Region V

Regional Needs Assessment and Priority Planning Report – 2016

Janine Sullivan-Wiley, Executive Director, Northwest Regional Mental Health Board, Inc.
Jennifer DeWitt, Executive Director, Central Naugatuck Valley Regional Action Council
Allison Fulton, Executive Director, Housatonic Valley Coalition Against Substance Abuse

Representing the forty-three towns of northwest Connecticut:

Barkhamsted, Beacon Falls, Bethel, Bethlehem, Bridgewater, Brookfield, Canaan, Cheshire, Colebrook, Cornwall, Danbury, Goshen, Hartland, Harwinton, Kent, Litchfield, Middlebury, Morris, Naugatuck, New Fairfield, New Hartford, New Milford, Newtown, Norfolk, North Canaan, Oxford, Prospect, Redding, Ridgefield, Roxbury, Salisbury, Sharon, Sherman, Southbury , Thomaston, Torrington, Warren, Washington, Waterbury, Watertown, Winchester/Winsted, Wolcott, and Woodbury

FY 2015-16

TABLE OF CONTENTS

Appendices

INTRODUCTION

This report summarizes the findings of a bi-annual process wherein each of the five regions in the state develop a report indicting the needs and priorities of the region, based on an extensive needs assessment and planning process.

Many data sources are incorporated into this report and the determination of the region's needs and priorities. These included:

- Program evaluations conducted throughout the year by the Regional Board's Catchment Area Councils. Each one identifies strengths, issues, needs and barriers.
- Monthly Catchment Area Council meetings: each meeting has a standing agenda item to identify any local area issues.
- Consumer Action Group regular meetings and brainstorming session/focus group to identify priorities, needs and new ideas/service suggestions.
- Focus groups held in each of the three catchment area councils (one council had two such events) to identify priorities.
- Provider survey (done online through Survey Monkey).
- Opiate Forums
- Data collected by the two Regional Action Councils in this region.
- In all, **over 200 stakeholders** were involved in meetings convened by the Regional Board that identified issues and unmet needs. They represent citizens from all corners of the region.

OVERARCHING ISSUES, BARRIERS AND CHALLENGES:

- There is a need for more affordable, safe and accessible housing. (Noted every year.)
- There is limited affordable public transportation. This can make it difficult for clients to find and maintain employment, limits where people reliant on public transportation can live, and is a challenge for any independence. (Noted every year.)
- The PNPs have not seen increases in many years – and are now at risk of funding reductions.
    - Limited funding is a barrier to program development, program performance, and agency stability.
    - For staffing, the chronically low funding impairs hiring and retention. High staff turnover is a barrier to client recovery when clients have to keep starting over with new staff.
    - Programs are no longer able to do "more with less" but are now forced to do less. Hours of operation and staffing levels have been reduced. This all has direct client impact.
- Workforce issues:
    - Shortage of bilingual staff.
    - The persistent turnover in staff within the PNP programs as they move to higher paying jobs makes it very difficult "to ensure quality care, a continuity of care and the development of programming initiatives." It is also a barrier to clients as they eventually choose to not form a connection with staff due to the repeated losses – a type of trauma itself.
    - There is a persistent and severe shortage of psychiatrists. The impact is noted under "outpatient", below.

- The new Coordinated Access Network places unfunded mandates on agencies that are already exceedingly financially stressed. It also seems to have shifted some use by homeless individuals from shelters to hospital emergency rooms and – in one area the police station lobby - for a safe, warm place to spend the night without having to go through the CAN protocols.
- The separate silos of mental health and substance abuse treatment persist.
- Clients with co-occurring disorders continue to have difficulty accessing appropriate substance abuse treatment. Clients in substance abuse treatment are often not provided mental health care within even an IOP level of care.
- With a service system that is generally at or over capacity, it is difficult to make successful referrals for clients. Individuals may remain in an inappropriate level of care because the right level is not available. This can include a high level of care such as an emergency department or inpatient bed.
- Staff spend significant time on the phone trying to access information from SSA and DSS, often spending hours on hold waiting to be assisted.
- Having family participation in client recovery can be challenging.
- Access to medical care is challenging for people with HUSKY, primarily due to a dearth of primary care physicians and specialists who accept Medicaid. This issue had been noted in years past, but has again been identified as an issue.
- Prescription drug prices are climbing rapidly. This has serious implications for general affordability, as well as state expenditures through Medicaid. The cost of the Narcan auto-injector went from $700 to $3500. The cost of EpiPens went up over 32% in this year alone. Our Board has begun to work with the office of Sen. Chris Murphy on this.

One **unique barrier** was noted:

- DPH licensing requirements inhibit innovation. This was completely new, and might be something that could be addressed by inter-agency discussions.

STRENGTHS:

- CIT training of police continues to expand. There is more recognition among law enforcement of the unique needs when approaching people with mental illness and substance use disorders.
- Community education has expanded. This year the community Education Project in this region reached all 43 towns and over 180 locations. 317 people have been trained in MHFA through the Regional Board.
- Stigma in the area of substance abuse and the value of treatment has seen improvement.
    - There is increased awareness of opioid issues across all communities. More than five Opiate Forums were held in the region, including in Goshen, Winsted, Waterbury, Danbury and Oxford. Changes in attitudes of public officials and decision-makers have been observed, acknowledging that there are opiates in all communities, that they affect all walks of life, something needs to be done, and a willingness to address these within local communities.
    - There has been considerable expansion in the availability of Narcan. The Regional Board and local opiate task forces have had ongoing reports within the community of where it was/was not available. Now many/most first responders carry Narcan. Widespread training is being completed.
    - There have been creative, local initiatives such as the development of a pamphlet by St. Mary's Hospital, *"Your life was saved today. Death eliminates recovery. You don't have to do this alone."* It is being put in belongings of every person who came into the ED with an overdose.

- The system continues to have a robust advisory structure that is inclusive of all stakeholders: people in recovery/consumers, family members, providers and members of the community at large. The system enables communication both ways from the local to the state-wide. The level of dedication of the local CAC, Regional Board and Consumer Action Group members is impressive.
- Collaboration between the state-operated and private not-for-profit agencies in strong.
- Legislators from both parties are committed to seeing that the needs of people with mental illness and substance use disorders are met, even as they struggle with shrinking state revenues.
- In Region V there is strong collaboration between the Regional Action Councils and the Regional Board.
- Despite the persistent and corrosive level funding of the PNPs, they continue to provide excellent (although shrinking) services.
- State-operated services in this region have demonstrated creativity in responding to staff losses.
- Wellness has a stronger and stronger emphasis. Treatment for those who want to quit or stay smoke-free is available in all clubhouses in this region. Policies regarding smoking have been changed in almost all programs. No longer does one find clouds of smoke at entrances; smoking is largely removed altogether of to a remote part of the property. There are groups or classes in yoga, healthy eating and nutrition in many programs. The foods and beverages served in psychosocial programs have become notably more health-oriented. Spirituality as a value for recovery is more pervasive.

MAJOR DEMOGRAPHIC TRENDS:

Within the mental health system:

- More young adults are entering the system. They are typically dually diagnosed and exhibit risky behaviors.
- In general, more of the clients in the system – of all ages – have co-occurring substance use issues.
- Several programs noted an increase in referrals for Spanish-speaking clients. The pool of Spanish-speaking staff is extremely small; they may be impossible for a program to find and hire.
- The aging population is presenting with more complex medical needs.
- Increasingly medically compromised clients are requiring more care and medical intervention. This increases the financial and staff challenges within an agency.
- Clients in residential care are utilizing more community nursing services. Residential programs have seen that many discharges have been to higher levels of care with residential support enabling clients to live in the community until medical issues become so involved that they require admission into a nursing or rest home, the latter of which are in short supply.
- Complicating these medical needs is the limited availability (for people on Medicaid) of primary care physicians, and specialty medical care including dentists and psychiatrists.
- There is a need for elder-specific mental health residential care. Older clients are less willing to accomplish goals to move on. They are looking for permanency in their later years.

<u>Substance abuse</u>:

- Increasing use of opiates in all communities, increasing deaths by overdose.

ISSUES BY SPECIFIC SERVICE:

Some issues or barriers were specific to certain service types/programs. They are therefore identified by service area below:

Outpatient treatment:

- There is a chronic shortage of psychiatrists, in both the private and the state-operated programs.
  - The lack of psychiatrists has resulted in reduced or closed admissions to some outpatient programs, and extreme strain on the psychiatrists remaining. This creates capacity issues in general.
  - Psychiatrists are generally serving an extremely high number of people on their caseloads, and are often unable to absorb new clients if a doctor on the staff leaves. With all of the system at or over capacity, other programs are unable and/or unwilling to absorb new patients.
  - For Suboxone treatment, each doctor is typically at their maximum allowable (by law) caseload. If another doctor is on vacation they cannot cover for their colleague's clients.
- Most parts of the region have had sporadic or persistent lack of access to outpatient mental health treatment.
  - For many months and for the foreseeable future, Danbury Hospital's outpatient treatment program (CCBH) is closed to admissions except through their crisis unit or from their inpatient unit.
  - Major transitions are underway, causing considerable instability in hospital-provided outpatient programs:
    - Family Services of Waterbury is closing its doors on August 12, 2016. This will drop a large number of clients on a service system that already above capacity.
    - Waterbury Hospital is in the process of being purchased by Prospect Medical Holdings. This is their third attempt at a successful sale. In the prior two years we have documented a significant drop in clients served in their programs, period closures to admissions, and a general drop in involvement in the service system.
    - St. Mary's Hospital has been acquired by Trinity Health. No loss in service has been noted. Conversely, they are now operating 161% over capacity.
    - Danbury Hospital is in the process of transitioning ALL of their outpatient programs (except for IOP) to the Community Institute for Health (CIFC). Their medical and dental programs are transitioning at this time, the behavioral health programs will follow in about a year. In the interim, there is no one with a full commitment to outpatient treatment except the very small state-operated program (Western CT Mental Health Network)
  - Other outpatient programs do not have the capacity or the interest in greatly increasing their capacity. Some years back, Wellmore closed their adult mental health outpatient program completely.

Substance abuse treatment:

- In general, accessing substance abuse treatment at the time the client is ready is difficult if not impossible.
- Inpatient drug facilities have a lack of available beds.
- Increases in opioid use and deaths. At the Waterbury forum, it was reported that there had been 379 overdoses in that city alone.

Residential services:

- Recommended maximum lengths of stay can be inadequate for dually diagnosed clients when trying to stabilize mental health symptoms, implement goals and plan for discharge when resources are limited.
- MRO requirements in the group home setting (reaching 40 billable hours for each client every month) are challenging when clients are allowed to come and go and participate in other services (e.g. local psychosocial program). But to not allow such experiences reduces client choice and is a barrier when the client has to move to a lower level of care where it will be necessary to use other community resources.
- Clients often have difficulty having a roommate.
- Residential Counselors are "barely make a living wage."
- There is far less capacity than is needed at the supervised apartment level.
- Stigma is a barrier for programs trying to develop new housing locations.
- The change in support from a 24/7 program to the next available level of care is often too steep for clients to tolerate.
- There is great challenge working with clients on substance abuse issues when they are in pre-contemplation phase.
- Clients often don't have the funds to move their belongings to a new apartment.
- When clients get comfortable and feel safe in a program it can be difficult to encourage clients to a lower level of care. An expectation of clients always needing to move on can be unrealistic for some clients.
- Housing opportunities are very limited for people coming out of incarceration, which is common for those with a history of addiction.

Supported employment:

- Reaching fidelity in supported employment; Employment Specialists are not embedded in all clinical programs.
- SE programs in the Waterbury area are below capacity, but one of the major potential referral sources (Waterbury Hospital) has not been a collaborative partner in this for some time now.
- Clients with substance abuse and criminal histories have difficulty getting employment.
- Clients fear losing entitlements if employed.
- High unemployment rates make job development and placement difficult. Waterbury continues to have the highest unemployment rate in the state.
- Staff are challenged by the dual roles of job development and client support, which require very different skill sets.

Sub-regional/ local issues:

- Mobile Crisis is difficult to access when needed (Greater Danbury/ CA #21)
- Some areas have seen low numbers of referrals for Supported Employment (CA #20 & 22)
- Housing prices are the highest in the Danbury area. It may be difficult to impossible to find housing at or below the Fair Market Level, which is needed to use Section 8 certificates.
- There are no group homes in greater Danbury.
- Waterbury Hospital/ Grandview's Adult Behavior Health outpatient program clinicians have not participated in service system meetings for approximately one year.
- The need for affordable transportation is especially acute in the northwest part of the region.

IDEAS FOR INNOVATION:

Participants in the focus groups held were asked for suggestions for **innovations**/ ways that things might be done differently, perhaps that would be less expensive, more effective or efficient. The following were suggested:

- End the Mental Health and Substance Abuse silos.
- Develop and utilize alternative methods for pain management.
- Home-based services with peer supports.
- 23 hour crisis beds.
- Different model for Inpatient care. Develop different models for a protective environment on hospital grounds.
- More publicity regarding 211 and mobile crisis
- Walk-in center for behavioral health
- Diversion from Emergency departments for those with basic needs (i.e. people going to ED for warm, safe place, safety)
- Outreach and follow-up when people need a new level of care or service
- Mobile units for services, on a fixed schedule to serve rural communities, maybe by van, in town hall or churches.
- Telemedicine
- Utilize town social workers / more training for them.
- Peer support: (The Consumer Action Group had several suggestions that related to peer-supports.) ☼
    - Initiatives such as the Consumer Action Panel in Torrington.
    - Peer-run respite and crisis services
    - More use of peers, and more peer training.
    - Have Medicaid reimburse (and then publicize this) classes / help from the lowest level possible e.g. by MHA1-level staff or peers
- Mindfulness – include in more programs
- More art and self-expression such as adult coloring (books)
- Help consumers with starting businesses, marketing and sales information to increase self-sufficiency.
- Teach self-care vs. needing to get help from others.
- Have providers do with, not for.
- Medical cab/bus to connect people in isolated areas, decrease isolation and medical problems
- Assist clients (not just advocate) with medical appointments, make sure clients are well-groomed, showered.
- Promote self-knowledge.
- Tutoring (math and writing).

PREVENTION RECOMMENDATIONS

- The most effective prevention infrastructure requires that evidence-based primary substance abuse prevention education be imbedded in k-12 classrooms across all CT public schools. Currently, it is not. In addition, family and community education is strongly needed, and is an essential part of this process.

- The CT Prevention Network should receive funding to coordinate and conduct twice yearly statewide prevention forums to improve systematic delivery of evidence-based prevention practices. If we do not bolster our current primary prevention practices as a state, then we will continue to "chase the dragon" of addiction, overdose, and synthetic drug trends.

- For secondary prevention, delivering intervention services for that at-risk or in-crisis population, we should amend our customary service delivery and screening practices. Tools such as SOS, A-SBIRT, QPR, and MHFA have become necessary components to be used in primary prevention settings as well. They are an integral part of the formula for creating overall health and wellness in our communities.

- With the diminished perception of harm due to decriminalization and medical marijuana approval in CT, it is imperative to provide accurate information about the negative effects marijuana, in particular with the youth population. In other states, ample allocations have been put in place to address this important prevention area.

- There should be a legislative review of the standards for merchant education for tobacco, alcohol, medical marijuana, and gambling.

- There is an emerging trend of increased suicide in our service area and across the state. There continues to be a strong need for integrative suicide prevention supports directed by the state to deliver local-level support.

REGIONAL PRIORITIES

Part of the process this year was a mandated selection of three (and only three) priorities to be chosen from the five core areas as defined by DMHAS.

The priorities in this report, and as reported to DMHAS, were based on the online provider surveys that were completed (although less than half of the providers in the region completed the survey), surveys completed by Catchment Area Council (CAC) members, focus groups including two CAC focus groups, a Consumer Action Group (CAG) focus group, evaluations completed over the course of the past year, monthly CAC and Board meetings in which local and emerging issues are identified through a specific agenda item, and a meeting with the two Regional Action Council (RAC) Directors in this region.

The priorities as noted and reported reflect consensus with the Region V RACs: the Housatonic Valley Coalition Against Substance Abuse and the Central Naugatuck Valley Regional Action Council.

The top three priorities in Region V were determined to be:

Priority 1: Outpatient treatment. Per the provided definition, this category included OP (Outpatient), PHP (Partial Hospital Program), IOP (Intensive Outpatient Program), forensic, ACT (Assertive Community Treatment), case management, care coordination, BHHs (Behavioral Health Homes). *Many respondents felt that items grouped here varied greatly in their value in a ratings process.* In this region, it was specifically Outpatient care (including mental health and substance abuse treatment) that was most cited.

Priority 2: Inpatient (incl. psychiatric and forensic). This was the only category that was for only one type/level of service. As such, it is the only category whose inclusion or lack thereof is not confounded by the addition of dissimilar services.

Priority 3: Residential, crisis & respite, mobile crisis, CIT. Of these, it was residential care that was cited specifically as a top priority.

In ranked order, the last two were:

Priority 4: Recovery Support Services: (housing, peer, advocacy, social rehab/clubhouses, Supported Employment, transportation).

Priority 5: Education, research, prevention. Many respondents cited the value of community education and prevention.

It is crucial to note that the *different stakeholder groups did not always have the same priorities*. Most importantly, **the Consumer Action Group identified the various Recovery Supports as most needed**.

Also, as noted above, most of the categories included quite disparate services, only one of which might reflect the level of priority indicated. Many respondents were uncomfortable with the groupings.

It is also **crucial to note** that ***without prevention and community education***, the high and increasing demand for outpatient care, and eventual need for inpatient care for a certain subset*, will continue and over time, increase.*

As often noted in the focus groups, ALL of the service system – and prevention and education – are needed for Connecticut to have healthy communities.

APPENDIX 1:

Data from evaluations:

Each year, the Northwest Regional Mental Health Board evaluates over twenty programs in the region, in addition to general service system overviews. In each review, emerging issues and trends, barriers and challenges to delivering services are identified.

This report includes information from twenty evaluations conducted this fiscal year through Catchment Area Councils #20, 21 and 22.

Data from focus groups held in CAC #20 and #22 and the Consumer Action Group:

Critical Services:

Participants were asked to identify what **services they felt were critical to keep**, even if there had to be reductions due to state budget cut-backs: (NOTE: a star - ☆ - means this was identified in multiple focus groups. Area that were the highest priority for the Consumer Action Group are identified with a "☼."

- Outpatient services: individual, group and med management, IOP ☆
- Inpatient beds ☆
- Transportation ☆
- Housing (for homeless) ☆
- Residential services ☆
- Recovery supports: Psychosocial centers/ clubhouses and peer support ☆☼
- The Boards/ CACs/CAG ☼
- RSS positions ☼
- Advocacy Unlimited ☼
- Home-based supports
- Prevention
- Psychiatrists – incl. for children and med management
- Detox – easy access
- Continuity of care
- Case management/ care coordination
- Supported employment
- Crisis services/ CIT
- Services for people who are homeless/ just entering the system
- Peer training
- CLRP

APPENDIX 2:

Themes from the Opiate Forums held in Region V in 2016

There have many forums addressing opiate use and overdoses held in Region V in 2016, including the towns of:

Danbury/Bethel
Morris
Oxford
Waterbury
Winsted

Several themes and noteworthy attitudinal changes were observed in these forums:

- There was very positive response to the stories from people in recovery about their own journey. People who spoke were treated with great respect and appreciation for their contribution and experience to advise a change process. They tended to get the most (and often first) applause. This reflects a reduction in stigma.
- There have been changes in the attitudes of law enforcement/ police departments:
    - From a "lock them up" to " opportunity to intervene"
    - Increased acceptance of the use of Narcan.
- Communities that once denied an opiate problem in their town now see it as a critical issue needing attention. "It's all of us."
- Changing attitudes on the part of community leadership. This has ranged from acceptance that this is an issue for even the smaller or wealthier suburbs (e.g. Ridgefield) to Waterbury where the mayor spoke – at the public forum – about his eagerness for another Methadone maintenance program to be added in the city. There was a time where any new or additional substance abuse treatment location would have been fiercely opposed.
- Heroin impacts different communities in different ways: Waterbury is hard hit by people from other parts of the state (i.e. the southwest region) coming to Waterbury to buy heroin as it is cheaper in Waterbury.
- Increased acceptance of medication assisted treatment across a broad spectrum of individuals and stakeholders (community members, leaders).
- There is however NOT unanimity in opinion within the recovery community itself regarding abstinence vs. the use of medication assisted treatment. Some people in recovery have been strongly outspoken that his is just another addiction.
- There is a need to address the opiate epidemic all along the continuum:
    - Upstream: reduce the rampant and heavy prescribing of opiates for everything (e.g. a one month's supply for a pulled tooth).
    - Early intervention for people who may be just becoming addicted.
    - Support and intervention for people who have become addicted, with multiple pathways available.
    - Recovery support: again, with multiple pathways. NA does not work for everyone.

Appendix 3- Client Demographics

In the charts in this appendix, where data from multiple regions is included, Region 5 is highlighted, as is the average percentage state-wide for ready comparison. For example, in the first chart, the percentage of males and females is almost identical to the state average. Such similarity is ***not*** the case across all of the demographic data that follows.

Below are some of the definitions used in the charts and tables. The numbers of clients are unduplicated unless otherwise noted.

Definitions

Unduplicated cases: total unique cases. If a client was seen more than once in a program or service, they are only counted once.
Active clients: clients with at least one admission, or discharge, or an open episode.
SA only: Clients have at least one episode of care in FY15 that is in a substance abuse and/or forensic substance abuse program, but NOT in a mental health or forensic mental health program during the same period of time.
MH only: Clients have at least one episode of care in FY15 that is in a mental health and/or forensic mental health program, but NOT in a substance abuse (SA) or forensic substance abuse program during the same period of time.
MH & SA: Clients have at least one episode of care in FY15 that is in a substance abuse and/or forensic substance abuse program, AND at least one episode of care in FY15 that is in a mental health or forensic mental health program.)

Demographics: Gender

The chart below shows the client profile by gender. All clients in this region had this data point identified. Roughly 40% are female, 60% male, with one transgendered individual. Region V is almost exactly at the average for the state in this demographic.

		Program Region					Total
		Region 1	Region 2	Region 3	Region 4	Region 5	
gender	Female	6,641	12,634	6,241	15,340	7,316	48,172
		38.2%	38.2%	44.5%	41.6%	40.3%	40.3%
	Male	10,709	19,951	7,785	21,518	10,821	70,784
		61.7%	60.3%	55.5%	58.3%	59.6%	59.2%
	Transgender	0	2	1	1	1	5
		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Unknown	13	488	7	26	4	538
		0.1%	1.5%	0.0%	0.1%	0.0%	0.5%
Total		17,363	33,075	14,034	36,885	18,142	119499
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Client demographics: Age

Number of All Unduplicated Active Clients.

In this demographic, Region 5 is again close to the state averages.

						Total
	Region 1	Region 2	Region 3	Region 4	Region 5	
18-21	874	1392	702	2064	978	6010
	5.0%	4.2%	5.0%	5.6%	5.4%	5.0%
22-24	1142	2313	1012	2945	1308	8720
	6.6%	7.0%	7.2%	8.0%	7.2%	7.3%
25-34	4399	8561	3792	9840	4633	31225
	25.3%	25.9%	27.0%	26.7%	25.5%	26.1%
35-44	3368	6330	2634	7074	3453	22859
	19.4%	19.1%	18.8%	19.2%	19.0%	19.1%
45-54	3867	7489	3104	8129	3753	26342
	22.3%	22.6%	22.1%	22.0%	20.7%	22.0%
55-64	2701	4829	2049	5178	2675	17432
	15.6%	14.6%	14.6%	14.0%	14.7%	14.6%
65+	929	1449	724	1525	1055	5682
	5.4%	4.4%	5.2%	4.1%	5.8%	4.8%
missing/unknown/errors	83	712	17	130	287	1229
	0.5%	2.2%	0.1%	0.4%	1.6%	1.0%
Total	17363	33075	14034	36885	18142	119499
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Racial and ethnic profiles

Region V is higher than the state average for individuals who are white, and below the state average for individuals who are Black/African-American.

The percentages for racial group are 72.1 % White (the highest percentage of any region except for Region III), 14% "other," 10.7% Black/African-American, 0.5% Asian, 0.4% multi-race, 0.3% American Indian/Native Alaskan, and 0.2% Native Hawaiian/Pacific Islander.

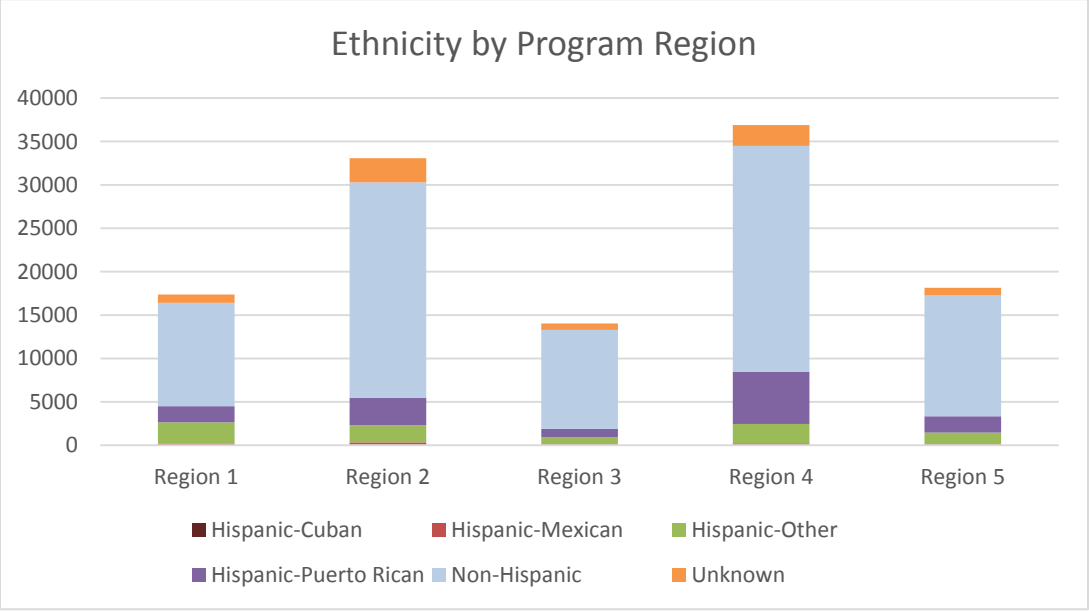
Region V data in this demographic is the most complete of any region with only 1.8% unknown.

		Program Region					Total
		Region 1	Region 2	Region 3	Region 4	Region 5	
	American Indian/Native Alaskan	35	171	149	209	46	610
		0.2%	0.5%	1.1%	0.6%	0.3%	0.5%
	Asian	118	210	106	351	90	875
		0.7%	0.6%	0.8%	1.0%	0.5%	0.7%
	Black/African American	3764	5416	1176	6171	1948	18475
		21.7%	16.4%	8.4%	16.7%	10.7%	15.5%
	Native Hawaiian/Other Pacific Islander	25	52	49	77	32	235
		0.1%	0.2%	0.3%	0.2%	0.2%	0.2%
	White/Caucasian	9941	21415	10669	22645	13078	77748
		57.3%	64.7%	76.0%	61.4%	72.1%	65.1%
	Multi-race	58	140	48	478	74	798
		0.3%	0.4%	0.3%	1.3%	0.4%	0.7%
	Missing/unknown	587	1639	352	1315	334	4227
		3.4%	5.0%	2.5%	3.6%	1.8%	3.5%
	Other	2835	4032	1485	5639	2540	1653
		16.3%	12.2%	10.6%	15.3%	14.0%	13.8%
Total		17363	33075	14034	36885	18142	119499
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Ethnicity

Again, Region 5 is close to the state averages. The graph below uses the raw numbers of clients; it is clear in this graph that regions 2 and 4 have higher populations than the other three regions. Region five serves the **third highest number** of clients of the five regions.

	Program Region					State-wide Totals
	Region 1	Region 2	Region 3	Region 4	Region 5	
Hispanic-Cuban	48	78	47	88	56	317
	0.3%	0.2%	0.3%	0.2%	0.3%	0.3%
Hispanic-Mexican	161	254	61	144	65	685
	0.9%	0.8%	0.4%	0.4%	0.4%	0.6%
Hispanic-Other	2440	1980	833	2221	1343	8817
	14.1%	6.0%	5.9%	6.0%	7.4%	7.4%
Hispanic-Puerto Rican	1850	3161	947	6025	1887	13870
	10.7%	9.6%	6.7%	16.3%	10.4%	11.6%
Non-Hispanic	11906	24817	11406	26007	13903	88039
	68.6%	75.0%	81.3%	70.5%	76.6%	73.7%
Unknown	958	2785	740	2400	888	7771
	5.5%	8.4%	5.3%	6.5%	4.9%	6.5%
Total	17363	33075	14034	36885	18142	119499
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Living Situation

Unduplicated Active Clients - Most Recent Periodic Assessment

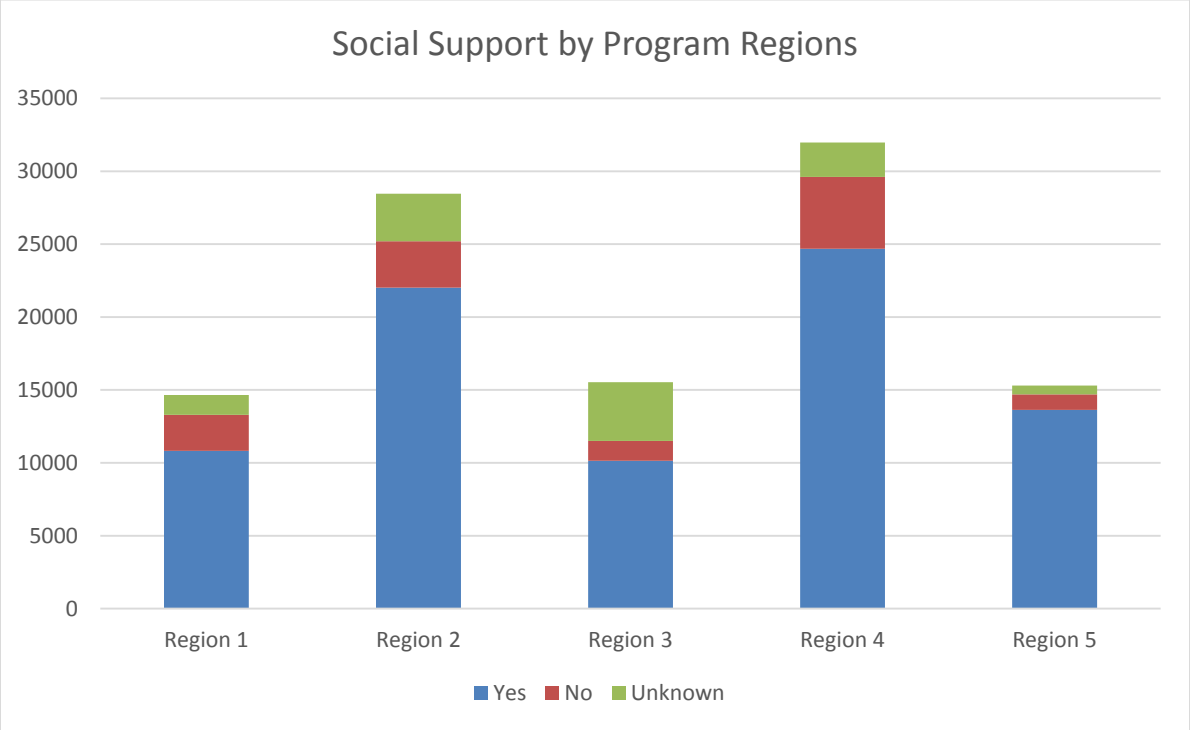
In Region 5, only a slightly higher percentage of clients live independently than the state average. A lower percentage is homeless- tied with Region 3 for the lowest percentage in the state.

		Program Region					Totals
		Region 1	Region 2	Region 3	Region 4	Region 5	
	Independent living	12413	23774	10574	25059	12609	84429
		84.7%	83.5%	68.1%	78.4%	82.4%	79.7%
	Dependent living	772	1869	2794	1195	1246	7876
		5.3%	6.6%	18.0%	3.7%	8.1%	7.4%
	Homeless	657	1200	401	1079	404	3741
		4.5%	4.2%	2.6%	3.4%	2.6%	3.5%
	Other	188	602	986	3087	557	5420
		1.3%	2.1%	6.3%	9.7%	3.6%	5.1%
	Unknown	625	1010	774	1549	487	4445
		4.3%	3.5%	5.0%	4.8%	3.2%	4.2%
Total		14655	28455	15529	31969	15303	105911
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Interaction with Family/Friends

The chart reflects social connectedness vs. isolation. An answer of "yes" reflects social interaction with family/friends; "no" means the client reported the absence of such interaction. Region 5 clients report the highest level of interaction with family and friends of any region; considerably higher than the state average.

		Program Region					Total
		Region 1	Region 2	Region 3	Region 4	Region 5	
	Yes	10828	22016	10138	24686	13637	81305
		73.9%	77.4%	65.3%	77.2%	89.1%	76.8%
	No	2465	3189	1365	4926	1064	13009
		16.8%	11.2%	8.8%	15.4%	7.0%	12.3%
	Unknown	1362	3250	4026	2357	602	11597
		9.3%	11.4%	25.9%	7.4%	3.9%	10.9%
Total		14655	28455	15529	31969	15303	105911
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



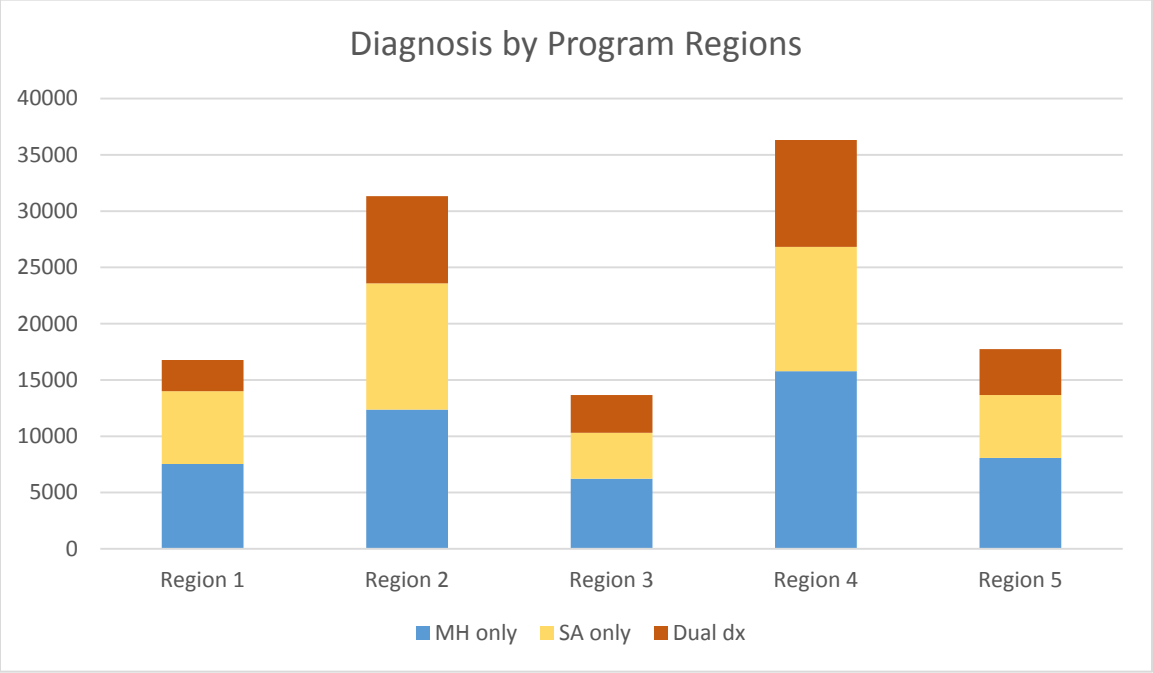
Employment Status
Unduplicated Active Clients* Reported (Most Recent Periodic Assessment)

The percentage of clients employed competitively is quite similar across the state, ranging from a low of 20.1% to a high of 28.4%. Region 5 is close to the highest rate at 27.9%. Interestingly, Region 5 also has close to the highest rate of unemployed, over the state average. This apparent paradox may be partly due to the relatively low percentage deemed "not in the labor force" – that is more clients ARE considered in the labor force and either working or not employed.

	Program Region					Total
	Region 1	Region 2	Region 3	Region 4	Region 5	
Employed Competitively	4168	6649	3124	8324	4269	26534
	28.4%	23.4%	20.1%	26.0%	27.9%	25.1%
Employed Non-competitively	74	185	91	190	72	612
	0.5%	0.7%	0.6%	0.6%	0.5%	0.6%
Student or Training	204	345	108	377	162	1196
	1.4%	1.2%	0.7%	1.2%	1.1%	1.1%
Disabled	2759	5502	2428	5602	2542	18833
	18.8%	19.3%	15.6%	17.5%	16.6%	17.8%
Unemployed	4430	9487	4676	7966	5072	31631
	30.2%	33.3%	30.1%	24.9%	33.1%	29.9%
Not in Labor Force	2289	4951	4024	7409	2560	21233
	15.6%	17.4%	25.9%	23.2%	16.7%	20.0%
Other	160	340	224	638	308	1670
	1.1%	1.2%	1.4%	2.0%	2.0%	1.6%
Unknown	571	996	854	1463	318	4202
	3.9%	3.5%	5.5%	4.6%	2.1%	4.0%
Total	14655	28455	15529	31969	15303	105911
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Unduplicated Active Clients by Diagnosis Type (MH, SA or both) by Region

	Program Region					Total
	Region 1	Region 2	Region 3	Region 4	Region 5	
MH only	7539	12371	6230	15774	8082	49996
	44.9%	39.5%	45.6%	43.4%	45.5%	43.2%
SA only	6469	11210	4076	11053	5579	38387
	38.5%	35.8%	29.8%	30.4%	31.4%	33.1%
Dual dx	2774	7750	3356	9488	4086	27454
	16.5%	24.7%	24.6%	26.1%	23.0%	23.7%
Total	16782	31331	13662	36315	17747	115837
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



APPENDIX 5: SERVICE STATISTICS

Numbers receiving mental health treatment, substance abuse treatment, or both in FY 2015

This chart shows the numbers of individuals receiving treatment for mental illness (MH), substance use disorder (SA), or both. The percentages are not far off from the state averages, with the largest difference being in those receiving both MH and SA treatment (7.4% - less than the state average of 9.1%). Note also the variation across the five regions.

For all five regions, far more people are admitted for treatment for substance use than for mental illness each year. This is not the same as the total number of clients in treatment at any given time, as the length of service may be different for these two service types.
As seen in the first table, these are 48% (SA) and 44.7% (MH). This may be attributable to lengths of stay being typically longer for people receiving mental health services. For those receiving mental health AND substance abuse treatment in the one year is 7.4%.

	Program Region					Total
	Region 1	Region 2	Region 3	Region 4	Region 5	
SA only	8,525	16,193	5,857	17,930	8,700	57,205
	49.1%	49.0%	41.7%	48.6%	48.0%	47.9%
MH only	7,258	13,133	6,781	16,181	8,108	51,461
	41.8%	39.7%	48.3%	43.9%	44.7%	43.1%
MH & SA	1,580	3,749	1,396	2,774	1,334	10,833
	9.1%	11.3%	9.9%	7.5%	7.4%	9.1%
Total	17,363	33,075	14,034	36,885	18,142	119,499
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Number of discharged clients by Discharge Reason

A good goal for all community services would be that clients complete treatment in accordance with their needs and preferences, or be assisted into other supports that would advance or help maintain their recovery. This does not seem to be the case as often as would be the ideal.

The charts below show what happened when people ended treatment (inclusive of both mental health and substance abuse treatment). In Region 5, 61.4% of clients completed their treatment or continued it elsewhere. Hopefully, this is a statistic that can be improved upon in a recovery-oriented system with more and more staff trained in and utilizing motivational interviewing and the stages of change.

	Program Region					Total
	Region 1	Region 2	Region 3	Region 4	Region 5	
Treatment Complete	5548	10887	3547	11301	5103	36386
	39.6%	36.7%	28.2%	41.3%	34.3%	36.9%
Continuing Tx Elsewhere	1992	3987	2534	3213	4037	15763
	14.2%	13.4%	20.2%	11.7%	27.1%	16.0%
Not Completed	2952	6310	3634	7836	2737	23469
	21.0%	21.3%	28.9%	28.6%	18.4%	23.8%
Other	1528	3022	1118	1449	595	7712
	10.9%	10.2%	8.9%	5.3%	4.0%	7.8%
Exclude	1966	5265	1687	3359	2404	14681
	14.0%	17.7%	13.4%	12.3%	16.1%	14.9%
Unknown	40	206	45	215	21	527
	0.3%	0.7%	0.4%	0.8%	0.1%	0.5%
Total	14026	29677	12565	27373	14897	98538
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

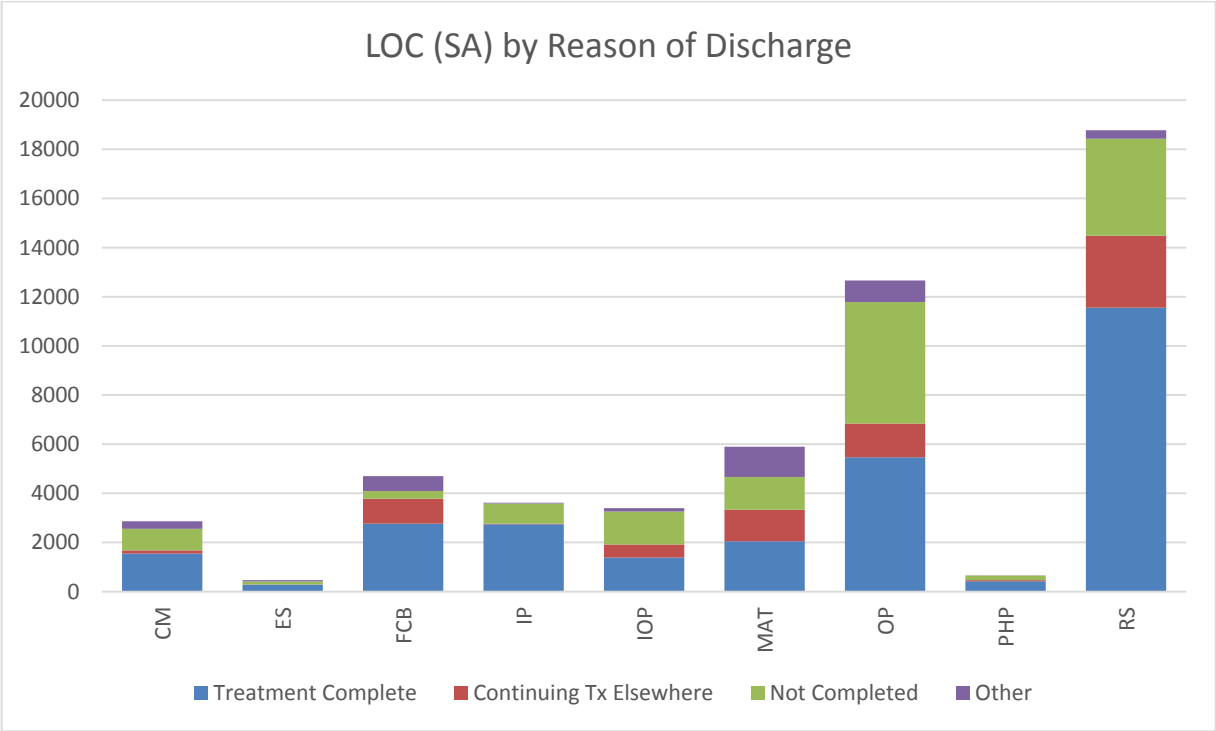
Reason for Discharge by Type of Service/ Level of Care

The table below illustrates the differences in reason for discharge across various types of **substance abuse treatment services**. For example, the highest rate for "treatment complete" is for inpatient treatment (75.8%), which makes sense: the person is discharged when deemed to no longer need that level of care. 80.5% of clients in community-based forensic services are either "treatment complete" or "continuing treatment elsewhere." That makes sense as for that population treatment is often mandated. Of more concern would be "outpatient," where only 54.1% are discharged either because treatment was complete or they moved to a different level of care and "case management" where 58.7% complete or continue care at another level.

Type	Level of Care	Discharge reason				Total
		Treatment (Tx) Complete	Continuing Tx Elsewhere	Not Completed	Other	
SA Tx	SUBSTANCE ABUSE TREATMENT					
	Case Management	1546	134	879	306	2865
		54.0%	4.7%	30.7%	10.7%	100.0%
	Employment Services	285	4	126	54	469
		60.8%	0.9%	26.9%	11.5%	100.0%
	Forensics Community-based	2765	1014	315	604	4698
		58.9%	21.6%	6.7%	12.9%	100.0%
	Inpatient Services	2740	22	820	34	3616
		75.8%	0.6%	22.7%	0.9%	100.0%
	IOP	1382	538	1339	138	3397
		40.7%	15.8%	39.4%	4.1%	100.0%
	Medication Assisted Treatment	2046	1282	1338	1231	5897
		34.7%	21.7%	22.7%	20.9%	100.0%
	Outpatient	5465	1379	4936	880	12660
		43.2%	10.9%	39.0%	7.0%	100.0%
	PHP	421	43	190	9	663
		63.5%	6.5%	28.7%	1.4%	100.0%
	Residential Services	11553	2932	3947	347	18779
		61.5%	15.6%	21.0%	1.8%	100.0%
	Total	28203	7348	13890	3603	53044
		53.2%	13.9%	26.2%	6.8%	100.0%

MENTAL HEALTH SERVICES					
ACT	48	124	73	61	306
	15.7%	40.5%	23.9%	19.9%	100.0%
Case Management	511	311	642	510	1974
	25.9%	15.8%	32.5%	25.8%	100.0%
Community Support	757	647	395	123	1922
	39.4%	33.7%	20.6%	6.4%	100.0%
Crisis Services	1190	2581	281	824	4876
	24.4%	52.9%	5.8%	16.9%	100.0%
Education Support	32	19	57	14	122
	26.2%	15.6%	46.7%	11.5%	100.0%
Employment Services	612	288	819	293	2012
	30.4%	14.3%	40.7%	14.6%	100.0%
Forensics Community-based	621	237	157	515	1530
	40.6%	15.5%	10.3%	33.7%	100.0%
Housing Services	3	94	2	3	102
	2.9%	92.2%	2.0%	2.9%	100.0%
Inpatient Services	530	259	14	128	931
	56.9%	27.8%	1.5%	13.7%	100.0%
Intake	72	143	204	186	605
	11.9%	23.6%	33.7%	30.7%	100.0%
IOP	284	160	109	21	574
	49.5%	27.9%	19.0%	3.7%	100.0%
Outpatient	2573	2868	5953	1210	12604
	20.4%	22.8%	47.2%	9.6%	100.0%
Prevention	1	3	38	22	64
	1.6%	4.7%	59.4%	34.4%	100.0%
Residential Services	355	495	244	69	1163
	30.5%	42.6%	21.0%	5.9%	100.0%
Social Rehabilitation	594	186	591	130	1501
	39.6%	12.4%	39.4%	8.7%	100.0%
Total	8183	8415	9579	4109	30286
	27.0%	27.8%	31.6%	13.6%	100.0%

This information is rendered graphically, below.



CM=Case Management; ES=Employment Services; FCB=Forensics Community-based; IP=Inpatient Services; MAT=Medication Assisted Treatment; OP=Outpatient; Prev=Prevention; RS=Residential Services; SR= Social Rehabilitation

Percent of Clients Receiving Care in Their Region of Residence

Most clients receive services in the region in which they live, with the notable exceptions of inpatient and residential services.

That reflects that an appropriate inpatient bed, or space within residential substance abuse services, may only be available in another region and cross region referrals are common.

	% Clients Receiving Care within Their Region of Residence	
Care Type	**Yes**	**No**
Crisis	96.8%	3.2%
Inpatient or Residential	66.3%	33.7%
Clinical Outpatient	92.7%	7.3%
Case Management	84.7%	15.3%
Recovery	97.3%	2.7%

Criminal Justice Involvement

Unduplicated Active Clients -based on all assessments in fiscal 2015

Fortunately, only 7.1% of clients in Region 5 (inclusive of mental illness and substance use disorders) had involvement with the criminal justice system, although that is the highest of any region and is above the state average of 5.6%.

	Program Regions					Total
	Region 1	Region 2	Region 3	Region 4	Region 5	
Yes, CJ Involved (n of arrests>0)	928	1239	648	2045	1092	5952
	6.3%	4.4%	4.2%	6.4%	7.1%	5.6%
No, not CJ Involved (n of arrests=0)	12700	22200	13857	27731	13370	89858
	86.7%	78.0%	89.2%	86.7%	87.4%	84.8%
Unknown	1027	5016	1024	2193	841	10101
	7.0%	17.6%	6.6%	6.9%	5.5%	9.5%
Total	14655	28455	15529	31969	15303	105911
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

APPENDIX 5: DETAIL REGARDING SUBSTANCE ABUSE TREATMENT AND TYPES OF DRUGS USED

Abstinence from Alcohol and Drug Use
Unduplicated Active Clients (based on primary drug)

		Program Region					Total
		Region 1	Region 2	Region 3	Region 4	Region 5	
Yes, abstinent		6346	12019	5710	12499	6416	42990
		57.4%	54.6%	49.0%	53.7%	52.2%	53.5%
No, abstinent		4545	9211	5723	10706	5593	35778
		41.1%	41.9%	49.1%	46.0%	45.5%	44.6%
NA		164	779	216	86	276	1521
		1.5%	3.5%	1.9%	0.4%	2.2%	1.9%
Total		11055	22009	11649	23291	12285	80289
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Yes, abstinent = Days used in last 30 days =0
No, not abstinent = Days used in last 30 days>0
NA= No drug use reported

Alcohol and Drug Use (based on up to 3 drugs reported)

		Program Region					Total
		Region 1	Region 2	Region 3	Region 4	Region 5	
Yes, abstinent		5520	9934	5151	11191	5705	37501
		49.9%	45.1%	44.2%	48.0%	46.4%	46.7%
No, abstinent		5371	11296	6282	12014	6304	41267
		48.6%	51.3%	53.9%	51.6%	51.3%	51.4%
NA		164	779	216	86	276	1521
		1.5%	3.5%	1.9%	0.4%	2.2%	1.9%
Total		11055	22009	11649	23291	12285	80289
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Yes, abstinent = Days used in last 30 days =0
No, not abstinent = Days used in last 30 days>0
NA= No drug use reported

Reported primary Drug Used (at the time of admission to treatment)

Primary drug at admission: all active clients

While alcohol and heroin tied as the primary drug at admission for the majority of people served in these programs tracked, “other opiates” was higher for this region than any other. Just shy of 40% were admitted for some kind of opiate.

		Program region					Total
		Region 1	Region 2	Region 3	Region 4	Region 5	
	Alcohol	1737	6362	2682	5207	2311	18299
		26.4%	41.2%	44.6%	36.3%	33.5%	37.2%
	Heroin, Non-prescription Methadone	2642	4835	1705	4809	2310	16301
		40.2%	31.3%	28.3%	33.5%	33.5%	33.1%
	Other Opiates	337	651	360	416	437	2201
		5.1%	4.2%	6.0%	2.9%	6.3%	4.5%
	Crack, Cocaine	490	1276	390	912	583	3651
		7.5%	8.3%	6.5%	6.4%	8.5%	7.4%
	Marijuana, Hashish, THC	919	1489	759	2531	1005	6703
		14.0%	9.7%	12.6%	17.7%	14.6%	13.6%
	Other	447	814	121	461	246	2089
		6.8%	5.3%	2.0%	3.2%	3.6%	4.2%
Total		6572	15427	6017	14336	6892	49244
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

On the next page is a chart that looks more closely at the Young Adult population.

Reported primary Drug Used (at the time of admission to treatment)

Primary drug at admission for **young adults** in Region 5 (18-25, fifth column)

This chart emphasizes the primary drug at admission for young adults. There is one additional column (on the far right of the chart) that has the data for all ages, in Region 5. It is included in this chart for ease of comparison to the Young Adult data.

The most striking difference in the primary drug at admission for young adults versus all age groups was the lower level for alcohol use: 33.5% for the all-age group vs. 18.2% for young adults. This may reflect lower use or lower problems related to alcohol at this age as compared to other drugs.

Three drugs tracked (heroin, non-prescription methadone, and other opiates) are opiates. When considered together, this makes opiate the highest use group at 39.8% for all ages and 46.5%for young adults, making opiate use the #1 drug at admission for that age group.

The inverse was true for marijuana, hashish, THC where young adult admissions were at 28.8% whereas for all ages it was 14.6%.

		Program region					Total	
		Region 1	Region 2	Region 3	Region 4	Region 5		All ages/ region 5
Drug	Alcohol	156	574	228	629	228	1815	2311
		15.0%	25.6%	24.2%	25.1%	18.2%	22.7%	33.5%
	Heroin, Non-Prescription Methadone	376	850	322	725	499	2772	2310
		36.2%	37.9%	34.2%	28.9%	39.8%	34.7%	33.5%
	Other Opiates	44	107	62	58	84	355	437
		4.2%	4.8%	6.6%	2.3%	6.7%	4.4%	6.3%
	Crack, Cocaine	18	87	28	54	26	213	583
		1.7%	3.9%	3.0%	2.2%	2.1%	2.7%	8.5%
	Marijuana, Hashish, THC	387	513	275	974	361	2510	1005
		37.3%	22.9%	29.2%	38.8%	28.8%	31.4%	14.6%
	Other	57	114	27	68	57	323	246
		5.5%	5.1%	2.9%	2.7%	4.5%	4.0%	3.6%
Total		1038	2245	942	2508	1255	7988	
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Region 5 was neither the highest nor the lowest for any category except for “other opiates” and “marijuana, hashish and THC,” each of which was higher than any of the other regions.

Reported use of all drugs at admission – all ages

The following chart details what drugs – all of them – clients (all ages) reported using at the time of admission for treatment. The total percentages add up to much more that 100% as many individuals reported using more than one.

For all ages, alcohol was the most frequent, followed by heroin /non-prescription methadone.

For comparison, we have added a column at the far right of this chart which details the drugs used by Young Adults (age 18-25) in Region 5. The profiles of young adults when compared to the all-age group are quite different. Note the higher use of all drugs *except* for alcohol (48.4% vs. 35.4%) and crack/ cocaine (19.5% vs. 31%).

The totals add up to far more than 100% because many admissions involved more than one drug.

		Program Region					Total	YAs
		Region 1	Region 2	Region 3	Region 4	Region 5		Reg.5
drug	Alcohol	2740	8026	3377	6742	3333	24218	446
		41.7%	52.0%	56.1%	47.0%	48.4%		35.4%
	Heroin, Non-Prescriptive Methadone	3044	6811	2102	5661	2790	20408	586
		46.3%	44.1%	34.9%	39.5%	40.5%		46.5%
	Other Opiates	678	1427	813	1154	1023	5095	201
		10.3%	9.2%	13.5%	8.0%	14.8%		16.0%
	Crack, Cocaine	1941	5475	1565	4264	2135	15380	246
		29.5%	35.5%	26.0%	29.7%	31.0%		19.5%
	Marijuana, Hashish, THC	1907	5097	1902	4889	2483	16278	711
		29.0%	33.0%	31.6%	34.1%	36.0%		56.4%
	Other	1119	2681	523	3629	979	8931	233
		17.0%	17.4%	8.7%	25.3%	14.2%		18.5%
Total		6574	15434	6017	14336	6892	49253	1260

*clients can report more than one types of drug, % is based on the number of clients in each region.