rated by referral sources as top barriers.

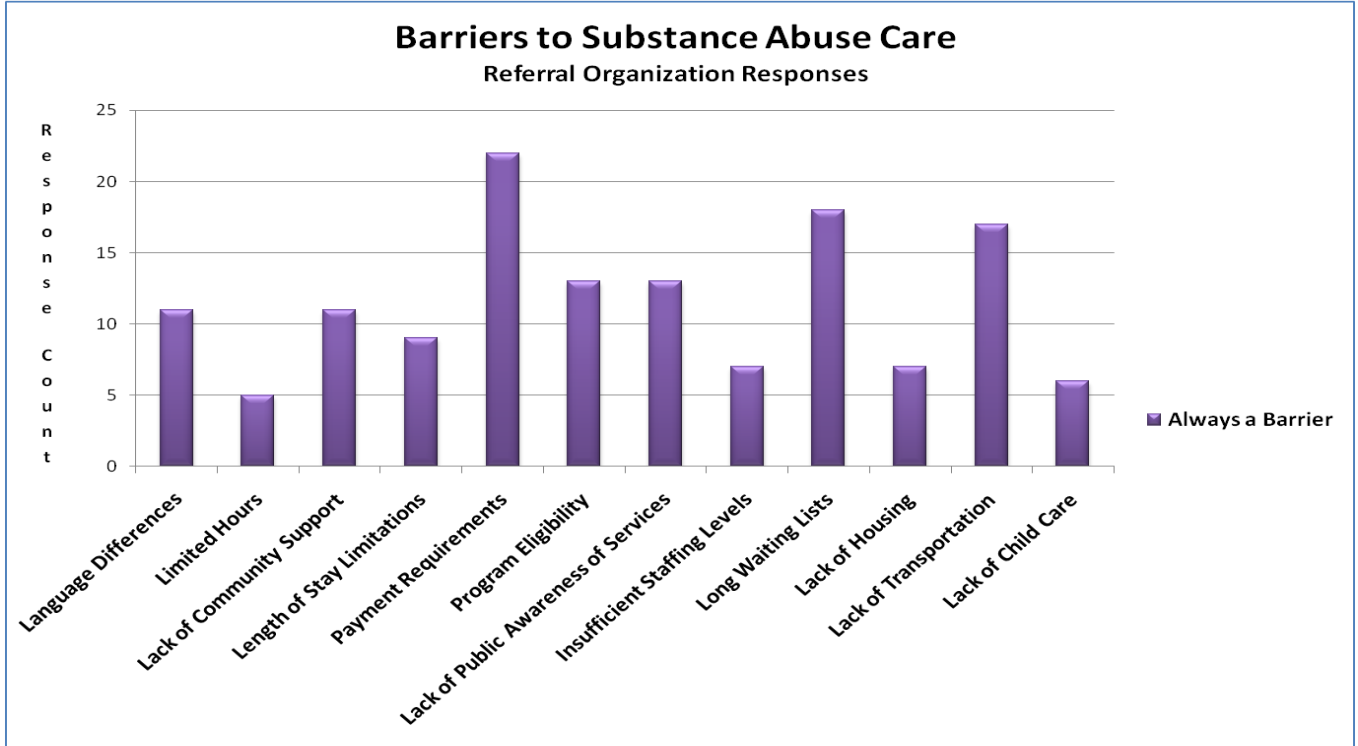
Lack of childcare was also cited as a significant barrier in both mental health and substance abuse systems. For both systems lack of coordination between mental health and substance abuse providers and limited hours of operation were listed as minor barrier issues.

**B. Referral Organization Results**

The survey asked referral organization respondents to indicate whether 12 different items were barriers. Respondents were directed to think of those things which may hinder people from getting or continuing mental health or substance abuse services indicate “which of the following in your experience pose a barrier to getting services”. The items replicated 12 of the items that appeared on the list for providers. The graphs below show items that were rated by referral organization respondents as always a barrier with regards to mental health care and substance abuse care:



With regard to the mental health service system, over half of the respondents identified three items as always a barrier - lack of transportation (60%), payment requirements, i.e. insurance, fees (57.8%), and long waiting list (51%). Over a third a respondents identified two additional items- lack of public awareness of services (42.2%) and language differences (37.8%). Fewer than 20% of respondents identified lack of child care (17.8%), insufficient staffing level (15.6%), and limited hours of operation (13.3%).



With regard to the substance abuse service system, over half of respondents identified payment requirements, i.e. insurance, fees (57.9%). The next most identified items by over a third of respondents were long waiting list (47.4%), lack of transportation (44.7%), program eligibility requirements (34.2%), and lack of public awareness of services (34.2 %). Fewer than 20% identified the lack of housing (18.4%), insufficient staffing levels (18.4%), lack of child care (15.8%), and limited hours of operation (13.2%).

*Brief Summary: Referral Organization Report on Barriers*

For both mental health and substance abuse service systems, respondents identified the same three items as the top three barriers – lack of transportation, payment requirements, and long waiting list. Over half of respondents identified each of the three items for mental health service system, and over half of respondents identified payment requirements in the substance abuse system. Similarly, respondents identified the same three items among the least barriers – insufficient staffing levels, lack of child care, and limited hours of operation.

Lack of public awareness of services was the fourth most often cited barrier in both systems. In a later section in the report referral organizations gave many examples of lack of public awareness and how working with referral organizations could help increase awareness.

Similar to ratings on other categories, referral organizations reported that transportation was “always a barrier” more often in the mental health system than in the substance abuse system.

#### 4. Challenges and Solutions/Strategies regarding Mental Health and Substance Abuse Service Systems

Providers and referral organizations responded in their own words to open ended questions about challenges and solutions/strategies to address challenges in both the mental health and substance abuse systems. Although some attempts were made to group them into meaningful categories for presentation and discussion, individual responses gathered in open ended questions are listed to give a fuller picture of what respondents said, rather than simply summarizing in graphs.

Some items are important for how many times they were cited, and this will be noted in parenthesis. Other items are important for their sheer impact in being highly descriptive, new information, or because of the seriousness of the concern.

Challenges and solutions/strategies as presented, however, often merged into each other. Often strategies did not present a clear plan of action, but rather were very general statements or simply restatements of the challenge, such as offering “create more housing” as a strategy to the challenge of “not enough housing.”

##### A. Provider Survey Results

DMHAS funded providers were asked in separate open ended questions to think of the current mental health or addiction services systems and indicate its three most important challenges. Providers were then asked to suggest solutions or strategies to the challenges they had identified.

Challenges are listed below with the open circle symbol and strategies with the arrow symbol. Since it appeared that responses fell under the same general categories for mental health and substance abuse systems, responses for both systems are listed under four general categories of challenges (lack of available services, inadequate funding, need for system planning, and workforce shortages) and two general categories for solutions/strategies (funding and system planning).

**Challenges identified by DMHAS providers** in the mental health and substance abuse systems (Because providers were limited to three responses, the number of times similar responses were received is noted below in parentheses along with the content of responses for both mental health and substance abuse services):

- **Lack of Available Services:**
  - **Mental health service system challenges** (13 responses) included general comments about timeliness for appropriate interventions and placements and long wait times, as well as comments about specific services – a year or more wait for **case management**, wait list for **supportive services**, lack of **housing**, unavailable **inpatient beds**, and need for more **transportation**, mental health **facilities**, and wait list for **residential services** which are already at capacity and may be affected by **downsizing of state hospitals**;
  - **Substance abuse service system challenges** (10 responses) included comments about lack of bed availability ( **inpatient beds** in general **and long term inpatient beds**, beds in the **men’s center**, and **beds for women**); lack of **stable housing**, especially for those completing programs; and lack of **employment** for those completing programs.
- **Inadequate Funding:**
  - **Mental health service system challenges** (11 responses) included comments about flat or decreasing funding, increasing numbers of uninsured clients due to lack of jobs

- or resident status, volume of demand outstrips capacity of resources to provide adequate care, grant funding dropping off, resources shrinking due to budget cuts and retirements, responding to unfunded mandates and aging IT and physical plants;
- **Substance abuse service system challenges** (8 responses) included comments about lack of funding, unfunded mandates, limited dollars, eroding payer base, high volume of service demands, and increased costs to maintain credentialed and qualified staff.
- **Need for System Planning:**
  - **Mental health service system challenges** (10 responses) included comments regarding need for clear vision and strategic plan communicated to everyone, coordination across continuum of care, inconsistent guidelines for DMHAS services by LMHA staff, aging population not adequately planned for, people falling through cracks, shifting burdens to acute care hospitals, treatment too short term, and need to be proactive and need to engage people in recovery more deeply in making change;
  - **Substance abuse service system challenges** (5 responses) included comments regarding lack of treatment strategies for cocaine/crack addicted clients, requirement to be high or drunk to get in some programs, time limitations for programs, continued development of services for co-occurring clients especially those with mental illness, and inpatient treatment eligibility barriers for clients with serious medical conditions.
- **Workforce Shortages:**
  - **Mental health service system challenges** (6 responses) included comments regarding general shortage of adequate staff in down economy and specifically people with expertise in medical conditions, bilingual staff, and Spanish speaking clinicians;
  - **Substance abuse service system challenges** (4 responses) included comments about reluctance to work with mental health issues due to lack of training, lack of medical expertise to treat addictions, and lack of solid training resources for staff development in certain elements of addiction/substances.

**Strategies Identified by DMHAS providers** (This section presents statements that seem to provide a direction, pathway, or guidance that is more descriptive than simply a restatement of the challenge, i.e., suggesting “more housing” if the challenge was “lack of housing”. Refer to the bolded items listed among the challenges in the section above for specific service areas that were identified as needing to be addressed, but without specific strategies suggested):

- **Funding:**
  - Mental health service system strategies**
    - Find ways to better share resources
    - Community wide dissemination and system wide awareness of available resources
    - Move more to privately operated organizations
    - Consolidate all funding streams into single payer system
    - Greater flexibility in managing DMHAS dollars versus “sid code by sid code”
    - Prioritize funding
    - More federal funding
    - Loan forgiveness, training incentives, waive fees
    - Eliminate regulatory obstacles
  - Substance abuse service system strategies**
    - Contact legislators to advocate for more dollars
    - Single payer
    - Loan forgiveness, waive fees, training incentives
    - Eliminate regulatory obstacles
    - Elimination of redundant data requirements from State data systems

- **System Planning:**

- Mental health service system strategies**

- Use provider forums to communicate the plan for next three years
    - Coordinate efforts to match system awareness of available resources and community awareness of available resources to help people find and stay connected to help
    - Review policies and update based on LMHA and provider input
    - Cross provider training/round tables with persons in recovery to identify best practical strategies for inclusion of person centered planning in a meaningful way
    - Clarify agency referral processes and responsibilities
    - Accepting best practices models
    - More job training and placement
    - Plan, plan, plan
    - Intensive therapy available as needed or desired

- Substance abuse service system strategies**

- Continued advocacy at systems level, “street level”, and consumer level
    - Training addicts in recovery for employment
    - Continued training and education
    - Work with providers to design strategies to improve treatment
    - Clarify wait times and beds
    - Require DMHAS funded inpatient treatment settings to have protocols to include clients with serious medical conditions
    - Identify and support development and greater availability for cocaine/crack addiction treatment
    - Create more longer term treatment beds
    - Medications for outpatient detox and maintenance

*Brief summary: Provider Reports on Challenges and Solutions/Strategies*

Categories of response regarding challenges in both mental health and substance abuse service systems followed the same pattern. Although more responses were listed in regard to the mental health service system, for both service systems the greatest number of responses concerned lack of available services (23 responses), followed by inadequate funding (19 responses), need for system planning (15 responses), and workforce shortages (10 responses).

A similar pattern continued with regard to strategies to address the challenges. The two main areas of response for both mental health and substance abuse system concerned funding and system planning/development. With regard to mental health services, almost half of the responses from providers focused on suggestions to address funding, indicating that providers are intensely concerned about mental health funding and possible strategies that might make a difference. In comparison, less than a third of the suggestions for substance abuse services focused on funding.

Providers offered a number of strategies to address funding. Some of the strategies focused on ways to maintain and better manage services without increased funding, such as, ways to better share resources, community wide dissemination and system wide awareness of available resources, and greater flexibility in managing DMHAS dollars versus “sid code by sid code”. Other strategies included ways to find additional funding and/or eliminate requirements or complicated systems so that agency resources could be used for more direct services. Strategies included more federal funding, loan forgiveness, move more to privately operated services, consolidate all funding streams into single payer system, and eliminate regulatory requirements and redundant data requirements from State data systems).

Other strategies pertained to system planning and development. Providers offered suggestions, for example, to provide information to referral organizations, as well as the general community, regarding available resources to help people find and stay connected with available services; review and update policies based on provider input; and conduct cross provider training/round tables with persons in recovery to identify best practical strategies for inclusion of person-centered planning in a meaningful way. Providers also suggested specific services to improve services, such as longer term treatment beds, more care for crack-cocaine addicts, and inclusion of clients with serious medical conditions.

## B. Referral Organization Results

Referral organizations were asked to respond in open ended questions about the challenges for both the mental health service system and substance abuse treatment service system in their area. They were also asked to give their suggestions for improving the current mental health and substance abuse treatment service systems in their area. Respondents were not limited to indicating the top three challenges as were providers. Many respondents gave numerous responses, and numbers of similarly repeated responses are presented only where noteworthy.

Referral organization responses are presented below separately for mental health and substance abuse systems, with challenges represented by the open circle symbol and strategies by the arrow symbol.

### **Challenges and Solutions/Strategies Identified by Referral Organizations in the Mental Health System:**

- **Transportation/Accessibility**
  - Ability to quickly offer an intake evaluation & actually engage clients in treatment
  - Availability of referral to be seen immediately
  - Lack of public transportation is biggest challenge, transportation to treatment and inpatient services
  - Long wait lists, and limited services
- **Service Availability and Concerns**
  - Not adequate outpatient services
  - Hours and personnel available during evening, overnight, and weekends
  - Lack of time and resources to conduct prevention work
  - Lack of psychiatrist to refer to
  - Denials, premature discharge,
  - Admission criteria restrictive for inpatient services
  - Not enough follow up after inpatient stays and patients go in and out of the hospital
  - Difficult to refer people who don't speak English
  - Not always responding to the underlying need of the individual
  - Too much time wasted not getting long term care
  - No daycare, children are taken to sessions for lack of day care
- **Staffing**
  - Too few staff, understaffed, unstable staffing
  - Maintaining adequate staff volume to meet demands
  - High turnover in therapists at many local agencies
  - Need improvement of staff abilities
- **Insurance/cost**
  - Insurance limits length of stay and sometimes more time is needed
  - Funding always a challenge

- Lack of financial resources to develop services
- Low reimbursement
- Often when payment is on sliding scale the amount is at times too much for the individual to pay
- Will not take certain insurances
- Lack of availability for those who have no private insurance
- **Housing**
  - Homelessness due to strict public housing policies (criminal and credit background checks)
  - Not enough group homes or long term places for those whom aren't able to live independently
  - Too few to no groups homes or other supportive living situations, no place to "revolving door" hospital patients as they have no place that would improve the possibility of functioning successfully in the community
  - Number of beds/waiting lists
  - Supportive housing very inadequate
- **Public Awareness and Communication**
  - Describing the system, who is involved, how, what is provided, local connectivity
  - One challenge is making the community aware of all of the services they can take advantage of, if they so choose
  - Lack of outreach, welcome, mistrust of outsiders impacts access to treatment
  - Persons get stuck at times when counselors refuse to share information or are unwilling to cross boundaries
  - Language barriers
  - Cultural differences between more rural area and city based agencies
- **Raise Community Awareness and Outreach**
  - More outreach to community re all of the services available to them
  - More awareness of services at each agency
  - Provide resource lists of providers offering sliding scale payment and Title 19 coverage
  - Providers need to be linked more closely with the individual community so that local services can refer more easily and residents are more aware of services
  - The further removed agencies are from the community, the less I see adults accessing them
  - Make services predictable and better known availability to the public
  - Continue to remove the stigma of mental illness- we can do this!
  - Provide follow up for folks discharged from the local psych units
  - Address the housing crisis
- **Increase Treatment and Support Services**
  - Assist clients with following up on medical and basic need applications (which will aid in treatment engagement/overall compliance)
  - If insurance limits length of stay then more outpatient services are needed at a reasonable cost
  - More group treatment would be less expensive, but don't cancel group when small
  - Don't be afraid of getting young folks into genuinely helpful treatment quickly, have watched a family struggle as the system passed around a child never committing to long term help that was needed
  - Increased hours and staffing to lessen waiting lists
  - Better/faster screening so that referrals can be seen sooner
  - Keep young offenders out of jail and get them into psychological treatment

- Mental health clinics which would serve those who are underinsured
- Need more ways to transition teens into some of those routine adult services, the relationships established with youth supports don't seem to have an adult counterpart
- While I understand the need for privacy, there are situations where individuals have been denied the fullest possible level of help and treatment because of overcautious reactions to privacy issues.
- Offer bi-lingual groups
- The isolation for gay people can be acute
- Offer childcare to increase coming to treatment
- Set up regional supportive housing that truly provides supervision, job training, and supports people into recovery and beyond
- I would love to see more improved services for folks with mental health issues...the isolation they experiences reduces their quality of life
- **Transportation**
  - Advocate for public bus to run from Rt 6 in Bristol through Plymouth to Rt 8. This would allow for para transit for those unable to use public transportation
  - Mental health agencies to provide transportation or help support it financially
- **Staffing**
  - Continue to promote mental health professional development and training to stay abreast of new treatment methods
  - Increase drug and alcohol counselors

### **Challenges and Solutions/Strategies Identified by Referral Organizations in the Substance Abuse System:**

- **Lack of bed availability (8)**
  - Not enough in facility beds/programs-getting people inpatient treatment is a real challenge
  - Length of stay limitations for high utilizers
  - More long term inpatient treatment needed
  - It is extremely difficult to access in-patient services unless at a very critical level
- **Co-occurring Services**
  - Hard with those with both substance abuse and mental health problems, a common issue
  - Not all substance abuse programs treat /address the mental health component equally
  - There are many mental health providers, for adults in particular, who will not treat the mental health problems if addiction is active, and yet the addiction services do not fully address the mental health needs
  - More integrated programs of community based treatment are needed
  - The split between mental health and substance abuse systems is still not working together enough
- **Other Service Concerns**
  - No continuum of care, range of services need to be broader
  - Lack of tox screens
  - Significant prescription drug and heroin problem
  - There are no services for elementary aged children from families with addiction just teens who are already using.
  - There are no parenting services specifically for these issues with their children, there appears to be a limited number of experienced therapists, many are young, parents like to speak with therapists with parenting experience

- Housing for people who don't have a clean background check
- Sad overwhelming need that stresses the system, the difficulty of such a large portion of the population needing services making meeting the need difficult
- **Transportation (4)**
  - Transportation in general
  - Transportation can be a major issue for many seeking services
  - Transportation to/from aftercare
- **Insurance/cost**
  - Insurance reimbursement, especially for adolescents
  - Speedier processing of benefits
- **Public Awareness and Communication**
  - Stigma in general, and stigma of needing help (4)
  - Making the community aware
  - Making the community aware of all the services they can take advantage of
  - Linking discharge planning with community resources
- **Raise Community Awareness and Outreach**
  - Outreach and referral systems, put a face on them and get them out there
  - More outreach to the community, be more visible so people know what is available to them
  - Services can become more community based ie a satellite office
  - School based referrals and services
  - Better outreach through local media and Community Access TV
- **Increase Treatment and Support Services**
  - More mobile response teams, or accepting more cases
  - Regular toxicology screenings to assist clients in engaging in treatment
  - Seamless coordination
  - The range of options for services needs to be broader
  - Increase inpatient services
  - Longer lengths of stay
  - Medication management
  - Housing options
  - Create funding for child care
  - Saga clients should be able to access taxi transport for outpatient services with a therapist or drug alcohol counselor
  - Speedier processing of benefits
  - Great need for adult protective services in this state, not just Elderly Protective Services
  - Enhance prevention efforts- give more teeth and resources to SAACs to expand their wonderful work
- **Co-occurring treatment**
  - Adolescent addictions treatment services are desperately needed in this community, particularly community based treatment that included both mental health and substance abuse treatment
  - Continue with longer mental health treatments when the addiction is under control
  - More integrated programs of community based treatment are needed
- **Transportation**
  - Transportation incentives
  - Treatment providers need to be on public transportation lines
  - Create funding for transportation

*Brief summary: Referral Organization Reports on Challenges and Strategies*

Referral organizations listed a longer and wider array of challenges. This might be in part because they were not limited in the survey to the top three challenges as were providers. The following summary, while trying to paint a picture of what emerged in open ended questions, was dependent on individual responses and may not represent a consensus in the community. Their concerns are, nevertheless, treated with respect and are accepted as evidence of issues that need to be further investigated.

Several familiar challenges were listed. Transportation appeared on the list of challenges in both the mental health and substance abuse systems. Housing was especially a challenge in the mental health system (including group homes or other long term places for people who aren't able to live independently, as well as supportive housing), and in the substance abuse system especially lacking for people who do not have a clean background check.

In addition to numerous specific service issues, they cited insurance and other costs in the mental health system (insurance limits lengths of stay, low reimbursement, and even sliding scales are too much for some people to pay) and in the substance abuse system ( need speedier processing of reimbursements and insurance reimbursement especially for adolescents).

Most notable in both systems was their recognition of public awareness and communication as a major challenge. This is an area where referral organizations uniquely saw a need in the mental health system for making the community aware of all of the services they can take advantage of, including describing the system, who is involved, what is provided, and the local "connectivity". In the substance abuse system they again saw the need to make the community aware of all of the services they can take advantage of and linking discharge planning to community resources.

With regard to strategies in the mental health system, they further identified raising community awareness and outreach as a major concern. They wanted to see more outreach to the community regarding all of the services available to them, more awareness of services at each agency, and to make services "predictable" to the public. With regard to substance abuse services they wanted better outreach and referral systems including school based referrals, more visibility so people know what is available including through media and Community Access TV, and services more community based, for example, through satellite offices.

Many of their comments indicated that they want the community to know about DMHAS funded services, as well as all of the other services available. In previous discussions with town social services providers, for example, we have learned that they have a commitment to their citizens just by virtue of being a resident in their town. Thus, they are eager to have access to all available resources.

Referral organizations saw themselves as playing a critical role in helping their citizens. They want state funded providers to be linked more closely with the individual community so that local service can refer more easily. One referral source noted that the further removed agencies are from the community, the less I see adults accessing them.

Their desire to be a part of the solution was evidenced in a concern to remove the stigma of mental illness; one respondent stated "we can do this!" Stigma was cited even more often in the substance abuse system, especially the stigma of needing help.

Also with regard to the substance abuse system, lack of bed availability and co-occurring services were repeated themes. There were 8 responses regarding lack of bed availability (not enough availability in facility beds, long term stays especially for high utilizers, and the challenge of getting people into in-patient treatment at all unless at a very critical level).

With regard to co-occurring services, there was recognition that this was a common problem in some areas, and that there was still “a split” between mental health and abuse systems and a need for greater integrated programs in some communities. Respondents reported that there are many providers who do not treat the mental health problems if addiction is “alive” and that many addiction services do not fully address the mental health component equally. In contrast, however, in rating barriers to services on pages 11 and 12 DMHAS providers identified lack of coordination between mental health and substance abuse systems as one of the least frequent barriers for both mental health and addictions service systems.

One respondent underscored the importance of how one problem in the community can precipitate other problems. The respondent described a cascade of challenges that started with long wait lists that ultimately affected the ability of referral organizations to communicate with providers - “Clients wait too long to get evals and then even longer to get into treatment. Treatment providers are required (by funding sources) to keep group sizes down which causes wait lists. When this happens clients from other funding sources (CSSD) suffer because they are placed on waiting lists. Because of the lengthy waiting lists the communications between referral source and treatment providers is compromised”.

## 5. Strengths

### A. Provider Survey Results

DMHAS funded providers were asked to think of the current service system and identify its three most important strengths. Responses are listed below for the mental health and addictions service systems under three general categories (positive characteristics of DMHAS management and leadership, array of services, and specific service achievements):

#### **Strengths Identified by DMHAS Providers for the Mental Health Service System:**

- **Positive Characteristics of DMHAS Management and Leadership**
  - Experience in creative service system design and delivery
  - Evolution of care systems into the LMHA
  - Prioritization of the most needy clients, e.g. uninsured, undocumented, clinical services available no matter their finances
  - Integration of mental health and primary healthcare
  - DMHAS and community providers values are congruent
  - Great partnership with DMHAS at OOC
  - Great Commissioner- good leadership
  - Efficiency in PNPs (half the cost of state operated services)
  - In PNP’s innovative, not business as usual
  - Services tailored to individual needs
  - Proactive elements of system
  - Outcome focused
  - Recent increase in staff training resources
  - Move to utilization management
  - Many staff who care

- Consumer influence re models and standards of care
- Use of evidence based practices, e.g., DBT, IDDT
- DMHAS willingness to discuss variety of options for care
- **Array of Services**
  - Great community care options as compared with other states
  - Continuum of care
  - Spectrum of services
  - Variety of resources, settings, levels of care
  - Community providers network
  - Locations at various sites throughout city
- **Specific Service Achievements**
  - Recovery focused and oriented services (3 comments)
  - Within 30 days clients see therapists
  - Wrap-around services, state agencies have capacity for wrap-around services (2 comments)
  - Co-occurring services
  - Case management
  - Evidence based practices
  - Supported pharmacological care, availability of medication (2 comments)
  - Availability and access to services (2 comments)

#### **Strengths Identified by DMHAS Providers for the Substance Abuse Service System:**

- **Positive Characteristics of DMHAS Management and Leadership**
  - Recovery oriented system
  - Integrated model, mental health and substance abuse as one (2 comments)
  - Dedicated, caring, and credentialed personnel
  - Well established providers throughout state
  - Utilizing outside services, such as outpatient facilities, DSS
  - Cultural competent staffing
  - Services not stigmatized as are mental health services, greater community acceptance
  - Proactive elements of system to seek out and provide opportunities and services
  - Stage based treatment
  - Quality
  - Superior clinical training
  - Ability to build on natural supports such as NA, AA, etc.
- **Array of Services**
  - Continuum of care
  - Good range and variety of services, e.g., transportation, case management (2 comments)
  - Increased levels of care, e.g., recovery houses, sober houses
- **Specific Service Achievements**
  - Co-occurring services, including screening and increased understanding of co-occurring needs (4 comments)
  - Improved access (2 comments)
  - Availability of beds in women's center
  - Quality case management
  - Evidence based practices
  - Services available in Spanish
  - Detox almost always available when needed
  - Outpatient services often available and minimal waits (2 comments)

*Brief Summary: Provider Reports on Strengths*

The strengths identified for the mental health and substance abuse systems are substantial. Strengths appeared to fall in similar categories for both mental health and substance abuse service systems, viz., positive characteristics of DMHAS management and leadership, the array of services, and specific service achievements. The listing of positive characteristics of DMHAS management and leadership are impressive (especially in regards to the mental health system), as are the specific qualities cited in both service systems.

**B. Referral Organization Results**

Referral organizations were asked in open ended questions to identify the strengths of the mental health and substance abuse systems in their area. Referral organizations identified the following strengths:

**Strengths Identified for the Mental Health Service System:**

- **Availability and Quality of Services**
  - Availability in general and accessibility
  - When staffing is not an issues, ability for clients to access individual therapy
  - Availability when no wait list
  - Responsive and timely in conducting intakes
  - Many options, good array of services
  - Location in my town is easy to get to and hours flexible
  - Most are multi-cultural
  - Great social club in area
  - Older adult services
  - Case management available
  - Services provided at no cost to community
  - Services provided promptly
  - Quality of services is good
- **Public and Private Systems**
  - We utilize both the public and private systems equally
  - We have a mental health agency and several hospitals
  - Regional organization and support
  - Fortunate to have several providers close by, many agencies
  - Good resource in town for children and families with short waiting lists
  - Long time presence in the community with a good working relationship with town
  - Many private, individual practitioners
  - Community collaboration
  - Network of providers
- **Staffing**
  - Availability of staff that genuinely cares about its clients
  - Good staffing pattern
  - Prompt, courteous, timely in calling back with information
  - Once a client is engaged the staff are willing to discuss treatment with referring source
  - Qualified personnel
  - Dedicated staff
  - Some excellent services with caring skilled clinicians
  - Responsive to requests for treatment

**Strengths Identified for Substance Abuse System:**

- **Availability and Quality of Services**
  - Generally good with engagement, accessibility, available and quick response most of the time
  - Overall the substance abuse services in this region seem to be very helpful in making a genuine difference in the lives of those I have known who used the services.
  - No waiting lists
  - Good support groups in town
  - Once enrolled, staff are more than willing to discuss treatment with referral source.
  - Best practice counseling programs, caring skilled clinicians
  - Specific agencies were named as excellent, an easiness in getting people help, providing services at no cost to community members
  - New models like harm reduction
  - Multicultural programming
  - Addition of Suboxone
- **Community Collaboration**
  - Excellent community collaboration
  - Nice partnerships with youth service bureaus for at risk families and prevention activities, strong youth prevention programs and family strengthening programs provide a non-stigmatizing link
  - Number of facilities, relationships among treatment providers
  - Network of self help groups following discharge
  - Good community awareness
  - Easily cooperative among many agencies
  - Staff call back with information, prompt

*Brief Summary: Referral organization reports on strengths*

While there are clearly variations in how individual referral organizations view their local services, it is heartening to see individuals giving praise for availability and quality of services they receive (good prompt services, responsive in doing intakes, many options, flexible hours, quality services, new models); recognizing local providers; strengths of staff (staff that genuinely cares about clients, caring skilled clinicians, staff that call back promptly); and community collaboration (excellent community collaboration, easily cooperative among many agencies, nice partnerships, good working relations with town). It was clear, however, that within the mental health system, having a mix of public and private services was valued.

Learning about the strengths that were identified, while not representing a uniform experience in the community, tell us about what is valued and what might be important to assess in future surveys.

**6. Use of Standardized Assessment Tool**

Provider surveys asked if agencies used a standardized assessment tool for mental health and substance abuse evaluations. Providers were asked if their agency used a standardized (researched and validated with psychometric properties) tool such as the Brief Symptom Index, Positive and Negative Syndrome Scale, Global Appraisal of Individual Needs, Structured Clinical Interview for DSM, etc. when conducting a mental health evaluation. They were asked if their agency used a standardized (researched and validated psychometric properties) assessment tool such as the Global Appraisal of Individual Need, Addiction Severity Index, Structured Clinical Interview for DSM, etc. when conducting a substance abuse evaluation.

*Brief Summary: Provider Reports on Use of Standardized Assessment Tools*

In conducting a mental health evaluation, 66.7% of respondent reported that they used a standardized assessment tool and 33.3 % responded that they did not. In conducting a substance abuse evaluation, 80% reported that they used a standardized assessment tool and 20% did not.

### **Section III: Focus Group Results: Mental Health Service Needs, Challenges and Solutions, Strengths**

#### **1. Service Priorities for Mental Health Service System**

Eighty participants at focus groups conducted at six CAC meetings were asked to respond to the list of services that DMHAS had asked providers to rate in the questions regarding availability and wait times. On separate flip charts, consumers, family members, referral organizations, and providers placed colored dots on the three services that they rated as the “most needed services to fill current gaps” in the mental health service system.

Participants identified the top 10 most needed services to fill current gaps from most needed to least needed as follows (number of votes for each item are listed in parenthesis):

1. supportive housing (35),
2. supported employment (30),
3. transportation (29)
4. followed by case management/community support programs (22),
5. clubhouses (16),
6. supported education (15),
7. peer to peer services (14),
8. young adult community treatment (12),
9. respite (11), and
10. outreach/engagement (10).

Family members, providers, and referral organizations listed their top three needs in alignment with the general overall ratings (i.e., supportive housing, supported employment, and transportation) as the top three needs for their group. Consumers listed transportation in their top three, making **transportation one of the top three choices in every group of participants**. However, consumers rated clubhouses as their top need, case management/community support programs the same as transportation for a tie as second top need, and rated **supported education as their third top need above supported employment** which was their top four need. Thus, **consumers differed from the other groups in their concerns, with clubhouses, case management/community support programs, and supported education taking on significance along with the overall rated top concerns of housing, supported employment, and transportation.**

*Brief Summary: Focus Group Reports on Service Priorities*

Since the 2002 Regional Service Priority Report, supportive housing and supported employment have been listed among the top concerns and since 2004, transportation has been listed as a top concern. This pattern continued within the focus groups with supported housing, supported employment, and transportation identified as the top three most needed services.

With regard to the top 10 items listed by DMHAS providers this year as the least available, transportation is the only item from the top ten needs identified in focus groups that is also listed on the top ten services rated as least available by providers. The services identified as least available by providers are, except for transportation, highly intensive, restrictive services, primarily for the most high need consumers.

What do the various ratings mean in terms of setting priorities for funding services? In setting service priorities for funding, which services would you choose as a funding priority - services identified in focus groups as needed to fill service gaps or services listed by providers as not available? The questions are different and the numbers are small for priority setting - 80 focus group participants versus 34 provider agency survey responses. The questions posed to focus group participants and providers were different; one focused on availability of services versus top need to fill service gaps (it is also possible that focus group participants had other sets in mind when identifying priorities). It is, however, notable that the items identified by the focus groups as top concerns fall mostly among the services identified by providers as more often available. There is value in asking both questions, but the responses do pose questions regarding needs assessment and the development of the next biennial budget – two goals of the surveys.

In order to gain a better perspective on how providers viewed the significance of rating service availability versus identifying service need, an additional focus group was held with 8 providers of mental health services. They felt that there are two different sets of consumers who currently have different needs. One set needs more services to help them reach their goals for living a better life in the community; these needs were represented in the focus groups, perhaps because consumers in attendance were living in the community and were more focused on what they and others like them need in the community to help in their recovery. In the ratings of least available services, however, providers were identifying what is needed for another group of consumers who have very serious needs for more intensive levels of care.

There was also a cautionary view that lack of availability does not necessarily mean that you need more of it. Providers were not asked on the survey to rate what they thought were the most needed services to fill gaps in the system or what they considered the priorities for the biennial budget.

There is another cautionary view gathered from NCRMHB's "A Day in the Life" interviews with people in recovery living in the community. A lot of people with psychiatric disabilities reported being "stuck" where they are and unable to take a next step that would give them a better life. They identified things they wanted in life (such as, better food, get a job, learn a skill, go to school, have friends, see their family), but they were often unable to take the steps to reach their goals. This is also a need. Setting priorities requires decisions about what is needed most in a system based upon what various groups of clients need, including those individuals who are aiming for higher life goals in the community and those who need safe, restrictive, intensive settings for their level of care.

## 2. Challenges and Solutions/Strategies

Challenges and solutions/strategies are listed below for the mental health system for areas cited most often in the six focus groups as needed to fill service gaps (Challenges identified by participants are listed with the open circle symbol, and solutions/strategies are listed with the arrow symbol):

### Challenges and Strategies Identified in Focus Groups for Mental Health Service System:

- **Housing**
  - Shelter comes first, reduces other life burdens across the board
  - Lack of affordable housing
  - Subsidized housing is limited, needed to support affordability
  - Lottery for Section 8 opens and a regular citizen won't even know lottery is open, not enough Section 8
  - Would have lost supportive housing if parents weren't around, what happens when people don't have family
  - Gridlock because can't leave hospital because no housing
  - People should not have to come to Hartford for housing
  - 2-3 year wait for supportive housing
  - Need transition from family home
  - Coming out of jail need a place to get used to being in community
  
- **Supported Employment**
  - Fear of losing benefits with part time employment, fear losing medications, don't come out ahead financially with part time employment, fear of losing support system as they move on into employment
  - Consumers don't even know how to look for it, consumers don't know whether to disclose disability; many are afraid to disclose, fear of being labeled so don't seek employment services, stigma in our own minds – fear of trying, lots of people don't have skills to maintain job
  - A lot of places are open to people with physical benefits, but not psychiatric disabilities
  - BRS is negative
  - Need ways not to isolate, need structure in life, like volunteer jobs, not just employment
  - Helps people feel better, self worth, 180 degree turnaround with job, important part of recovery
  - Seeing other work makes people feel it's possible so more of us will become success stories
  - People interviewed in A Day in the Life project want to work
  - Need work to live, especially in this economy, need employment with living wage, scary not to have job security, job is important for Medicaid even if just a few hours
  - Voc club is unbelievable for people who want to work
  - Need not just supported employment, but also development of employment for consumers
  - Need more programs like Easter Seals
  
- **Transportation**
  - People in outer towns cannot participate in lots of activities, including clubhouses

- People get too comfortable with clubhouse issues and with disability transportation which is limited and don't reach beyond that
  - Need buses to go to where jobs are, not just to Hartford and airport
  - For basic appointment, difficult getting there by bus with transfers, takes 3 hours from north to south end of Hartford, 3 hours to get to class at community college
  - Takes \$11.00 a night to see my mom
  - Primary care doctors not on busline
  - Buses not reliable, need to have extra time
  - Catch 22 criteria for Dial-A-Ride, very limited, running out of money
  - Expand Dial-A-Ride service area to areas with no public transportation
  - Charge a fee (pass for year) to underwrite services
  - Use peer networks
  - Pay people money to drive
  - Develop network of volunteer transportation providers through build of /exchange of credits
  - Help with walking or biking in some areas, may be faster than bus
  - Negotiate with cab companies
  - Increase use of disability transportation services
  - Need more training about transportation
  - Teach how to use medical taxi, agency shuttle
  - Independent Transportation Network
  - Think out of the box, don't just think big buses
  - Expand buses, maybe small ones, and other transportation for work sites
  - Provide more transportation tokens
- **Case Management (CM)/Community Support Program (CSP)**
    - Case manager discussed new plan with me, but I don't understand what it is about
    - Don't know what CSP is- do providers know what it is
    - Lack of clarity about change of CM services, fear a loss, how many services will be lost in change to CSP, how do people navigate
    - Fall out in community re gaps left after changes
    - Introducing changes in what family members appreciate a lot, for a period of months during realignment where his mom was the amateur CM
    - CSP supposed to teach, but this is not an education deficit for some people- needs will not be met via education
    - People need CM and to know where to refer to
    - People apprehensive-CM has been link to outside world
    - Need to know timeline, get the word out
    - Tell us why it is more effective
    - Make sure people can get their meds and med monitoring and someone to talk to
- **Supported Education**
    - Important for going forward in life
    - Fear of going back to school and then the stigmatism encountered in the past
    - Want to work at something that requires more education
    - Start at the GED level
    - Need help with employment writing, resume writing, skill training, practice for job interviews
    - Redirection for employment for people who have degrees and were not successful
    - Need loan forgiveness

- **Young Adult Services Community Treatment**

- Good support in school, then nothing after graduated
- Dramatic increase in demand
- Lack of age appropriate services in regular DMHAS services
- No clear transfer from youth to adult
- Need transfer from family homes
- Change age limit to 30 for young adult services
- They are our future
- Increase funding for Young Adult Services (YAS) to meet demands
- Provide YAS or YAS type services in all LMHAs
- Provide appropriate services for young adults who were never in DCF

- **Other**

- Not enough time and advanced practice nurses
- What will happen when I get older- frightening, physical problems too, need to find some treatment , people to relate to me as older person
- When alone at night, frightened
- System so far removed from community- don't know it, mental health community insular
- Inconsistency of therapist- turnover
- Haven't attended to healthy living and nutrition support, people die 25 years earlier
- Not enough doctors
- Co-occurring hard to find
- 6-8 weeks wait for psychiatrist- bottle neck, people go without meds while they wait, waiting for crisis to happen, keeps ER full, revolving hospital door
- Jail diversion, not enough, stay too short
- Courts don't understand MH- my son turns down the help offered
- Need co-occurring services especially residential treatment, more wet and dry
- When in crisis need someone to talk to right then
- Need wraparound services

*Brief Summary: Challenges and Solutions reported in Focus Groups*

Challenges and solutions were listed for the top three needs identified in focus groups- housing, supported education, and transportation. Participants recognized the importance of housing (shelter comes first, reduces other life burdens across the board); supported employment (helps people feel better, 180 degree turnaround with job, important part of recovery), and transportation (people in outer towns cannot participate even in clubhouse, cannot go to where the jobs are).

In listing challenges, participants saw largely forces outside DMHAS and outside themselves that controlled access to housing and transportation. With regard to supported employment, however, they listed fears among people in recovery themselves as a challenge (fear of losing benefits, losing support system, not coming out ahead financially, fears of being labeled so don't seek, fear of trying-stigma in our own minds), as well as lack of abilities (consumers don't even know how to look for employment, don't know whether to disclose or not, don't have skills to maintain job). There were also outside challenges (places open to people with physical disabilities only, BRS is negative).

There were few strategies offered, except for transportation (see 14 strategies on page 30, including charging a fee for a year pass, use peer networks, help with walking and biking, negotiate with cab companies, and the Independent Transportation network being tried in some communities). There

was encouragement to think out of the box- not just think of big buses. In previous focus groups, participants have suggested matching people with psychiatric disabilities and those with physical disabilities where one can do what the other cannot (for example, someone with physical disabilities has a car and can drive, but not carry groceries) to mutually assist one another with transportation and other needs.

Strategies for housing included needing transition from family home and coming out of jail. Strategies for employment included the development of employment in addition to more vocational clubs and other programs.

Numerous challenges and strategies were cited for three other areas – Case Management/Community Support Program, Supported Education, and Young Adult Services. These three areas were rated high on the list of needs to fill gaps, as well as generating much discussion in focus groups.

Case management or the new Community Support Program (CSP) was discussed in terms of importance (case management has been a link to the world), unknown factors about the change to CSP (I don't understand the new plan, fear a loss, how do people navigate), concern over impact on family (about family members losing case management, a service they valued highly, and having to be amateur case managers themselves), and concern over fall out in the community where gaps were left after other changes). Strategies suggested included getting information and timelines out to everyone involved, telling why it is more effective, and making sure people can get their medications, as well as someone to talk to.

Supported education was rated higher as a need by people in recovery than supported employment, who recognized it as important for going forward in life and getting the kind of jobs they want. The suggested strategies to help people get basic education included focus on GED and redirection for employment for people who have degrees but were not successful.

With regard to services for young adults, participants identified the importance of serving young adults (they are our future) and challenges (often there is nothing offered once a person graduates from school and the support system stops, hard to transfer from family home to community, dramatic increase in demand in DMHAS funded services). Participants recommended increasing funding for YAS, as well as providing YAS or YAS type services in all DMHAS funded LMHAS and ensuring that young adults who are entering the DMHAS system who were not in DCF also receive these services or other age appropriate services.

### 3. Strengths of Mental Health System

Focus group participants were asked to identify strengths in the mental health system. There were many participants in each focus group and discussion began with challenges and solutions/strategies because these issues seemed most pertinent to the goal of identifying information for budget purposes, one of the main goals of the priority setting process. There was, however, little time left to identify strengths during the one and a half hour meeting for each of the six focus groups. No doubt the list would be much longer given more time.

Focus group participants identified the following strengths in the mental health system:

- **Service system**
  - A system is in place
  - Get support from system

- DMHAS leadership mitigated impact of budget cuts, continued leadership
- Training Academy
- Ample evidence for how CSP model is working in other states
- **Services**
  - Clubhouses
  - WRAP
  - Warmline
- **Other Organizational and Community Support**
  - NAMI for family and person in recover
  - Advocacy Unlimited
  - Keep the Promise
  - Friend to Friend
  - Collaborative efforts between Genesis Center and police and shelter
  - Cooperation with employers, such as Walgreens employment program
  - Opportunities to volunteer
  - Some property managers provide support, especially for elderly
  - CIT Training
  - Open House events
  - CMHA van
  - Celebrate Recovery

#### Brief Summary: Strengths reported in focus groups

Although the focus groups could reserve only a short amount of time for identifying strengths, it was clear from the strengths identified that participants valued local services, as well as the leadership that DMHAS provided. They looked not only at DMHAS funded services, but also what else was accessible locally in the community, including the activities and support provided from advocacy and other community organizations, as well as from each other (warmlines, WRAP, and clubhouses.)

## **Section IV: Overview of Mental Health Findings from Focus Groups and Surveys**

### **Major Themes and Emerging Concerns**

#### **Major Themes:**

#### **1. The Top Ten List of Priorities Over Time**

Since the 2002 Priority Setting Process, housing and supportive employment services have been listed among the top seven priorities and transportation was added to the list in 2004 and remained high on every list since. Although questions have varied over the years in surveys and focus groups, housing, supportive employment, and transportation have been consistently identified as top needs or concerns. In 2010 focus groups, they were identified as the top three most needed services to fill gaps in the mental health system and emerged in survey responses from providers and referral organizations in response to both mental health and substance abuse systems. In 2008 services for youth and/or young adults began to appear on the top ten list of needs. In 2010 services for young adults were number eight on the focus group list and were cited in the top half of the list (as number 11<sup>th</sup> in the list) of least available services identified by providers.

## **2. Transportation**

In 2010 transportation needs appeared on all lists of mental health needs, including barriers, challenges, and solutions/strategies. Since transportation is not strictly a “mental health” service, its funding and provision are primarily outside the mental health system and present a unique challenge to address.

Transportation also made the top ten list of services identified as least available in the provider survey. It was notable that transportation was cited in that list, since the other nine service areas identified as least available were highly restrictive, intensive services for people with high levels of need.

## **3. Intensive, Highly Supervised or Restrictive Services**

In the top ten list of services identified by providers as least available in surveys, providers identified intensive, highly supervised or restrictive services. These included sub-acute treatment, licensed group homes, co-occurring mental health and substance abuse residential treatment supervised apartments, acute mental health operated inpatient treatment, young adult services inpatient treatment, intensive outpatient counseling, assertive community treatment, and acute mental health hospital inpatient treatment. All of the nine services other than transportation that were identified in the CAC focus group top ten needed services, in fact, were not among the least available services identified in the provider surveys.

A follow up discussion with a focus group of providers confirmed that there are a group of clients who have serious needs and that these services are, in fact, not available for them. Questions were raised about whether more of these services are needed or some other alternatives are warranted. There are also broader questions regarding how to make budgeting decisions incorporating both the needs of people who require more intensive services and those consumers needing services to help in reaching their highest levels of recovery and need housing, employment, and transportation in the community.

## **Emerging Mental Health Concerns**

In focus group discussions, several areas of emerging needs were cited:

### **1. Access to Psychiatrists**

Participants cited 6-8 weeks wait to see a psychiatrist which creates a huge “bottleneck” and other problems that occur as a result. Participants reported that people go without medications while they wait; the emergency room stays full or has people revolving in an out while they wait, and community providers “wait” for a crisis to happen. Strategies recommended included providing incentives for doctors to go into psychiatry, rotating medical students into state funded mental health facilities and agencies, having the state pay for medical malpractice insurance for psychiatrists treating publicly funded clients, and state loans and/or forgiveness of loans for medical students going into psychiatry.

### **2. Spiritual Support**

Participants identified the need for being in caring communities that help them with their spiritual needs and other needs of their daily lives. Some participants identified the faith community of having

the potential to meet this need. Providing people in recovery with spiritual support is something the mental health providers often feel that they cannot do. Perhaps turning to pastoral counselors to further explore the help that may be present in faith communities would be a first good step. Some participants, however, had found that their faith communities were not supportive. Others thought that there would be cultural differences among churches in their willingness to reach out to people with mental illness.

### 3. Rising Level of Poverty and Joblessness

Many participants felt that the rising level of poverty, joblessness, and financial stress in general in our society presented a challenge to the mental health system. They wanted to discuss further the impact on demand for mental health services in the DMHAS system and level of responsibility in addressing these needs, including prevention of more serious mental health issues.

### 4. Wellness and Integration of Mental Health and Physical Health Services

Participants want to look to the future and address the changes anticipated in federal and state healthcare reform (90 % of people will be covered by health care and able to choose any willing provider); the integration of physical and mental health (to address the serious medical issues of consumers who die on average 25 years younger than the general population), and needed community collaborations (for example, with Federally Qualified Health Centers).

## Section V: Overview of Priority Setting Process

There is a desire on the part of Regional Mental Health Boards and RACs to ensure that this process provides the needed information to DMHAS that will help set priorities and inform the budget. There was also time contributed and earnest caring among survey and focus group participants that their participation would make a difference. We look forward to continuously improving the Priority Setting Process and look forward to discussing with DMHAS how this could best be accomplished. The following items list some issues to discuss in future Priority Setting Processes for Region IV:

- A. Different methods employed over time
- B. Different questions asked of different groups
- C. Need for focus groups with substance abuse providers & clients similar to those within the mental health system
- D. Need to survey people in recovery and family members
- E. Need to gather information about various groups of people in recovery in both the mental health and addictions service systems
- F. Need to follow up re barriers, disconnects, & major themes
- G. Need to discuss different results with different analyses and questions
- H. How to reconcile judgments re lack of availability versus other assessments of needs
- I. Unified reporting on mental health, substance abuse, and prevention
- J. How to get better information on strategies which tend to merge with challenges
- K. Value of regional priorities in the mental health system with four LMHAs in Region IV.

We thank DMHAS for this opportunity to involve providers, referral organizations, consumers, and family members in this process.